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Notes for contributors

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Foreword

The report of the Joint Parliamentary Scrutiny Committee on the *Draft Mental Health Bill 2004* was published just prior to the publication of the May 2005 issue of the JMHL. Indeed readers may recall that Lucy Scott-Moncrieff generously found the time to provide within that issue a personal, preliminary and speedy response to their findings[1].

In July 2005 the Government responded to the Committee's report[2]. Some of the Committee's recommendations were accepted wholly or in part, but the Government indicated its disagreement with various parts of the report. The Introduction to the response concluded as follows:

> 'Plans to introduce the Mental Health Bill into Parliament in this session were announced in the Queen's Speech. We are now redrafting the Bill to take account of changes to be made following consideration of the Committee's report. We are also looking at a number of other issues, mainly technical ones, that have arisen.'

As this issue of the JMHL goes to press, no Bill has been introduced. Press reports indicated that it had been shelved[3], but there has been no official announcement confirming this. On the contrary, Department of Health activities such as their consultation on the race equality impact assessment on the Bill[4], would suggest a continuing intention to proceed. Presumably the position will be clearer by the time of publication of the May 2006 issue.

In the meantime, this issue of the JMHL provides an opportunity for further reflection on the Government's response to the Scrutiny Committee's Report, and on provisions within the 2004 Draft Bill.

We begin with a thought-provoking comment by Alex Carlile, the chair of the Scrutiny Committee. In '**Legislation to Law: Rubicon or Styx?**', Lord Carlile Q.C. explains the work of the Committee before focusing on three areas which gave its members 'especial pause for thought'. He provides a brief comment on the Government's response, before concluding with an expression of hope that when the time comes for Parliament to debate the subject, the work of the Committee will be looked at with 'analytical determination'. Few will disagree with his plea that 'the opportunity must not be wasted'.

Phil Fennell was the specialist legal advisor to the Scrutiny Committee. As such he was ideally placed to hear the evidence presented, and to observe the Committee's analysis of it. In his article '**Protection! Protection! Protection! Déjà vu all over again**', he pays tribute to the Committee's work, and in the course of his careful reflection on aspects of the Government's response, he expresses considerable concern about what he describes as 'the Government's grudging approach' to the Committee's recommendations. Early in the article, Professor Fennell helpfully looks back over the various stages of 'reform', commencing with the appointment of the Expert Committee in 1998[5].

There can be little doubt that the various nearest relative 'provisions' within the *Mental Health Act 1983* have given rise to growing concern over the years. The *Human Rights Act 1998* has enabled the Courts to rectify some of the resulting injustices[6], but imaginative judicial interpretation has not always been possible[7]. It is not surprising that one area on which for some time there would appear to

1 *'A sense of 'Déjà Vu'' pp 77 - 82, JMHL May 2005.*

2 *Cm 6624 (July 2005).*

3 *The Independent on Sunday 30/10/05; the Guardian 31/10/05*

4 *Gateway ref. no. 5796 - the consultation was open until 25/11/05.*

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

6 *For example, R (on the appl'n of SSG) v Liverpool City Council (1) Secretary of State for Health (2) and LS (interested party) (Admin. Court) (22/10/02)*

7 *For example, R (on the appl'n of M) v Secretary of State for Health [2003] EWHC 1094 (Admin)*

have been consensus[8] over the need for change, has been these provisions. So the 'nearest relative' is to disappear, and instead statute is to create the 'nominated person'. Victoria Yeates in her article '**Death of the Nearest Relative?...**' expands on the Scrutiny Committee's concerns about this creation, and powerfully argues that the nominated person provisions as presently drafted 'represent a significant erosion of the rights of families'. Ms. Yeates contends that 'enlightened mental health legislation should achieve a balance between respect for patient autonomy and empowering those who know and care for them, to bring mental health professionals to the negotiating table to achieve the most appropriate outcome', and by implication she invites readers to conclude that the Bill's provisions will not have that result.

Writing in the Guardian in March 2005, David Brindle, their public services editor, submitted that the forthcoming general election offered an opportunity for reflection on mental health law reform, and 'in the event of another Labour victory, quiet burial of the big-bang approach to reform'[9]. Instead he suggested that 'new ministers should take a deep breath, revisit the *1983 Mental Health Act* ..... and consider how it could be modified further to meet their main objectives'. David Hewitt, writing in the Times in the same month[10], did not make the same suggestion, but he did pursue a comparable theme, and within this issue of the JMHL he has expanded upon it. Mr. Hewitt (recently appointed as a Visiting Fellow to Northumbria University's Law School) suggests that in making its current proposals, the Government has held up '**An Inconvenient Mirror**', and he asks '**Do we already have the next Mental Health Act?**'. He looks at the changes which have been made to the 1983 Act over the last twenty years by Parliament and the Courts, and he concludes that they may have 'brought us rather close to the *Draft Mental Health Bill*', adding that 'that will be an uncomfortable thought for many people'.

In the May 2005 issue, Denzil Lush, the Master of the Court of Protection, described how the *Mental Capacity Act 2005* will change the role of that court[11]. With the Act coming into effect in April 2007, it is highly appropriate that within this issue we are able to publish two further articles about the Act. Penny Letts was specialist advisor to the Joint Parliamentary Scrutiny Committee on the *Draft Mental Incapacity Bill*, and therefore (like Professor Fennell in respect of the *Draft Mental Health Bill*) is very well qualified to write about '**The *Mental Capacity Act 2005*: the Statutory Principles and Best Interests Test**'. Ms. Letts provides invaluable guidance to the five statutory principles intended to underline the Act's provisions, before going on to consider in greater depth the principle of acting in the best interests of an incapacitated person. Phil Fennell generously makes a second contribution to this issue with his consideration of '**The *Mental Capacity Act 2005*, the *Mental Health Act 1983* and the Common Law**'. He re-visits what he calls the 'interface' question – 'When may the common law or, after 2007 the *2005 Mental Capacity Act*, be used to admit to institutional care and treat without consent, and when will use of the *Mental Health Act* be required?'. He suggests that 'in determining how to bridge what has become know as the 'Bournewood Gap'', it is not only the decision in *HL v United Kingdom*[12] which needs to be considered but also the decision of the European Court in the summer of 2005 in *Storck v Germany*[13].

Those who read the article by Ms. Scott-Moncrieff referred to in the opening paragraph of this Foreword, may recall her firm conclusion that 'the Government should seriously consider adopting the Scottish Act; lock, stock and barrel'. She was referring of course to the *Mental Health (Care and Treatment) (Scotland) Act 2003*. Hilary Patrick was a member of the Millan Committee[14], and so she

8 *For example, paragraph 12.18 of the Expert Committee's Report called for 'the new Act to make provision for the identification of a 'nominated person''.*

9 *Society Guardian 30/3/05*

10 *Times Law, 29/3/05*

11' *The Mental Capacity Act and the new Court of Protection' JMHL May 2005, pp 31-40*

12 *Application no. 45508/99. ECtHR judgment 5/10/04*

13 *Application no. 61603/00. ECtHR judgment 16/6/05*

14 *The Millan Committee's report 'New Directions' was published by the Scottish Executive in January 2001.*

has been close to developments in Scotland for some time. Whilst acknowledging that Scotland 'leads the way in mental health and social care reform in the UK', Ms. Patrick shares within this issue of the JMHL, '**Reflections from Scotland**', and in so doing she identifies '**Difficult decisions ahead**'. In particular she considers problems with the *Adults with Incapacity (Scotland) Act 2000*, before expressing other concerns in relation to vulnerable adults.

Litigation within the world of mental health law continues unabated. Perhaps of most significance in the period since the last issue was published, have been the pronouncements from the House of Lords in two particular cases – in both instances allowing appeals from the Court of Appeal. On 13th October, in *R v Ashworth Hospital Authority (now Mersey Care National Health Service Trust) ex parte Munjaz*[15], their Lordships (by a majority) reasserted that the provisions of the Code of Practice are guidance not instruction, and that Ashworth HSH was entitled to have a seclusion policy which deviated from the Code's provisions in relation to seclusion, provided it was compatible with the European Convention on Human Rights ... and they concluded that it was so compatible. A week later in *R (on the application of MH) v Secretary of State for Health (and others)*[16], their Lordships unanimously quashed the declarations of incompatibility which had been made in the lower court in respect of 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. Time has not allowed for a detailed analysis of these decision within this issue (but hopefully this can be rectified in the next issue), but an earlier decision by the House of Lords on the relevance of mental disorder classification – *R (on the application of B) v Ashworth Hospital Authority*[17] – is subjected to critical analysis by Kris Gledhill in '**The House of Lords and the Unimportance of Classification: A Retrograde Step**'.

Two other cases – both of considerable practical significance for practitioners – are covered within this issue. In '**'Hospital' treatment further defined**', Susan Thompson and Stuart Marchant review the judgment of Mr. Justice Ptichford in the case of *R (on the application of CS) v MHRT and Managers of Homerton Hospital (East London and the City Mental Health Trust)*[18], whilst in '**The Balancing Act**', Helen Kingston considers the consequences (particularly for approved social workers) of Mr. Justice Bennett's decision in *R (on the application of E) v Bristol City Council*[19].

The issue concludes with one book review. Professor Herschel Prins has been at the forefront of the debate about the plight of offenders with mental health problems for many years. The first edition of his book '**Offenders, Deviants or Patients?**' was first published 25 years ago. Dr. Celia Taylor, a consultant forensic psychiatrist, welcomes the third edition which was published in 2005[20], finding it to be 'an extremely perceptive book'.

As always, we are very grateful to all those who have so generously contributed to this issue of the JMHL. I must apologise both to them and to all subscribers, that there has been a delay in its publication. Every effort will be made to minimise the risk of a similar delay with the May 2006 issue.

John Horne

Editor

15 *[2005] UKHL 58*
16 *[2005] UKHL 60*
17 *[2005] UKHL 20*
18 *[2004] EWHC 2958 (Admin)*
19 *[2005] EWHC 74 (Admin)*
20 *Taylor & Francis Ltd (2005)*

Legislation to Law: Rubicon or Styx?

Alex Carlile[1]

I wrote this article as a reflection on the activities of the Joint Scrutiny Committee on the Draft Mental Health Bill 2004[2]. My credentials for authorship are that I acted as the Chair of the Committee, elected by the Committee at the beginning of its proceedings.

An important factor in recent events is the placing of the draft Bill before such a committee. What is a Scrutiny Committee?

Normal Parliamentary procedure for legislation involves sequentially five stages in each House of Parliament – first reading (publication without debate); second reading (debate on principles on the floor of the House); committee stage (clause by clause analysis, usually by a Standing Committee in the Commons and in committee of the whole House in the Lords); Report stage on the floor of the House, with some major amendments debated; and third reading (final set piece debate with vote as to whether the Bill as amended should be passed) . With arcane exceptions and variations all Bills have to go through these procedures prior to receiving the Royal Assent. Implementation may be delayed thereafter, and often is to enable structures to be established so that the new laws can be effective. Delay in implementation may be of especial importance where there is significant change to an old set of standards or public bodies.

Relatively new procedures allow for a prolonged but better informed procedure. By resolution of the Houses of Parliament a special Select Committee, described as a scrutiny committee, can be established to consider and advise on a draft Bill. This route to new legislation is intended to be of especial utility where the reform of the law does not involve significant party political controversy, and where a powerful evidence base would be advantageous in determining the final shape of the Bill. It is useful too on an issue like the compulsory use of mental health powers, where there are well-informed groups with divergent opinions. A conventional legislative Standing Committee does not receive and hear evidence in the normal course of events. A Scrutiny Committee does.

Our report on the Draft Mental Health Bill followed a call for papers to which over 450 responses were received. Having seen them all I know their range, from comments faxed on the front of a cereal packet to hefty policy papers. All interested public bodies contributed, many practitioners, and a considerable cohort of service users. From the respondents we invited 124 witnesses to give oral evidence, taken at some speed but after full consideration and analysis of their written submissions.

1 *Lord Carlile of Berriew, Q.C.*

2 *Draft Mental Health Bill Cm6305–1*

We made 107 recommendations for change to the Draft Bill[3]. That there were so many changes to be made was surprising given that there had been a previous attempt at a Bill[4], and before that, the detailed advice of an expert committee chaired by Professor Genevra Richardson, of London University[5]. Our proposed changes dealt with many matters of detail, but with some core issues too. For the purposes of this article, I focus on three areas that caused us especial pause for thought.

A significant part of the Bill is designed to deal with the small group of severely disordered patients often described as suffering from Dangerous Severe Personality Disorder [DSPD]. This group can represent a totally unpredictable and very real danger to the life and safety of others and themselves. There have been some very well publicised cases of DSPD sufferers who have been known to mental health services, been detained and/or treated and at some later time have murdered others either close to them (including in at least one case their social worker) or some member of the public chosen more or less at random. Naturally there is a desire at large to anticipate and limit the damage DSPD cases may cause. The stories make good news copy, lend themselves to exaggeration in terms of the mental health treatment potential available, and worst of all excite all too easily demands by elected politicians that "something should be done", usually equated with the assumption that something can be done.

The Committee was firmly of the view that where there is treatment available and a degree of therapeutic benefit, compulsory powers may well have a part to play in DSPD. This conclusion was consistent with the position in Scotland following recent legislation there. However, the Committee was always clear that the Bill was fundamentally flawed and too focused on addressing public misconception about violence and mental illness, in effect creating mental health ASBOs. We had no doubt that hospitals and their clinical staff should not be placed in the position of least worst jailers without any realistic medical intervention taking place.

The second area I would highlight here relates to the proposals for the use of compulsory powers in the community. These proposals, which reflects changes in (for example) parts of Australia, were drafted in an unrestricted way that could have the effect of hugely increasing the number of patients subject to compulsory powers. After hearing evidence almost all pointing in the same direction, the Committee was clear on this issue. It would be unacceptable to have thousands of new compulsory patients, hitherto considered as not requiring compulsion, who would be in the community but with a Sword of Damocles hanging over them should they put a foot wrong, psychiatrically speaking.

The Committee's view was that there may be some cases for whom community powers would be useful, but they would be few in number and circumscribed by the Act and Codes of Practice. A good use of such powers might be to ensure the continued use of critically important medication, including depot injections.

The third area I highlight is the important issue of the change from Mental Health Review Tribunals [MHRT] to Mental Health Tribunals [MHT]. It is accepted by all informed sources that an effect of the proposed new legislation would be to increase enormously the number of sittings of the new MHT, and the need for legally qualified chairs and other members. This produced

3 *Joint Committee Report on the Draft Mental Health Bill 23rd March 2005*

4 *Draft Mental Health Bill 2002 Cm 5538–I*

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

powerful evidence from the MHRT regional heads, and a real concern in the minds of the Committee members that there would be chaos unless the MHT was staffed and funded properly before the system comes into force.

The government response to our report was mixed[6]. At the time of its publication on the 12th July 2005, I accepted that the government had responded with significant improvements, but said that there was still a long way to go.

On the DSPD issue, although the language of the response could be taken as a rejection of the Committee's views, in fairness I consider that there is far less difference in substance than in language, once one jumps off the head of a semantic pin. Our insistence on therapeutic benefit was rejected. However, clarification on the floor of Parliament of what Ministers intend may well lead to the conclusion that the language of detention will reflect a reality of treatment. There may be some differences as to what therapeutic benefit consists of, for example if effectively it merely sedates or changes mood without addressing the underlying condition to any meaningful extent. However, I am hopeful that no clinician of whatever kind will be required by law to detain any patient in what might generally be described as an ethically unacceptable framework.

On the question of compulsion in the community, it was accepted that the principles for this new regime should be set out on the face of the Bill. This is certain to have the effect of limiting the scope and range of such orders, so that they will be used in a modest number of cases and hopefully to good effect.

On the third issue raised above, the government agreed to look again at the existing model for mental health tribunals, to see whether alternative options were available to safeguard patients' rights, while being more practical. There is a commitment that the tribunals must be ready to meet the new legal framework. My informal soundings leave me in no doubt that a good deal of work is being done on this within government, but that there is limited confidence amongst tribunal members that the new system will be fit for purpose on the day it opens for business.

Space does not permit a more detailed analysis of the government's response. We hope that they mean what they say about welcoming our recommendation that national training standards are created in the move from approved social workers to approved mental health professionals; and the need to review the costs of setting up mental health advocacy services; and that the Codes of Practice should restrict the use of compulsion for people suffering from learning disabilities, or from communicative disorders such as Autism or Asperger's Syndrome.

We hope too that Parliament as a whole, when debating the subject, will look with analytical determination at the report of their own Scrutiny Committee, made up of 24 interested and united members of both Houses, some with real material professional expertise, who considered and reported on a solid and representative evidence base. There is unlikely to be another major legislative slot for compulsory mental health powers in the next 20 years. This opportunity must not be wasted.

6 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill Cm6624 (July 2005)*

Protection! Protection! Protection! Déjà vu all over again. The Government Response to the Parliamentary Scrutiny Committee

Phil Fennell[1]

This article discusses the Government's Response to the Joint Parliamentary Scrutiny Committee Report on the Draft Mental Health Bill[2], from the bias of someone who served as the specialist legal adviser to the Committee.[3] The point of Pre-Parliamentary Scrutiny was explained by the House of Commons Modernisation Committee in 1998 as follows:

> 'Pre legislative scrutiny provides an opportunity for the house as a whole, for individual back-benchers and for the opposition to have a real input into the form of the actual legislation which subsequently emerges, not least because ministers are likely to be far more receptive to suggestions for change before the Bill is actually published. It opens Parliament up to those outside affected by legislation ... above all it should lead to better legislation and less likelihood of amending legislation'.[4]

1 *Professor of Law, Cardiff Law School*

2 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill 2004 Cm 6624 (July 2005)*

3 *I should like to pay tribute to the Commons and Lords and Committee Clerks and Managers who make this system work. Their ability rapidly to come to grips with mental health law and policy, to organise evidence sessions, and to manage the effective scrutiny of a complex Bill of more than 300 clauses effectively between October 2004 and late February 2005 impressed me immensely, as did the quality of the Committee and its Chairman. Together with Professor Tom Burns they made the most remarkable team of people I have ever had the pleasure of working with.*

4 *HC Modernisation Committee The Legislation Process (1997–1998 session HC 190 para 20)*

Scrutiny gives the key 'stakeholders' in draft legislation, to use Government parlance, the opportunity to voice their views on its workability and desirability. On its establishment in the summer of 2004, the Joint Parliamentary Scrutiny Committee on the Draft Mental Health Bill invited written evidence in response to a series of questions, asking whether the Draft Bill:

- Was based on unambiguous principles, which were both appropriate and desirable?
- Used a definition of mental disorder that was appropriate and unambiguous?
- Contained provisions for care and treatment in the community which were adequate and sufficient?
- Set conditions of compulsion which were sufficiently stringent?
- Achieved the right balance between protecting the personal and human rights of mentally ill people on the one hand and concerns for public and personal safety on the other?
- Was adequately integrated with what was then the Mental Capacity Bill? While the Committee was sitting, the European Court of Human Rights delivered judgment in *HL v United Kingdom* Judgment of 5 October 2004, requiring amendments to be tabled to the Mental Capacity Bill.
- Was in full compliance with the Human Rights Act 1998?

Finally the Committee asked those submitting evidence to comment on the human and financial resource implications of the draft Bill, whether the Government had analysed the effects of the Bill adequately, and whether sufficient resources would be available to cover any cost arising from the implementation of the Bill?

The Joint Committee received over 450 written submissions and heard evidence from 124 witnesses including representatives of all the professional groups involved in mental health care, from service users and from carers, and from all the key non-governmental organisations, including MIND, Rethink, Hafal, the King's Fund, and the Zito Trust, which represents victims and families of victims of mentally disordered offenders, from the Law Society, from the Bar Council, and from the Mental Health Review Tribunal. The evidence was of an extremely high quality, and the Committee was clearly moved by the testimony of service users and carers. The overwhelming weight of evidence was highly critical of the Bill.

In March 2005 the Committee reported, recommending a radical overhaul of the Bill.[5] Describing the case for reform as cogent, but not overwhelming, the Committee made 107 recommendations. Many of the changes proposed were based on the Scottish legislation, such as that guiding principles should appear on the face of the Bill, that conditions of compulsion should be introduced that the person's judgment in relation to accepting treatment was significantly impaired, and a condition of likely therapeutic benefit. The Committee accepted the broad definition of mental disorder used in the Bill, but recommended that there be exclusions stating that a person should not be treated as mentally disordered by reason only of addiction to alcohol or drugs. This has been accepted by the Government. However, the Government Response loftily dismissed many of the Committee's core concerns on the grounds that they 'miss the point' of mental health legislation. This article suggests that, far from missing the point, the Scrutiny Committee have identified key flaws in the Draft Bill.

5 *House of Lords House of Commons Joint Committee Report on the Draft Mental Health Bill, Session 2004–2005 HL Paper 79-1, HC 95-1. Session 2004–2005.*

In order to understand the Government's repeated rejection of criticism of its reform proposals, it is important to appreciate the importance of the public safety agenda as a driver of Government policy and to outline the key features of the reform process before turning to the Scrutiny Committee Report and the Government response.

The Process of Reform

This effectively began in 1998 with the famous pep talk from the then Health Minister Paul Boateng to Professor Genevra Richardson's Expert Committee that, whilst they were at liberty to consider 'root and branch reform', they should remember the Government's key imperative, to 'make clear that non-compliance with agreed treatment plans is not an option.' The Richardson Committee recommended a system that employed a broad definition of mental disorder, but narrower accompanying criteria for compulsion, that dispensed with the statutory review function of hospital managers, which removed the rights of the nearest relative, that provided for a single pathway to compulsion regardless of whether compulsion was to be in hospital or in the community, and that placed the Mental Health Tribunal at the centre of the system of safeguards, authorising compulsion, hearing applications for review of compulsion, and approving the compulsory treatment plan. Under their proposals, after 28 days compulsory assessment, a tribunal would authorise compulsory treatment either in hospital or in the community. The Committee sidestepped the issue of how compulsory powers in the community would be enforced. Clear undertakings had already been given by Minister Boateng at the committee launch, that compulsory treatment in the community did not mean forcibly injecting people on their kitchen tables. The Committee did not say anything about enforcement in the event of non-compliance with medication in the community.

The Richardson Committee was concerned that the broad concept of mental disorder might lead to a potential 'net widening' effect. Because of this, and their concern to produce a non-discriminatory and principled framework for intervention in the absence of consent, the Committee recommended the introduction of strict accompanying conditions of compulsion, including a capacity test.[6] Under their proposals anyone who lacked capacity could be subject to compulsion if necessary for their own health, or safety, or for the protection of others. Anyone retaining capacity could be subject to compulsion only if there was a substantial risk of serious harm to the health or safety of the patient or to the safety of others. The Committee also proposed a further condition of compulsion that there must be positive clinical measures, which were likely to prevent deterioration or secure an improvement in the patient's condition. Without this, they said, healthcare professionals might be forced 'to engage in activities they would regard as inappropriate and possibly unethical.'[7]

Richardson attached great importance to the inclusion of principles on the face of the Act which in their view would be educative and would provide a guide as to how provisions should be interpreted. The Committee recommended that some principles should be spelt out on the face of the legislation, whilst others should be reflected in the Code of Practice.[8] They regarded the principle of non-discrimination on grounds of mental health as central to the provision of

6 *Report of the Expert Committee, Review of the Mental Health Act 1983 DoH 1999, para 5.96.*

7 *Ibid., para 5.99.*

8 *Report of the Expert Committee, Review of the Mental Health Act 1983 DoH 1999, paras 2.14 – 2.25.*

treatment and care to those suffering from mental disorder. However, they also recognized that it would not be appropriate to express the principle within the legislation itself. Instead they endorsed the approach of giving considerable emphasis in the Code of Practice to the principle that wherever possible the principles governing mental health care should be the same as those which govern physical health.

The Committee also recommended that the legislation should state one of its main purposes as being recognizing and enhancing patient autonomy. They then went on to list ten principles, noting at the outset that they did not intend them to be susceptible of specific enforcement on the part of individuals. The principles advocated included the least restrictive alternative, that necessary care, treatment and support be provided both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account of the safety of other patients, carers and staff. The other principles recommended included that there should be a preference for informal and consensual care, reciprocity, participation, equality, respect for diversity, recognition of carers, provision of information, and effective communication.

As is well known to readers of this journal, the Government selected the features of the report that pleased them, and rejected those that conflicted with the public safety agenda[9]. They rejected the idea of having any principles on the face of the legislation, in favour of aims to be fleshed out by principles in a 'less binding' Code of Practice. They accepted the broad definition of mental disorder, but rejected the more limiting conditions of compulsion. Most important, they accepted the central role for the Mental Health Tribunal in imposing compulsion. The Government built on the Richardson Committee's rationale that because the central safeguard was a judicial body, other safeguards could be watered down or dispensed with, such as the right of objection to compulsion vested in nearest relatives, and the statutory second opinion system in relation to treatment without consent.

In 2000, the Government issued a two volume White Paper, *Part 1 The New Legal Framework, and Part 2 High Risk Patients*[10], following which the Department of Health and the Home Office together produced the Draft Mental Health Bill 2002, lauding their own efforts as an example of 'joined-up government'.[11] The crucial factor in any understanding of the process of mental health law reform, and the reason for the repeated rejection of criticism of the Draft Bills is that the Home Office has been the dominant partner, and the Department of Health has tended to fall in line with a public safety agenda.

Although issued after policy was formed, the evidence base for Government policy on mental health law reform consists mainly of the findings of the *National Confidential Inquiry into Homicides by Mentally Disordered People* which reported in 2001. The Inquiry, due to report again in 2006, found that around one third of all perpetrators of homicide in England and Wales had a diagnosis of mental disorder based on life history. It must be remembered that this is mental disorder in the general sense and includes alcohol dependence, drug dependence and personality disorder, which were by far the most common diagnoses in this group. Fifteen percent had

9 *The Government's initial response was: 'Reform of the Mental Health Act 1983 – Proposals for Consultation'. Cm 4480 (November 1999)*

10 *Reforming the Mental Health Act, Part 1 The New Legal Framework, and Part 2 High Risk Patients, Cm 5016-1 and 2, 2000.*

11 *P. Fennell, 'Joined Up Compulsion: The White Paper on Reform of the Mental Health Act 1983' Journal of Mental Health Law June 2001, pp5–20.*

symptoms of mental illness at the time of the offence, and five per cent of all perpetrators had a diagnosis of schizophrenia. Nine per cent had a diagnosis of personality disorder. Alcohol and drugs were more likely to contribute to the offence in people convicted of homicide who were not mentally ill, and alcohol is a factor in 50% of all homicides.

A longitudinal survey of mental illness in people who kill strangers published in 2004 concluded that whilst stranger homicides increased between 1967 and 1997, the increase was not the result of homicides by mentally ill people and therefore the "care in the community" policy. Stranger homicides are more likely to be related to alcohol or drug misuse by young men, and alcohol was a factor in 56% of stranger homicides.[12]

The homicide statistics for 2002 show that in each year the number of people convicted of homicide where the court felt that the defendant's mental disorder was a sufficient to have diminished their responsibility for the offence was 24.[13] The number of homicides by people driving under the influence of alcohol or drugs is roughly equivalent to the number of people killed by people with mental illness. It is estimated that at least 50% of homicides are committed by people under the influence of alcohol, and each year alcohol plays a role in over 40,000 deaths, including 500 of young people.[14] It is interesting to compare the Government's response to the risk data about mental ill-health in its Mental Health Bills with its response to the risk from alcohol in the Licensing Act 2003, which allows 24 hour a day, seven days a week sale of alcohol.

A finding of the *Confidential Inquiry* which has influenced policy greatly was also that 9% of perpetrators (55 people) of homicide had been in contact with mental health services in the year before the offence. The policy implications derived from these findings by the Government was that these homicides might have been prevented by broadening the conditions of compulsion to allow more people with personality disorder and alcohol or drug problems to be subject to compulsory powers, restricting clinicians' discretion to discharge from compulsion in high risk cases, and ensuring that long term compulsory care in the community would be possible.

The basic premise of the reform proposals is that the system of supervision of restricted offender patients in the community, run by the Home Office Mental Health Unit, works well in terms of public safety, that there are few problems with the offender provisions in Part III of the 1983 Act, and all the problems are with the non-offender provisions in Part II. Home Office restrictions on clinicians' power to discharge are imposed on offender patients where necessary to protect the public from serious harm from offenders. If that system could effectively be replicated for non-offender patients, public safety would more effectively be secured. The Mental Health Bills 2002 and 2004 were designed to do just that, to introduce a concept of restricted non-offender patients, supervised by the tribunal, not the Home Office, whose discharge could only be ordered by the Mental Health Tribunal, not by clinicians. Moreover, they sought to ensure that these 'high risk' non-offender patients would enjoy more limited rights than those who did not pose a risk to others. Hence any statement of legislative principle should be flexible enough to be dis-applied to high risk patients. These are the non-negotiable bottom lines of policy. They are driven by the Home Office public safety agenda.

12 *Shaw et al. 'Mental illness in people who kill strangers: longitudinal study and national clinical survey' [2004] 328 BMJ, 734–737 (27 March)*

13 *Criminal Statistics, http://www.homeoffice.gov.uk/rds/pdfs2/cs2002vol2pt6.xls*

14 *http://www.ncl.ac.uk/nnp/teaching/disorders/substance/alcrelate.html*

The consultation on the 2002 Bill elicited over 2,000 responses, and the result was a resounding thumbs-down from stakeholders. Such was the opposition that psychiatrists, service users, and mental health charities banded together to form the Mental Health Alliance specifically to resist the Bill. The Department of Health and the Home Office rejected the evidence of the key stakeholders in their document *Improving Mental Health Law: Towards a New Mental Health Act*[15] which accompanied the Draft Mental Health Bill 2004, introduced in substantially in the same form as the much criticised 2002 version. The 2004 Draft did not include the 2002 procedures for admission of compliant incapacitated (Bournewood) patients, because the Government apparently did not anticipate that it would lose the case of *HL v United Kingdom*.[16]

The most important general question of principle facing the Scrutiny Committee was the balance struck between the personal freedoms and human rights of mentally disordered people and pursuit of the public safety agenda.

Did the Bill achieve the right balance between protecting the personal and human rights of mentally ill people on the one hand and concerns for public and personal safety on the other?

One of the main areas of contention between the Scrutiny Committee and the Government was the extent to which the public safety agenda has come to dominate mental health law reform and whether this dominance would be to the detriment of mental health services. Shortly stated, the Scrutiny Committee concluded that the balance was wrong, and the Government reasserted its position. The Government rebuke the Committee for having 'missed the point' that it is really 'a patient and public safety' agenda. This criticism is inaccurate, as the inclusion of 'personal safety' in the Committee's question shows. It is also less than frank. Whilst the Government talk about the need to guard against the risk of self harm, official policy documents consistently major on the Confidential Inquiry statistics from 2001 on homicides by mentally disordered people, and the self-harm statistics are rarely spelt out.

This is borne out in the two Departments' response to the Scrutiny Committee. They acknowledge that 'media coverage of homicides leads to a distorted view of the risk that is posed by mentally disordered people, the great majority of whom will never be a risk to anyone.' 'But', they continue, 'the fact remains that there are significant numbers of homicides by mentally disordered people each year – some of which are preventable', turning again for support to the 2001 report of the National Confidential Inquiry on homicides[17] and asserting that 'society has a reasonable expectation that the law will provide protection, as far as possible, from patients with a serious mental disorder who present a risk of harm to others'.[18]

The vast majority of written and oral evidence was highly critical of the balance struck by the Bill, giving rise to speculation as to how the Government would respond if the Scrutiny Committee's Report reflected that weight of evidence. The Government Response seeks to appeal, over the

15 *Department of Health and Home Office, Improving Mental Health Law: Towards a New Mental Health Act, 2004.*

16 *E.Ct.H.R Judgment of 5 October 2004.*

17 *Safety First: Five year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness 2001 http://www.national-confidential-inquiry.ac.uk.*

18 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill Cm 6624 2005, para 14.*

heads of those service users, carers, and professionals who did give evidence to the Committee (often of a powerful and harrowing kind), to the Banquo's ghost of the views of the general public:

> 'The Committee, while recognising that public protection is a relevant issue, does not in our view recognise the significance of this. The great majority of the evidence came from stakeholders who represent health and social care professionals and service users, and relatively little from those with responsibility for protecting the public or from the general public themselves – the majority of whom do not share the Committee's belief that the Bill is inappropriately concerned with public safety'[19]

So, with one mighty leap, the Committee's views can be disregarded In appealing to 'the general public and those responsible for protecting them', the Government is calling for support from a particular sector of 'public opinion' which it has already acknowledged may be influenced by the very media distortions they have earlier described as misleading. The key question for the Government Departments was to assert homicide prevention as the core goal of mental health legislation, with all other considerations in a secondary position.

The Purpose of Mental Health Legislation

The Committee said that 'The primary purpose of mental health legislation must be to improve mental health services and safeguards for patients and to reduce the stigma of mental disorder.'[20] The Government's Response was dismissive: 'The Bill is not about service provision, it is about bringing people under compulsion.'[21]

The Bill is about service provision in the sense that the Committee heard evidence from many authoritative quarters that the workforce requirements of the new legislation would divert clinician time from patient care into servicing the regulatory apparatus, and this at a time of considerable shortages of clinical staff, particularly in Wales. The Committee expressed 'major concerns about the resources needed to implement the Bill', stating their 'lack [of] confidence in the Government's models and assumptions of funding and staff necessary to make the new provisions work.' They asserted that 'without adequate staff and funding, the new tribunal will fail to improve patient safeguards, and mental health could remain the Cinderella Service of the NHS.'[22] This is a major concern. A regulatory apparatus which is staffed by clinicians, and which is resource intensive, will inevitably have an impact on services, in that more clinicians will be needed to meet demands for treatment.

Law performs a number of roles in relation to psychiatry. It authorises detention and compulsory treatment. It defines, with greater or lesser precision what treatment for mental disorder may include. It provides clinical authority to treat without consent. In order for these interferences to be legitimate, they must not only be authorised by law, that law must also provide safeguards to prevent their arbitrary use.

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19 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill Cm 6624 2005, para. 13.*

20 *House of Lords House of Commons Joint Committee Report on the Draft Mental Health Bill, Session 2004–2005 HL Paper 79-1, HC 95-1. Session 2004–2005, Summary, p 5.*

21 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill Cm 6624 2005, para. 10.*

22 *House of Lords House of Commons Joint Committee Report on the Draft Mental Health Bill, Session 2004–2005 HL Paper 79-1, HC 95-1. Session 2004–2005, Summary p 6.*

The Educational Function of Law

Law also performs an educational or ideological role, and its tone and language is capable of promoting positive or negative images of mental disorder and mentally disordered people. The tone of the Mental Health Bill reflects a perception of people who suffer from mental ill health as potential threats to society, and this was remarked on by witnesses before the Committee. This is best illustrated by comparing the style of the Mental Capacity Act 2005 with that of the Mental Health Bill 2004. Both allow treatment to be given without consent to people who suffer from mental disorder, the MCA on grounds of incapacity and best interests, the MHA on grounds of risk and necessity. The Mental Capacity Act includes statutory principles to which decision-makers must have regard, including the least restrictive alternative, the presumption of capacity, and that people shall not be treated as incapable merely because they make an unwise decision. These are based on common law, and reflect principles proposed by Richardson. The tone of the Mental Capacity Act is inclusive, with provisions requiring that decisions about best interests shall not be based merely on age, appearance, condition or aspect of behaviour which might lead someone to make unjustified assumptions about what might be in their best interests.[23] The inclusion of these principles implemented a recommendation of the Scrutiny Committee on the Mental Capacity Bill.

The language of the Mental Health Bill strikes a different note. It is the language of risk management rather than social inclusion. It reflects the Government's assertion that 'The Bill is not about service provision, it is about bringing people under compulsion.'[24] Some members of the Scrutiny Committee on the Mental Health Bill had served on the Committee for the Mental Capacity Bill and were struck by the contrast in style. In contrast to section 1 of the Mental Capacity Act 2005, Clause 1 of the Mental Health Bill 2004 is less concerned with principles than it is with how they might be departed from for certain groups. It provides for the production of the Code of Practice which will establish general principles based on aims stated in clause 1(3) that (a) patients are involved in the making of decisions, (b) decisions are made fairly and openly, and (c) the interference to patients in providing medical treatment to them during the treatment are kept to the minimum necessary to protect their health or safety or other persons. Clause 1(4) then states that the Code may provide that one or more of the general principles is not to apply in circumstances where its application would be inappropriate or impracticable, and in relation to decisions or persons specified in the Code. These statements of principle are non-contentious. If a decision is not made fairly, or a decision is made to impose compulsion without adequately informing the patient, it will be susceptible to judicial review. Similarly, application of a power which affects a Convention right in breach of the principle of minimal interference or proportionality would be susceptible to judicial review. So it would be pointless to seek to dis-apply them.

Principles on the Face of the Bill

One of the Committee recommendations the Government apparently accepted, was that principles should appear on the face of the Bill. I say 'apparently' because, whilst the Government Press Release states that 'The guiding principles will appear on the face of the Bill'[25], what the Response actually says is this:

23 *Mental Capacity Act 2005, s 4(1).*

24 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill Cm 6624 2005, para. 10.*

25 *Next Steps for Mental Health Bill, 13 July 2005 2005/0244.*

> The Government accepts that principles ought to be set out on the face of the Bill, provided that they can be drafted in a way that allows for due protection of an individual's rights and autonomy, while also facilitating practitioners and others to take decisions that are necessary to minimize harm.[26]

It may be that the Government has found that the principles cannot be drafted in order to allow sufficient flexibility to meet these potentially competing goals. Given that a key component of the public safety agenda is avoiding the possibility that rights or principles might get in the way of the public protection agenda, it is quite likely that the Government will not put principles on the face of the Bill, but will leave them to the Code. Of course, a lot depends on what the principles are.

The Scrutiny Committee recommended the principles to be found in section 1 of Mental Health (Care and Treatment) (Scotland) Act 2003 which requires anyone discharging functions under the Act to have regard a number of matters designed to promote patient participation and non-discrimination. The decision-maker must have regard to the past and present wishes of the patient, the views of the patient's named person, any carer, any guardian or welfare attorney for the purposes of the Adults with Incapacity Act. Decision-makers do not have to have regard to the views of carers, named persons, guardians or attorneys in so far as it is unreasonable or impracticable to do so.

Decision-makers must also have regard to the importance of the patient participating as fully as possible in the discharge of the function, the importance of providing adequate information to enable the patient to participate in decision-making, and the range of options available in the patient's case. They must have regard to the importance of providing the maximum benefit to the patient, and the need to ensure that, unless it can be shown that it is justified in the circumstances, the patient is not treated in a way that is less favourable than the way in which a person who is not a patient might be treated in a comparable situation. Finally, the decision-maker must have regard to the patient's abilities, background and characteristics, including age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background, and membership of any ethnic group.

When the person has had regard to all these matters they must discharge the relevant function in the manner that appears to involve the minimum restriction on the freedom of the patient that is necessary in the circumstances. Where people are subject to compulsion or have been detained, the decision maker must have regard to the need to provide appropriate services and continuing care for the patient. Where anyone, including Government ministers, is discharging functions under the Act, they must do so in a manner that encourages equal opportunities and in particular the observation of equal opportunity requirements.[27]

The Scottish Act requires decision-makers to 'have regard' to these principles. Having regard means that they should be considered, but that there is freedom to depart from them. In *R(Munjaz) v Ashworth Hospital Authority* Lord Hope of Craighead said that Guidance under the Mental Health Act Code of Practice was 'less than a direction, but more than something which those to whom it is addressed "must have regard to". Having regard to a principle was felt by Lord Hope to be less of an obligation than the duty to follow the Code's provisions which applies where a Convention right is engaged, unless there are cogent reasons not to.[28]

26 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill Cm 6624 2005, response to recommendation 4.*

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

28 *[2005] UKHL 58.*

The Government has sought to employ a 'belt and braces' approach to the subjugation of principles to risk management, by relegating principles to the Code, and providing for their dis-application. This pre-occupation with ensuring sufficient flexibility to ensure that principles will not be susceptible of general application risks losing sight of what a principle is: a guide to action across the board. As Lucy Scott Moncrieff so brilliantly summed it up in her evidence to the Committee, a principle which can be departed from is a 'nice idea', not a principle. The principle of proportionality applies across the board. There is no need to dis-apply it in order to justify detaining someone whose level of risk to self or others requires detention, because detention would be a proportionate response.

The Mental Health Tribunal

The Department of Constitutional Affairs will take responsibility for the Mental Health Tribunal, adding a third Government department to the process of joined-up Government. The additional need for tribunal hearings under the new legislation which would require a hearing to authorise compulsion and each time it is renewed, together with the need to ratify treatment plans, will dramatically increase the workload of the tribunal over that currently undertaken by the Mental Health Review Tribunal. The Committee received a memorandum of evidence from the Tribunal Chairs for England and Wales and the Liaison Judge, Judge Sycamore, stating with one voice that they felt the proposed new role for the tribunal would be hugely resource-intensive and disproportionate to its aims, as well as being cumbersome to the point of being unworkable.[29] The proposals for the new tribunal will transform it from a review body hearing applications for discharge from patients, to more of a mental health court, imposing compulsory treatment or detention and ratifying treatment plans. This change of ethos of the tribunal should not be underestimated. Nor should the likely numbers of cases to be processed by tribunals.

General opinion is in favour of increasing safeguards. There seems to be broad consensus that a judicial process is the best form of safeguard, although as is persuasively argued by Victoria Yeates in this issue[30], it is an inadequate replacement for substantive rights such as the nearest relative's right to object to compulsory admission. Placing the tribunal at the centre of the system of safeguards poses the greatest threat to the workability of the new legislation because of the workforce implications, and as we have seen this was a major issue before the Scrutiny Committee. It was feared that the tribunal would be placed under such pressure of work that it would become like judicial certification under the Lunacy Acts; that the functions of the MHT would soon come to be carried out largely by their legal presidents, that the Tribunal would in effect become what one official dubbed a 'unibunal' for many purposes, and that its effectiveness in scrutinizing the need for compulsion would be compromised.

Widening the scope of compulsion

One of the central concerns of stakeholders was the potential net-widening effect of the new criteria and powers, and the numbers who might be subject to compulsion in the community. Since the

29 *Professor Jeremy Cooper, Mrs Caroline Kirby, Judge Philip Sycamore, Mr John Wright, Submission to the Joint Committee on the Mental Health Bill DMH (memo) 200, para 5.*

30 *'Death of the Nearest Relative?', Victoria Yeates – pp123–137 of this issue of the JMHL.*

Committee reported, the King's Fund has published its estimate of the numbers likely to be subject to community based treatment orders, concluding that the use of non-residential orders in England and Wales is likely to build over a period of 10–15 years to a figure of 15–25 per 100,000 population, that is around 8,000 people. The research estimates that the build up to that figure would be gradual, but that health services should plan over time for several thousand people in the community under orders, rather than the figure of less than 2,000 estimated by the Department of Health.[31]

Conditions of Compulsion

In the limited space available, I shall concentrate on one of the two additional conditions of compulsion proposed by the Scrutiny Committee and rejected by the Government. Both are modelled on the Mental Health (Care and Treatment) (Scotland) Act 2003. The first requires that the person's judgment *in relation to the decision to accept treatment* must be significantly impaired. The second is that there be treatment available which is of therapeutic benefit. The Richardson Committee recommended that capacity play a part in the conditions of compulsion, to the extent that a higher threshold of risk to self or others would be required to impose compulsion on a capable person. Richardson also recommended a similar test to that of therapeutic benefit. The Government has rejected both recommendations. They have done the same with the Scrutiny Committee recommendations.

The Departments were concerned that the significantly impaired judgment criterion would mean that there might be capable people who would escape compulsion even though they posed a substantial risk to others. The Millan Committee learned from this experience of Richardson and proposed the intermediate concept of 'significantly impaired judgement'[32], which was adopted. The Scottish Code of Practice emphasises that it is a separate concept to incapacity, even though similar factors are taken into account, including consideration of 'the extent to which the person's mental disorder might affect adversely their ability to believe, understand and retain information concerning their care and treatment, to make decisions based on that information, and to communicate those decisions to others.' The question whether judgment is significantly impaired bears a similar relationship to incapacity in the civil field, as that between diminished responsibility and McNaghten insanity in the criminal field. A person's judgment might be significantly impaired if they lacked insight into the fact that they had a mental illness, or where their ability to use information and weigh it in the balance to make a decision was impaired by a depressive illness.

The Government has rejected this proposal, reiterating its opinion that 'it is possible that people who are at very great risk to themselves or to others would nonetheless retain the ability to make unimpaired decisions about treatment.'[33] Dawson, in his excellent comparative survey of community treatment orders, suggests that the decision-making of people with less severe personality disorders would probably not be sufficiently impaired to meet the test, and that 'This is one principled way to exclude most persons with a personality disorder from cover by an involuntary patient regime.'[34]

31 *S. Lawton Smith, A Question of Numbers: The potential impact of community based treatment orders in England and Wales, Kings Fund Working Paper (September 2005), p 7*

32 *New Directions: Report on the Review of the Mental Health (Scotland) Act 1984. Scottish Executive January 2001*

33 *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill Cm 6624 2005, response to recommendation 26, p 16.*

34 *John Dawson, Community Treatment Orders: International Comparisons, May 2005, Law Foundation New Zealand, p 100.*

From the point of view of the public safety agenda, this would be seen as a major flaw. Yet from the point of view of non-discriminatory mental health law, and bearing in mind the purpose of the concept of significantly impaired judgement, it would bring mental health legislation regarding treatment without consent more closely into line with the common law.

Conclusion

The uncertainty as to whether a mental health bill will be introduced in this Parliamentary session continues. The Scrutiny Committee said that on balance the Government had made out the case for the new legislation. The Bill's goals in relation to compulsory treatment can currently be achieved under section 17 extended leave. If the fact that long term community compulsion is being achieved by the fiction of extended leave from detention troubles the national conscience, this could be remedied by amending legislation. The infringements identified in *JT v United Kingdom*[35] could be rectified by remedial order under the Human Rights Act 1998. Legislation to introduce protective care, or whatever the Government's preferred option is, to bridge the '*Bournewood* Gap' must also take account of the ruling in *Storck v Germany*[36]. The implications of having two statutory regimes for treatment without consent, the Mental Health Act and the Mental Capacity Act, need to be carefully thought through.

The current system whereby initial detention for assessment is authorised by properly trained professionals, and is subject to review by the MHRT, is compliant with the Convention. It would be better to inject sufficient human and financial resources into the MHRT, to enable it effectively to discharge the positive obligation under Article 5(4) of the Convention, than to take the leap in the dark to a new Mental Health Tribunal with vastly increased functions. Since other safeguards would be dismantled on the justification that the tribunal will provide more effective safeguards, it is important for us to be confident that the MHT will measure up to that onerous requirement. The Bill would move the system from one based on checks and balances between professional and family power towards one where faith would be placed almost entirely on a judicial body, supplemented by advocates with strictly limited powers and role. In stark terms, the Government has twice failed to secure the assent of the key stakeholders to what is effectively the 2002 Draft Bill. They might have been better advised to attempt a more modest amending measure, but much effort and prestige has been invested, and the departments seem determined to press ahead.

Future historians, and future generations of service users and their families will judge whatever legislation we produce at the beginning of this 21st century. They will find an impressive and moving body of evidence in the report of the Scrutiny Committee. Speaking personally, it was one of the great privileges of my life to witness that evidence, and see the Committee's reaction to it. Of course it is a question of judgment whether a mental health statute achieves a fair balance between a number of different functions, authorising treatment without consent and detention, providing rights to challenge compulsion, and promoting positive and inclusive rather than negative and stigmatising images of mental illness and mentally ill people.[37] The Scrutiny Committee felt that the Draft Mental Health Bill 2004 failed the test of holding these aspects of policy in a fair balance. The Government has rejected that view and reasserted its position.

35 *[2000] 1 F.L.R.909*

36 *E.Ct.HR Judgement 16th June 2005*

37 *P. Fennell, 'Convention Compliance, Public Safety, and the Social Inclusion of Mentally Disordered People' [2005] 32 JLS 90–110.*

A programme of mental health law reform which is content to allow the combating of stigma to be left to policy documents, and which is apparently oblivious to the powerful ideological force of law for good or ill, cannot fairly be described, as the Government seeks to do, as 'modern' or 'improved' mental health legislation.

The distinguished international commentator Professor John Dawson recently described Scotland's new legislation as 'state of the art' community treatment order legislation.[38] The Scrutiny Committee seemed to agree with this. The Government does not. Time will tell. One of the purposes of Pre-Parliamentary Scrutiny is to increase the chance of better, more workable legislation emerging, legislation which is sensitive to the position of those who will operate it and who will be subject to it. The Government's somewhat grudging approach to the Scrutiny Committee recommendations reflects its commitment and determination to pursue the public safety agenda above all others, and this is to be regretted. If things go wrong there will be no shortage of people in a position to say 'We told you so.'

38 *John Dawson, Community Treatment Orders: International Comparisons May 2005, Law Foundation New Zealand, p 98.*

Death of the Nearest Relative? Carers' and Families' Rights to Challenge Compulsion under Current and Proposed Mental Health Legislation

Victoria A. Yeates[1]

The Mental Health Bill 2004[2] has recently undergone pre-Parliamentary scrutiny[3] and the Government has now published its response.[4] The Bill has a number of worrying implications for carers and families of psychiatric service users. It contains extensive discretionary powers to detain people with a wide range of mental disorders, including alcoholism and addiction, as well as to impose conditions on service users[5] in the community, including a condition that the service user must desist from any specified conduct. The Bill places inordinate emphasis on public safety, which is likely to foster rather than reduce stigma.[6] Given that the powers are so wide, and that

1 *Senior Lecturer, Law School, University of Glamorgan*

2 *Department of Health, Draft Mental Health Bill 2004 and Explanatory Notes TSO 2004 Cm 6305-I and II.*

3 *House of Lords, House of Commons, Report of the Joint Committee on the Draft Mental Health Bill Session 2004–2005 HL Paper 79(1), HC Paper 95(1).*

4 *Government response to the Joint Committee's report on the draft Mental Health Bill 2004 [HL Paper 79-1 HC 95-1]*

5 *Patient is the legal term for service user.*

6 *The anti-stigma agenda is reflected in the National Service Framework for Mental Health: Modern Standards & Service Models Department of Health; September 1999, accessible at www.doh.gov.uk/pub/docs /doh/mhmain.pdf, and the Welsh Assembly Government, Strategy Document for Adult Mental Health Services in Wales: Equity, Empowerment, Effectiveness, Efficiency (2001). See also the report of the Social Exclusion Unit on Mental Health and Social Exclusion (9 June 2004) Office of the Deputy Prime Minister), where the Prime Ministerial foreword notes the need for 'determined action to end the stigma of mental health – a challenge not just for Government, but for all of us. '*

many service users liable to compulsion may be vulnerable or lack mental capacity, it is of great concern that carers and relatives will lose significant rights to resist detention or compulsory treatment of a family member or partner suffering from a mental disorder. The Scrutiny Committee has recommended that some of these rights should be retained, including the right to direct discharge a service user who is not dangerous to self or others. The Government's response to these recommendations is disappointing though no great surprise given its avowed commitment to the risk management / public safety agenda.

The dilemma for reformers is how to ensure that mentally disordered people who may need to be subject to compulsory powers have the support of a loved one or family member to press for the provision of care in the least restrictive setting. In many cases the person most suited to carry this function out will be the service user's nearest relative, as defined in section 26 of the 1983 Act, spouse, parent, sibling, gay or straight live-in partner, or long term cohabitant or carer. The Joint Parliamentary Scrutiny Committee on the Mental Health Bill 2004 heard evidence from carers and nearest relatives arguing passionately for the retention of the power of discharge. For example the seventy five year old mother of a man with severe mental illness said this: 'If the family do NOT wish it and cannot support the service user they will not use the law. *Please do not cover us all under the same proposal*. (emphasis added).. do not throw the baby out with the bath water.'[7] In other words, just because some nearest relatives are unsuitable or abusive, the rights of nearest relatives generally should not be reduced. The presumption of beneficence, that blood relatives and spouses will act in the best interests of their mentally disordered family members, no longer remains unchallenged.

This article explores the scope of carers and family members' current entitlements to be involved in decisions about the use of compulsion under mental health legislation and the impact of the European Convention on Human Rights on these rights. It then examines the proposals in the Draft Mental Health Bill in relation to family rights, the recommendations of the Joint Parliamentary Scrutiny Committee concerning carers and nominated persons and the Government's response to these recommendations. It will be argued that the 2004 Draft Bill would represent a significant erosion of the rights of families, which is potentially profoundly anti-therapeutic where a public safety agenda based on risk management predominates. It would involve a major shift in the boundary between the public and the private sphere, which is of constitutional significance, and it is argued that the Government should follow the recommendations of the Joint Parliamentary Scrutiny Committee.

The Public/Private Distinction

Bartlett and Sandland describe the existing process 'as very much the vestige of its nineteenth century predecessors' reflecting 'middle class Victorian ideologies of public and private life.'[8] Latterly the public/private distinction has been extensively criticised because state permission for unregulated self-expression within the family in fact could authorise violence and oppression,[9] including oppressive use of the power to apply for compulsory hospitalisation. However, the nearest relative under existing legislation has powers not only to apply for compulsion, but also to

7 *DMH (MEMO) 103 Evidence to the Joint Parliamentary Committee on the Mental Health Bill 2004*

8 *Bartlett and Sandland, Mental Health Law, Policy and Practice, Oxford University Press (2nd ed) (2003) 193*

9 *Peter Alldridge, Relocating Criminal Law (Ashgate 2000), 106.*

resist it, to resist removal of their family member from private care by the family into the care of the state. At a time when a person's mental health is in crisis, they will benefit from someone who has a close connection and who can support the case for care in the least restrictive setting, in short, the case against compulsory hospitalisation. The nearest relative concept provides this.

Respect for privacy and family life are fundamental tenets of liberal rights theory, protected by Article 8 of the European Convention on Human Rights, which requires interference with these rights to be in accordance with law and proportionate. Conflict between different parties' Article 8 rights may occur. For example, a family may consider it part of their right to respect for family life to participate in decisions about the care of the mentally ill family member. On the other hand the service user may consider their right to respect for privacy to dictate that the family should have no such involvement, as would be likely in cases where family members are exploitative, disinterested or ineffectual.

Balancing these competing rights may be difficult. Obviously the choice of a capable service user as to who should be their nominated person should take priority over the rights of other family members. There are undoubtedly cases where service users legitimately consider that they do not want any involvement by the person identified as 'nearest relative' under s 26. The core problem is that many service users need someone to uphold their rights, but strict application of the statutory formula often produces a person who is unacceptable to them. A further problem is that the service user's perception of who is appropriate to represent their interests may be skewed by their mental disorder.[10]

The Nearest Relative

The concept of nearest relative was introduced in 1959 as the person entitled to apply for detention, to be consulted about compulsion, in certain cases to block compulsion, to discharge the service user from hospital, and to appeal to the MHRT if discharge is blocked on grounds of dangerousness to self or others. The 1983 Act retained the nearest relative concept but sought to 'modernise' it by providing for a person who has lived with the service user for six months or more as man and wife to be treated as a spouse. Any common law partner with whom the service user has been residing as husband or wife counts as the husband or wife, provided the service user is separated from anyone to whom they are married. Since the Human Rights Act 1998 this includes gay partners.[11] Anyone with whom the service user has been residing for at least five years is also added to the list of potential relatives. The Act rightly provides that a relative who is caring for the service user or with whom the service user ordinarily resides will take priority over others higher up the list of family ties.

There is increasing recognition of the fact that carers can be 'experts by experience' and should have a significant say in the care plan, especially since it is they who will be almost entirely responsible for its delivery. The carer will often, but not always, be the person best placed to know the service user as a person, and therefore able to decide when the time has come for admission to hospital, and when care can safely be provided in the community. The way in which the current

10 *See Evidence 254 given by Cliff Prior of Rethink House of Lords, House of Commons, Report of the Joint Committee on the Draft Mental Health Bill Session 2004–2005 HL Paper 79(ll), HC Paper 95(ll), Ev 254, Question 275.*

11 *R (SSG) v Liverpool County Council Secretary of State for Health and LH (interested party) 2002 where the court declared that a gay partner who had resided with the service user for more than six months should be entitled to be regarded as the nearest relative.*

Act works is that where there is a carer who resides with the service user that person (provided they qualify as a 'relative') will probably be the nearest relative, with a floor of rights on the basis of which they can, if necessary ask for compulsory admission to hospital or guardianship, but more importantly, can object to compulsory admission, have a power to discharge compulsory detention of the service user unless s/he is dangerous to self or to others, and to apply to the MHRT if discharge is blocked.

There are two aspects of the reform proposals in the 2004 Bill. The first is welcome, and is aimed at recognizing the right of a capable service user to determine who their nominated person should be, and displace someone who is unsuitable. The second, which is deeply unwelcome to many carers, is the partial dismantling of the floor of rights which the nearest relative currently enjoys.

The Floor of Family Rights: Nearest Relative's Powers under the Mental Health Act 1983

Four planks make up the floor of rights: 1. to initiate compulsion; 2. to advocate for care in the least restrictive setting; 3. to direct discharge of a service user who is not dangerous to self or to others; and 4. the right to apply to a Mental Health Review Tribunal (MHRT) for discharge. The Human Rights Act 1998 has had a significant influence on the position.

1. Powers to initiate compulsion

(a) The power to apply for compulsory admission or guardianship

These powers entitle the nearest relative to hand the service user into the compulsory care of the state, from the private to the public sphere of care.[12] In practice this rarely happens, the Approved Social Worker (ASW) being the preferred applicant as better placed to carry out this task. It is questionable whether this power is appropriate in that it may cause resentment and possible feelings of betrayal between the caring relative and the service user. Few tears are being shed over the proposed loss of the nearest relative's right to apply formally for compulsion, such applications only to be used by public officials such as AMHPs[13]. The aim of this proposal is to limit the emotional toll on the relationship between the family carer and the service user.

(b) The power to ask for an assessment

The current right of the nearest relative to request assessment of the need for compulsory admission will be replaced under the Draft Mental Health Bill 2004 with a provision whereby 'any person' can apply for assessment, and will be entitled to written reasons if compulsion is not instituted.[14] This particular proposal has provoked alarm among a variety of stakeholders, their fear being this could lead to the creation of a 'busybody's charter', given the breadth of the new criteria for compulsory powers.[15] It is therefore submitted that the right to ask for an assessment and to be given reasons for not using compulsion should be limited to the nominated person or next friend.

12 *Mental Health Act 1983, s 11(1) which confers on the nearest relative the power to apply for admission for assessment for up to 28 days (s 2), for treatment (s 3), or into guardianship (s 7).*

13 *Approved Mental Health Professionals*

14 *Mental Health Bill 2004, cl 14 (1)*

15 *See evidence of Hafal, The Mental Health Alliance and of Health and Social Services Committee for the National Assembly for Wales to the Joint Scrutiny Committee on the Mental Health Bill 2004*

2. The power to advocate for care in the least restrictive setting[16]

Relatives and carers have an important role in acting as advocates for care in the least restrictive setting commensurate with the service user's mental health care needs. These rights are currently available to nearest relatives under the 1983 Act, in the form of the right to be consulted over compulsory admission, the right to object to compulsory admission for treatment, and the right to direct discharge provided the service user is not dangerous to self or to others. These rights are all subject to important qualification

(i) Detention for assessment under Section 2

Where an application for detention for assessment is made by the ASW, 'before or within a reasonable time after the application is made, the ASW must 'take such steps as are practicable to inform the person (if any) appearing to be the nearest relative of the service user.'[17] In *R (E) v Bristol City Council*[18] Bennett J followed the approach adopted by Richard Jones' *Mental Health Act Manual*[19] and held that the terms practicable and reasonable in section 11(3) and (4) had to be interpreted so as to give effect to the service user's right to respect for privacy under article 8 of the European Convention on Human Rights. On the facts E's Article 8 rights would have been infringed unless the words 'practicable' and 'reasonable' in s 11 were interpreted so as to take account of her wishes and her health and well-being. This is a welcome development in recognition of patient autonomy. Subject to this, in deciding whether it is appropriate to make an application the ASW must have regard to any wishes expressed by the service user's relatives.[20]

A nearest relative's objection may block admission for treatment under s 3, but not for assessment under s 2. Section 29(4) of the 1983 Act allows for the 28 day period of detention for assessment under s 2 to be extended if an application has been made for the displacement of the nearest relative, until that application has been disposed of by the county court.[21] A nearest relative's objection to s 3 admission may be circumvented by applying for admission for assessment under s 2, and then by applying to the county court to displace the nearest relative on grounds of unreasonable objection to admission for treatment. In *R (MH) v Secretary of State for Health and others* the issue before the court was the compatibility of the displacement system with the European Convention on Human Rights. What Buxton LJ called 'the section 29(4) problem' is that during that period of extended detention, a service user will not be able to apply to the tribunal for discharge. A patient capable of challenging their detention may have done so during the first 14 days of the section 2 but there is no provision within the MHA for the case of an incapable section 2 patient to be automatically referred to the tribunal. The nearest relative may direct discharge under section 23 but if that direction is barred by the responsible medical officer (RMO), the NR

16 *The least restrictive alternative is reflected in s 3(2) of the Mental Health Act 1983 and in a diluted form in the Mental Health Bill Clause 9(5) that medical treatment cannot lawfully be provided without him being subject to the provisions of this Act. Since the 2004 Bill allows for compulsory treatment in the community, this imposes a lower threshold for compulsion, a 'necessity for treatment'` test rather than a 'necessity for treatment under detention' test. Clause 1(4) which requires the Code of Practice to state as a principle that 'the interference to service users in providing medical treatment to them and the restrictions imposed on them during that treatment are kept to the minimum necessary to protect their health or safety or other persons.' The principle is further diluted in that it can be disapplied to groups or categories of service user.*

17 *Ibid., s 11(3)*

18 *Administrative Court [2005] All ER (D) 57 (Jan) 13 January 2005 (for a review of this case, see further on in this issue of the JMHL)*

19 *Most recently, at pp 81–83 in the 9th edition (Sweet & Maxwell, 2004)*

20 *Ibid., s 13(1)*

21 *Mental Health Act 1983, s 29(4).*

becomes impotent. S/he has no right of access to the Tribunal, which s/he would have if the patient were detained under sction 3. In *MH*, the mother of a young woman with a learning disability (MH) was subject to displacement proceedings in the County Court following the conclusion of the RMO that she had acted unreasonably when directing the discharge of the section 2 to which her daughter was subject. In *MH* the displacement proceedings lasted for more than two years. Despite the entreaties of Hale LJ in R(S) v City of Plymouth (2002) where she said "applications under section 29 have to be dealt with quickly", in this case it clearly was not. Throughout, neither the patient nor the nearest relative had the power to make an application to the tribunal (although it should be acknowledged that there was a tribunal hearing early in the life of the displacement proceedings as a consequence of the then Secretary of State being persuaded to exercise his power within section 67 of the MHA to refer the case of an 'unrestricted' patient at any time). In the unanimous opinion of the Court of Appeal the patient's lack of direct access to the tribunal was incompatible with the right to speedy review of the lawfulness of detention demanded by the provisions of Article 5(4). Subsequently on 20th October 2005, the House of Lords[22] (the sole judgment being given by Lady Hale) ruled otherwise, not least because of the Secretary of State's section 67 power.

(ii) Detention for treatment under section 3

Nearest relatives' rights are much more extensive in relation to detention for treatment under s. 3 of the 1983 Act. Section 11(4) provides that an application may not be made under s.3 by an Approved Social Worker if the nearest relative has notified the ASW or the local social services authority that he objects to the application being made. Furthermore, the subsection imposes a duty on the social worker, before making the application, to consult the person appearing to be the nearest relative,[23] unless it appears that 'in the circumstances such consultation is not reasonably practicable or would involve unreasonable delay', reasonable and practicable being interpreted so as to give effect to the service user's Article 8 rights, as held in the *Bristol* case.[24]

The obligation to consult the nearest relative is seen as so important that consultation with a person who could not reasonably appear to be the nearest relative might invalidate the detention as held in *Re S-C (Mental Service user: Habeas Corpus)*.[25] The Richardson Committee, whilst according 'the highest priority' to the identification of 'such a person' saw consultation as dispensable, considering that 'the consequences of there not being such a person at any particular stage in the compulsion process should not be sufficient to interfere with the validity of that process.'

3. The Power to order Discharge

A nearest relative may order the discharge of a service user[26] detained under section 2 or section 3. This right can be blocked by the issue of a barring certificate by the RMO who certifies the service user would, if released, be a danger to self or others.[27] The barring certificate is subject to review by the managers, who may overrule the RMO and the nearest relative also has recourse to a MHRT[28]

22 *[2005] UKHL 60*

23 *D v Barnet Health Care Trust [2001] 1 F.C.R. 218 The obligation on a social worker is to 'act in a common sense manner' when determining who is the nearest relative*

24 *Administrative Court [2005] All ER (D) 57 (Jan) 13 January 2005. Consultation means 'the communication of a genuine invitation to give advice, and a general consideration of that advice. R v Secretary of State for Social Services ex parte Association of Metropolitan Authorities [1986] 1 All ER 164.*

25 *[1996] 1 All ER 532.*

26 *Mental Health Act 1983 , s 23.*

27 *Mental Health Act s.25*

28 *Ibid, s.66*

In *R(O) v West London Mental Health Trust*[29] where managers reviewed a decision to impose a barring certificate, they continued detention in the hope of the service user acquiring insight into his illness. Collins J held that the managers had failed to specifically consider the issue of dangerousness to self or others, which if absent should lead to discharge.

The importance of the power of discharge and the fact that carers often have a much better perception than professionals of the needs of service users, is poignantly demonstrated by the case of Andrew Taylor, a young man with autism for whom no placement was available when he left school at 18.[30] Because of the uncertainty created by the fact that no suitable specialist placement was available, Andrew became disturbed and was detained in a psychiatric unit. Twice over an 18 month period a MHRT criticized Andrew's placement on the psychiatric ward, but he was able to leave only when his mother gave up work to care for him and exercised her power as his nearest relative to discharge on the basis that he would be in her care, and would not be a danger to himself or to others. Since discharge it seems he has made tremendous progress. Without intervention from the nearest relative he might still be inappropriately placed in hospital, despite the availability of review by the Tribunal.

4. The Right to apply to a Mental Health Review Tribunal

Nearest relatives have rights to apply to the MHRT if a service user detained for treatment is reclassified, if a certificate barring discharge of a section 3 detention is issued under s 25, or if the nearest relative has been displaced by the county court under s 29.[31] The nearest relative may also apply for the ending of supervised discharge to which the service user is subject, once within every period for which the supervised discharge is renewed, and once following any reclassification of the service user as suffering from a different form of mental disorder.[32] These will be replaced under the 2004 Draft Bill by a single right to apply to the Mental Health Tribunal (MHT) for discharge[33], but it should be remembered that MHT hearings in such circumstances will take some time to organise and in that sense will not be as effective as the existing right to direct discharge.

Displacement of Nearest Relatives

There are two ways around the objection of a nearest relative to detention for treatment: 1. a displacement order; and 2. an interim displacement order

1. Displacement Order

The grounds of displacement include that the nearest relative unreasonably objects to the application for admission for treatment, or has unreasonably attempted to exercise the power of discharge[34]. The unreasonableness of a nearest relative's objection is to be judged according to the standard of whether a reasonable nearest relative would object?[35] This test almost raises a presumption of unreasonableness where there is disagreement with the professional judgment of the doctors and the social workers as to what is in the interests of the service user. Bartlett and

29 *16 March 2005 Collins J.*

30 *Local Government Ombudsman, Report on an Investigation into Complaint No 02/C/17068 against Bolton Metropolitan Borough Council 30 November 2004. Thanks to Richard Jones for pointing out this report*

31 *Mental Health Act 1983, s 66(1)(d), (g), (h).*

32 *Ibid., s 66(1)(ga), (gb), and (gc).*

33 *Mental Health Bill 2004, cl. 54(2).*

34 *Section 29(3)(c)&(d) MHA 1983*

35 *W v L [1974] QB 711, per Lord Denning at 717–718.*

Sandland refer to 'an approach of extreme sympathy to medical opinion at trial' and conclude that 'it is difficult to see that s 29 applications do not in the end collapse into a question of the court's view of the best interests of the service user, and the courts are loath to take a view divergent from the service user's medical officers.[36]

2. Interim Displacement Order

In *R v Central London County Court ex parte London*[37] the Court of Appeal held that an interim order can be made displacing the relative and an application for admission under s 3 may be made during the currency of such an order if there are cogent reasons for doing so. The application for the interim order had been made *ex parte*, so the nearest relative was not heard. During the currency of such an order the displaced nearest relative loses their right not only to veto detention under s. 3, but also the right to seek the discharge of the service user under s. 23.

Displacement applications require judges to choose between professional medical expertise, acquired from clinical practice, and the increasingly recognised expertise born out of the carer role. It is now common in health care (including mental health) to speak of the 'Expert Carer' in recognition of the invaluable role of carers in maintaining the health of family members over prolonged periods of time. Carers are 'experts by experience', often able to assess a service user's needs more accurately than professional members of the care team by virtue of their in depth knowledge of how illness presents in their family member, and their active participation in care decisions should be encouraged.[38]

Hence a clash between the clinicians and the family or carer(s) about what action is in the best interests of the mentally ill service user, inevitably brings into play a conflict between these two types of expertise. When a subjective test such as 'What would the reasonable nearest relative do?' is applied in relation to displacement, judges are more likely to defer to professional expertise, even when it may be wrong and damaging to the service user. Judges who deal with these applications ought to receive training to apprise them of the vital role played by carers, and to be able to think themselves into the shoes of someone caring long term for a mentally ill person. The 2004 Bill proposes that these issues should be dealt with by the Mental Health Tribunal rather than by the county court. Whatever forum is chosen, the important thing is for carers, and those they care for, to feel confidence in a decision making process which directly affects one's status as a member of society in a most acute way.

They need, in Wexler and Winick's words:

> '[H]earings in which they can participate, in which they are treated with dignity, and in which they believe that they are dealing with trustworthy authorities who are motivated to be fair to them'.[39]

36 *P. Bartlett and R. Sandland, Mental Health Law: Policy and Practice,Oxford, University Press (2nd edition) 2004, 207.*

37 *[1999] 3 WLR 1.*

38 *See the development of the Institute of Psychiatry 'Expert Carers Initiative' to train carers www.iop.kcl.ac.uk/Departments/PsychMed/EDU/ExpertCarers.shmtl, following the speech by Stephen Ladyman MP Parliamentary Under-Secretary for Community Care of 6 October 2003.*

39 *David B. Wexler and Bruce J. Winick, Law In A Therapeutic Key, Carolina Academic Press 1996, 14*

Displacement and Human Rights

Whilst social services authorities may apply for displacement of an unsuitable nearest relative, the one person with no power in this regard is the service user. In *JT v United Kingdom*[40], this was held to breach the right to respect for privacy under Article 8. Under the statutory formula JT's nearest relative was her mother, who was living with a man who JT alleged had abused her in the past, and she had no power to apply to the court for displacement. The judgment of the Strasbourg Court noted that a friendly settlement was reached whereby the government undertook to introduce reform proposals to (1) enable a service user to make an application to the court to have his nearest relative replaced where the service user objected on reasonable grounds to a particular individual acting in that capacity, and (2) prevent certain persons from acting as the nearest relative of the service user. Almost five years later, no legislation has been introduced, as acknowledged by the Government in *R (M) v. Secretary of State for Health*[41] where Maurice Kay J. declared that ss 26 and 29 of the Mental Health Act are incompatible with the ECHR. The decision in *JT v United Kingdom* could have been complied with by remedial order amending the 1983 Act to entitle a service user with capacity to nominate someone to exercise the functions of nearest relative and to seek displacement of an unsuitable nearest relative, without abolishing the important powers and rights which go with the nearest relative role.

The reason why the Government has not chosen this path is that the Draft Mental Health Bill 2004 proposes to abolish the nearest relative in favour of a new 'nominated person' regime, and in the process undermine the floor of rights of families and carers to question the use of compulsory powers. The nominated person provisions in the 2004 Bill partially reflect proposals in the Richardson Committee Report.

The Richardson Committee and the Mental Health (Care and Treatment) (Scotland) Act 2003

1. The Richardson Committee

The Richardson Committee heard strong criticism of two key aspects of the nearest relative provisions: first the person identified as the nearest relative under s 26 may be unacceptable to the service user; and second the service user has no power to apply for displacement of an unsuitable nearest relative. The Richardson Committee responded to these concerns by recommending the removal of the nearest relative *altogether*, to be replaced by the nominated person, who 'should not have the powers of application and discharge currently possessed by the nearest relative.' **From service users' point of view, the main problem was not the extent of the nearest relative's rights, but their inability to exclude an abusive relative from exercising this role.** The Richardson Committee concluded that implementation of their proposals to introduce greater 'independent decision-making' (by authorization of compulsory in-service user or out-service user treatment by a Mental Health Tribunal (MHT)), would mean that the powers of such a statutory figure as the nearest relative 'should be reduced'[42] The Tribunal may be independent of the hospital, but the Draft Mental Health Bill proposals also state that a service user can be subject to assessment as a resident user or non resident user for up to 28 days on the say-so of the Approved Mental Health

40 (2000) 30 E.H.R.R CD 77.

41 [2003] E.W.H.C. 1094.

42 Review of the Mental Health Act 1983 November 1999 paras. 12.17 – 12.18.

Professional (AMHP) and two doctors, subject of course to the service user's and the nominated person's appeal to the Tribunal.

The right to be consulted over the need for compulsion gives the family standing to advocate on behalf of the prospective 'patient' and put the case against compulsion if they feel it necessary *before compulsion has been imposed*. In order for this to happen there needs to be someone who has status by virtue of an emotional or caring relationship to make objections, without having to wait until after compulsion for such a person to be appointed, although the nominated person would have the right to apply for discharge to the MHT. Reasonable objections to compulsion are best dealt with by way of prevention rather than cure given the potentially traumatising experience of compulsion.[43]

The important recommendation in terms of service user autonomy was that where possible, they should be empowered to appoint their own nominated person, and that this could be done by advance statement. 'Such a person might be a relative, friend, carer or advocate.'[44] Where there is no family, spouse or partner, it would be beneficial for the service user to be able to nominate a nominated person, and the Committee strongly recommended that 'the identification of a nominated person should be a central focus especially for those who are likely to be assessed for compulsion on future occasions.'[45] However, many people with a mental health problem do not foresee the possibility of compulsory powers being imposed, or may lack capacity to do so, and may not have had the foresight to appoint a nominated person in advance. The Richardson Committee considered this useful but decided against proposing a default provision based on s 26 of the 1983 Act to address the situation where a service user has not nominated anyone in advance. Again they felt such a provision would be unnecessary, particularly in relation to assessment, because of the rights of access to the MHT to appeal against compulsory assessment.[46] This ignores that fact that carers and relatives may provide safeguards which cannot be provided by the tribunals, by being in a position to offer care to the service user, to advocate against compulsion, and to discharge the service user from detention. The other problem is that there is no-one to act for the service user at the point where compulsory powers are being considered.

2. The Mental Health (Care and Treatment) (Scotland) Act 2003

The Mental Health (Care and Treatment) (Scotland) Act 2003 provides a framework to solve these problems. It creates a presumption in favour of a capable service user's choice of 'named person' and specifically provides for recognition of nominations made by a capable service user, including advance nominations[47], with the first default position being the primary carer. The second default position is the nearest relative, defined in a way which reflects modern family forms including same sex partnerships.[48] This system accords with the view of the Parliamentary Joint Committee on Human Rights on the 2002 Draft Mental Health Bill that service users with capacity to do so should have a fuller role in selecting their nominated persons, so as to ensure compatibility with the Convention.[49] It also enables the service user who has not nominated someone in advance to have a supporter prior to the imposition of compulsion rather than after it.

43 *No Force Campaign (DMH 44) House of Lords, House of Commons, Report of the Joint Committee on the Draft Mental Health Bill Session 2004–2005 HL Paper 79(1), HC Paper 95(1)*

44 *Richardson Committee Report, op. cit., para. 12.21*

45 *Ibid., para. 12.21.*

46 *Richardson Committee Report, op. cit.., para. 12.22.*

47 *Mental Health (Care and Treatment)(Scotland) Act 2003, s 250.*

48 *Ibid., cl 254(2)(b) and (7).*

49 *Draft Mental Health Bill: Twenty Fifth Report of Session 2001–02, HL Paper 181, HC 1294; London, HMSO, para. 84.*

The Mental Health Bill 2004

Under the 2004 Bill regime the nearest relative role is replaced by two figures, the carer and the nominated person, and the floor of rights is substantially diminished. Whereas in many instances one person will wear both hats, the carer will not necessarily also be the nominated person. This possible divergence of roles and functions provides the framework for potential confusion and conflict within the family. The person who performs the caring role may find themselves without the nominated person rights, diluted though they may be compared with the existing rights of the nearest relative, a clear case of responsibilities without commensurate rights.

The carer's role and rights

The carer's rights to be consulted are not automatic and are also limited to expressing views as to the likely impact of any medical treatment on the carer and service user, and to providing clarification as to the service user's wishes and feelings.[50] Therefore the main function of the carer is as provider of information to the clinical team, a useful but essentially passive role. The carer's right to be consulted will not be exercisable unless and until the service user's views have been sought and a determination is made by the AMHP that consultation is appropriate and practicable, appropriateness and practicability to be determined in the light of the *Bristol* case.[51]

The recommendation of the Joint Parliamentary Scrutiny Committee that the Bill should be amended to contain a presumption to consult a carer when examinations and assessments are being carried out unless the patient is expressly opposed to it has been rejected in the Government's response.[52] The Government believes the patient will receive greater protection where an AMHP exercises discretion as the burden of expressing an objection will be removed from the patient. In cases of exploitative or inadequate carers this may be so but in families with able, ethical carers the scene may be set for disharmony where the 'expert carer' clashes with the professional.

The nominated person

Fifteen clauses of the Bill are devoted to the appointment and displacement of the nominated person.[53] Priority is given to the autonomous choice of a capable service user subject to the important qualification that in the view of the approved mental health professional (AMHP) the person nominated is eligible and suitable. There are various mechanisms for overriding the service user's choice, so it may be some time after compulsion is imposed before the nominated person is appointed, tying up professional time, and creating uncertainty. The obvious problem here is that, because of the absence of recognition of advance statements appointing a nominated person, the service user is being asked to make a choice in relation to their nominated person when their capacity is considered to be sufficiently impaired to warrant the use of compulsory powers under mental health legislation.

If the service user lacks capacity or the person chosen is unsuitable or ineligible, the appointer (in most cases, the AMHP) must appoint the most suitable eligible person or, if there is none, the local social services authority. The service user must be consulted over the appointment (unless inappropriate or impracticable) but does not have an absolute veto over appointments. The AMHP merely has to have regard to the service user's views in deciding whether the appointment is

50 *Mental Health Bill 2004, cl 12.*

51 *Administrative Court [2005] All ER (D) 57 (Jan) 13 January 2005.*

52 *Government Response to the Joint Committee's report on the draft Mental Health Bill 2004 page 46*

53 *Ibid., cls 232–246.*

inappropriate, but is not bound by them.[54] This gives immense discretion to the AMHP.

The effect of these reforms will be to leave the service user unprotected at the point where s/he is most vulnerable, when compulsion is being imposed. The 2004 Bill provides that as soon as practicable *after* the person becomes liable to assessment, that is *after compulsory powers have been exercised*, the AMHP must appoint a nominated person for the service user, and notify the service user and the nominated person (also each person with parental responsibility for a service user under 16) of the fact that the service user is liable to assessment as a resident or a non-resident service user, of all the determinations made in his case and the reasons for them, and of the help available from Independent Mental Health Advocates.[55]

The nominated person has rights to be consulted at various points after compulsion has been imposed, and to make applications to the Mental Health Tribunal on the service user's behalf. The matters about which a nominated person is consulted must include whether it appears to him that the service user's wishes and feelings about that step are known or can be ascertained and, if so, what appear to him to be those wishes and feelings.[56] A service user's nominated person is entitled at any reasonable time to visit the service user[57].

A service user with capacity may place restrictions on the role of the nominated person. A service user 'who appears to the appointer to have capacity' can notify the AMHP that the nominated person is not to be consulted, notified, provided with any document, or account is not to be taken of any representations or requests made by the nominated person on any matter.[58] This means that the nominated person role may become a matter for negotiation creating scope to erode further the rights of a 'stroppy' carer or relative who may well be right, and have a fair case to put, like Mr and Mrs E in *HL v United Kingdom*[59] and Andrew Taylor's mother in the Bolton LGO case.[60]

The 2004 Bill erodes the nearest relative's rights to act as supporter of the rights of the service user. Unless the service user has had the prescience to nominate a person in advance (remember the Bill has no provision for advance appointments) the nominated person would not be appointed until *after* the service user is subject to compulsion. The Bill cuts away the current nearest relative right to advocate for the least restrictive alternative at the crucial stage prior to compulsory powers being exercised, that is *before* the process of compulsion rolls forward with its own momentum. Supervision of the system would be transferred to the mental health tribunal from the county court. Within this labyrinthine system the service user has a limited right, with the leave of the MHT, to apply for the revocation of the appointment of his nominated person.[61]

It is a curious way to address the issue of service user autonomy by proposing a system which fails to recognise advance statements appointing a nominated person, which contains no fall back position, and which introduces a complex system where the very people whose decisions may be challenged by the nominated person are given immense discretionary power over who that person should be.

54 *Ibid., cl 233(6), cl 235, cl 236.*

55 *Ibid., cl 19.*

56 *Mental Health Bill 2004, cl 238.*

57 *Ibid., cl 238(3)*

58 *Ibid., cl 239. If the nominated person is notified s/he must not do the things specified in the notice, and the requirements of the Act to consult the nominated person in relation to that matter do not apply.*

59 *HL v United Kingdom Judgment of the European Court of Human Rights 5 October 2004.*

60 *Local Government Ombudsman, Report on an Investigation into Complaint No 02/C/17068 against Bolton Metropolitan Borough Council 30 November 2004.*

61 *Draft Mental Health Bill 2004, cl 244.*

The Convention case law clearly recognizes that mentally disordered people need support to exercise their rights, particularly if they lack capacity.[62] It also recognizes that service users should have the right to sever legal ties with family members who have behaved abusively towards them in the past or are otherwise unsuitable to exercise the powers of nearest relative.[63] People with mental disorder sufficiently serious to warrant compulsion will stand a much better chance of doing well in the community if they have a carer. Any new legislation should contain proposals which enable relatives, nominated persons, or next friends, call them what you will, to have a firm footing of legal rights to advocate for the least restrictive alternative, and to look after non-dangerous family members in the community by discharging their compulsory detention. Instead the 2004 Draft Bill seeks to abolish these rights.

Whilst under the 1983 Act the carer will almost automatically be the nearest relative, the carer will not necessarily achieve nominated person status under the Draft Bill. This will potentially divide families and damage relationships where the carer bears responsibility for care, but may not even have the powers of the nominated person, limited as they are. Nearest relatives are often seen as an irritant or at best an irrelevance, and the proposed reforms pay little more than lip service to service user autonomy, except where it might be used to clip the wings of the nominated person, and can be seen as a somewhat unsubtle attempt by the state to wrest back control from the private family arena by replacing the robust but flawed nearest relative concept with limited rights for nominated persons and carers. If the Government was serious about Article 8 compliance it would have introduced a remedial order by now.

The Joint Parliamentary Scrutiny Committee

The Joint Parliamentary Scrutiny Committee heard a considerable body of evidence recommending acceptance of the principle that the service user should have greater rights to choose who should be the nominated person, but it rejected the reduction in the floor of rights for such a person proposed under the Draft Bill.[64] The Committee recommended that the nominated person should have broadly the same rights as the nearest relative. Removing the rights of the nearest relative would in the Committee's view erode the position of families and carers to take responsibility for the care needs of the service user and to avoid admission to hospital. The nominated person should be able to make an order for the discharge of a service user detained in hospital. The clinical supervisor should be able to block discharge only on grounds of likely dangerousness to self or others, subject to appeal to the MHT by service user, carer or nominated person.[65]

The Government has rejected these recommendations, arguing that they are unnecessary as the Bill provides ' a comprehensive package of additional safeguards' (namely, the clinical supervisor's on going review function, the review role of the MHT and the support provided by advocates and nominated persons). The Government states that compulsion should continue where treatment is

62 *HL v United Kingdom Judgment of the European Court of Human Right of 5 October 2004.*

63 *JT v United Kingdom (2000) 30 E.H.R.R CD 77.*

64 *Yens Marsen-Luther of the Institute of Mental Health Act Practitioners, said 'We are terribly concerned that the proposals to get rid of the opportunity for the nearest relative to discharge the service user if they are not a danger to themselves or others. We think this is throwing the baby out with the bathwater.' (the origin of this phrase is German and means a Treatise for fools!) House of Lords, House of Commons, Report of the Joint Committee on the Draft Mental Health Bill Session 2004–2005 HL Paper 79(1), HC Paper 95(1) para 398*

65 *Ibid., para 398.*

deemed necessary even though there may be no issue of dangerousness.[66] The shift towards greater state power could hardly be made any clearer

The Committee also considered that the rights and interests of a service user would be better safeguarded if a nominated person was able to act at the point when compulsory powers are first used, to exercise his powers from the start of the examination stage, and was entitled to participate in the examination.[67] Additionally the Committee recommended that patients have the right to independent mental health advocates from the start of the initial examination period.[68] The Government response acknowledges concerns that patients should have adequate support from advocates/nominated persons/carers before compulsory powers are applied but disappointingly states it is to be left to codes of practice to determine how this will be achieved.[69] It is submitted that such a vital function should be enshrined in the primary legislation.

The Committee recommended that service users should be able in advance to appoint a nominated person either by an advance statement or by a simple free-standing instrument. If no prior appointment had been made the Committee recommended using the default system adopted by the Scottish legislation whereby the carer would be the nominated person, or if there was no carer, the nearest relative.[70]

The Government response to the recommendation regarding advance statements is positive to the extent that there is a statement that they 'will carefully consider how this may be achieved in the Bill'.[71] Whilst this is encouraging it does not amount to a firm commitment as to how, or indeed if, this recommendation will be followed. The response to the default provisions recommendation is less enthusiastic. The Government acknowledges the time consuming and complex nature of appointing a nominated person who is both suitable and eligible but feels clarification can, once again, be left to 'guidance'.[72] It is submitted this is an inadequate response. Further, the Committee's proposals are rejected for 'not allowing scope for flexibility.' Reference is made to the patient who although lacking capacity, 'may still be able to indicate some preference and regard should be had to this' in deciding who is suitable and eligible. It is to be hoped that in practice this will translate in to a genuine process which facilitates patient autonomy rather than one that substitutes the predictability of a default system in favour of yet more state discretion.

Conclusion

A Mental Health Bill, even if enacted this session, is unlikely to come into force until 2008. In the meantime, if service users' human rights are not to be infringed, a simple remedial order should be introduced giving them the right, when capable, to make a statement about who they want to be their nearest relative (and who they do not want), and to enable them to seek to displace a nearest relative who is unsuitable (with the leave of the county court). Finally, in a case where the nearest relative is subject to displacement proceedings and detention under s.2 extended, the case should automatically be brought before a tribunal within seven days, and the relative should have standing to give evidence at that hearing.

66 *Ibid, page 44*
67 *Ibid., paras. 402–403.*
68 *Ibid, para 387*
69 *Ibid page 42*
70 *Ibid., para 402.*
71 *Ibid, page 45*
72 *Ibid, page 45*

The predominance of the risk-management/public safety agenda has led to the view that obstacles to the use of compulsory powers should be reduced, and objecting nearest relatives under existing legislation have the capacity to be obstacles. The Government view is that it is anachronistic for one person to play such 'a direct decision making role... simply by virtue of being the nearest relative.'[73] This says much about the proposed shift of power from the private to the public arena. Remarkable people like Mr and Mrs E and Andrew Taylor's mother were undoubtedly viewed by the professionals as misguided and obstructive. These carers were right, and they won their cases. Their expertise gained by experience as carers, and their close involvement in care had been set at naught by the decisions of the professional experts.

Enlightened mental health legislation should achieve a balance between respect for patient autonomy and empowering those who know and care for them to bring mental health professionals to the negotiating table to achieve the most appropriate outcome. Preserving nearest relative rights, regarding powers to challenge detention, is not destructive of patient autonomy but an essential ingredient in the often confusing and inexact process of coping with mental disorder and how best to manage it.

73 *Annex 4: Schedule of detailed comments on the draft Mental Health Bill with responses from the Government, page 247*

An Inconvenient Mirror[1] Do we already have the next Mental Health Act?

David Hewitt[2]

I. Introduction

The Government intends to replace the Mental Health Act 1983, and the most recent of its proposals were contained in the Draft Mental Health Bill published in June 2004.[3] (The Draft Bill has undergone 'pre-legislative scrutiny', and the Joint Committee appointed to perform the task published its report on 23 March 2005.[4] The Government published its response to that report on 13 July 2005.[5])

The 1983 Act is now very different to the statute introduced at the end of 1982. Parliament and the courts have made a number of significant changes over the last 20-odd years, and they have brought us a lot closer to the next Mental Health Act than many people – and possibly even the Government – suppose. In fact, those changes may have brought us rather close to the Draft Mental Health Bill. That will be an uncomfortable thought for many people.

This paper will consider five key aspects of the Draft Mental Health Bill:

- the provisions dealing with *risk* and *treatability*;
- the notion of compulsion in the community;
- the status of the Code of Practice; and
- the abolition of the Approved Social Worker.

The paper will ask whether, because of the changes of the last two decades, the current Mental Health Act has already arrived at much the same point. In addition, the paper will consider the position of incapable patients. Although the Draft Bill contains precious few proposals about

1 *This paper is based on a public lecture given at the Hull School of Health and Social Care on 27 January 2005*

2 *Solicitor and Partner in Hempsons. Visiting fellow, Law School, Northumbria University*

3 *Department of Health, Draft Mental Health Bill, September 2004, Cm 6305-I; Ibid, Draft Mental Health Bill: Explanatory Notes, June 2004, Cm 6305-II; Ibid, Improving Mental Health Law: Towards a new Mental Health Act, September 2004*

4 *Joint Committee on the Draft Mental Health Bill, Session 2004–2005, Draft Mental Health Bill, Volume I, HL Paper 79-I, HC 95-I, Volume II, HL Paper 79-II, HC 95-II, Volume III, HL Paper 79-III, HC 95-III. (A detailed paper on the Joint Committee's report may be found at www.hempsons.co.uk)*

5 *Department of Health, 2005, Government response to the report of the Joint Committee on the draft Mental Health Bill 2004, July 2005, Cm 6624*

them, the paper will ask whether recent developments have made a broad definition of mental disorder all but essential.

2. The Relevant Conditions

The Draft Mental Health Bill is about far more than 'detention'. The powers it contains will be capable of being used, not just in hospitals, but also in the community. A patient against whom the expanded powers are used will be said to be "subject to compulsion".

Once a person is found to be suffering from mental disorder, as that term is to be broadly defined, it will be possible under the Draft Bill to make him subject to compulsion if each of the Relevant Conditions is met.[6] There are five Relevant Conditions, and some of them are extremely controversial.[7]

(a) Risk

It is the Third Relevant Condition that deals with the *risk* a person must pose, either to himself or others, before he can be made subject to compulsion.[8]

It will be possible to make a person subject to compulsion if that is necessary for the protection of other persons.[9] That proposal is controversial in itself,[10] but the proposal concerning people whose only risk is to themselves is equally so.

For compulsion to be possible in those circumstances, the Third Relevant Condition says it will have to be "necessary, for the protection of the patient from suicide or *serious* self-harm, or *serious* neglect by him of his health or safety, [...] that medical treatment be provided" to him.[11]

The Government says that in comparison to the 1983 Act, "the threshold of harm to self has been raised".[12] It is certainly true that the current Mental Health Act affords the patient much less leeway: in allowing him to be detained for his own health or safety, it doesn't require that the risk is 'serious'.[13] Yet, for all that, it seems likely that the Draft Bill would do no more than give statutory recognition to the present state-of-affairs. Even now, there are so few in-patient beds that they can usually be given only to people who present a risk of suicide or a *serious* risk of self-harm or a *serious* risk of neglect.[14]

(b) Treatability[15]

According to the Fifth Relevant Condition, it will not be possible to make a person subject to compulsion unless "medical treatment is available which is appropriate in his case".[16] This is a very

6 *Department of Health, Draft Mental Health Bill, September 2004, Cm 6305-I, cl 2(5)*

7 *Ibid, cl 9*

8 *Ibid, cl 9(4)*

9 *Ibid, cl 9(4)(b)*

10 *See, for example: Joint Committee on the Draft Mental Health Bill, Ibid, vol I, paras 121 & 122; Department of Health, 2005, Ibid, Recommendation 20.*

11 *Ibid, cl 9(4)(a)*

12 *Department of Health, Improving Mental Health Law: Towards a new Mental Health Act, September 2004, para 3.15*

13 *MHA 1983, s 2(2)(b) & 3(2)(c)*

14 *See, Joint Committee, Ibid, Vol II, Ev 280 (David Hewitt), para 2.3*

15 *See, Joint Committee, Ibid, Vol II, Ev 280 (David Hewitt), para 2.2*

16 *Department of Health, Draft Mental Health Bill, September 2004, Cm 6305-I, cl 9(6)*

controversial proposal.[17] Some critics of the Draft Bill claim that it represents a dilution of the current 'treatability test'.

The treatability test is contained in section 3 of the Mental Health Act 1983. It provides, amongst other things, that a person suffering from psychopathic disorder may be detained only if he is 'treatable'.[18] Critics say this test is being diluted because it makes it too hard to detain psychopaths.

In fact, and perhaps surprisingly, the Government agrees with this analysis. It says the treatability test,

> "[...] has led to uncertainty about whether a patient's disorder can be treated or not, irrespective of any opinion that they remain a risk to themselves or others. Some patients are not being brought under the Act even when it is appropriate to do so."[19]

This conclusion is wrong. The Government has misunderstood several important legal judgments and, as a result, exaggerated the strength of the treatability test. Its proposal is a solution to a problem that doesn't exist.[20]

As used in the Mental Health Act, the term 'medical treatment' currently includes, "nursing [...] and care, habilitation and rehabilitation under medical supervision".[21] This is a very broad definition, which the courts have broadened still further. Now, the treatability test will be satisfied, and a patient will be detainable under the 1983 Act, if hospital treatment will prevent deterioration in his condition, or make him less uncooperative or more insightful;[22] or if it is likely to impact on his symptoms, even if it won't touch the substantive illness.[23] In *Wheldon*, the High Court said, "It is plain [...] that the concept [of treatability] is a very wide one";[24] while in *Reid*, the House of Lords said the definition of 'treatment' was now so wide that its purpose "may extend from cure to containment".[25]

There must be very few patients whose condition – or the *symptoms* of whose condition – cannot be alleviated, or whose deterioration cannot be prevented, by some form of clinical intervention. It is difficult, therefore, to see how the treatability test in the 1983 Act is anything other than a dead letter, and surprising, perhaps, that the Government should be willing to risk so much to abolish it.[26]

The desire to make psychopaths detainable, and the mistaken belief that they aren't already detainable, are at the centre of the Government's plans for a new Mental Health Act. In fact, some might say that they have distorted those plans. That is unfortunate. But it shouldn't just colour our view of the Draft Bill; it should also affect the way we think about the *current* Act.

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17 *Department of Health, 2005, Ibid, Recommendation 74*

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

19 *Department of Health, Draft Mental Health Bill: Explanatory Notes, June 2004, Cm 6305-II, para C9.10. See also, Department of Health and Home Office, Reforming the Mental Health Act – Part I: The new legal framework, December 2000, Cm 5016-I, paras 1.15 & 3.5; Department of Health, Draft Mental Health Bill: Explanatory Notes, June 2002, Cm 5538-II, para 2.11*

20 *David Hewitt, Treatability Tests, Solicitors Journal, 146 (37), 4 October 2002, pp 886 & 887*

21 *MHA 1983, s 145*

22 *R v Canons Park Mental Health Review Tribunal, ex parte A [1994] All ER 659, CA, per Roch LJ*

23 *R v Secretary of State for Scotland, 1998 SC 49, 2 Div*

24 *R (Wheldon) v Rampton Hospital Authority [2001] EWHC 134 (Admin), per Elias J at para 14*

25 *Reid v Secretary of State for Scotland [1999] 1 All ER 481*

26 *In fact, it would seem that the Government has an even wider conception of treatability. In its response to the Joint Committee, it said that compulsion need not be limited to those cases where treatment will improve a patient's condition or prevent it deteriorating. See, Department of Health, Ibid, Recommendations 21 & 22. This raises the possibility that it will be lawful to confine and compulsorily treat a mental health patient for the sole purpose of making his/her condition worse.*

3. Non-resident Patients

Under the Draft Mental Health Bill, a person to whom compulsion is applied when he is not in hospital will be a 'non-resident patient'.[27] The Government has been disingenuous about its motive for making this change.[28]

(a) Motive

Most recently, the Government claimed that non-resident patients were the embodiment of the principle of the 'least restrictive alternative'. This principle is best summarised in the Mental Health Act 1983 Code of Practice, which states that anyone who is subject to the Act should,

> "be given any necessary treatment or care in the least controlled and segregated facilities compatible with ensuring their own health or safety or the safety of other people."[29]

This is the spirit the Government wishes to invoke now. In a paper published alongside the Draft Bill, it said:

> "The intention of allowing patients to be under formal powers in the community is to provide greater flexibility to practitioners so that the principle of least restriction can be put into effect."[30]

However, five years ago the Government said something rather different. In its White Paper it said,

> "At the moment clinicians have to wait until patients in the community become ill enough to need admission to hospital before compulsory treatment can be given. This prevents early intervention to reduce risk to both patients *and the public*".[31]

Far from reflecting the 'principle of least restriction', it seems that community compulsion – in other words, the 'non-resident patient' scheme – is necessary *to protect the public*. Here, and not perhaps for the first time, the Government might be accused of trying to appeal to two different, even antipathetic, constituencies.

The Government may have been disingenuous about is plans, but is it possible that community compulsion is already a reality; that many people outside hospital are 'non-resident patients' in all but name?

(b) Leave

It is necessary to consider the case of *DR*.[32] In that case, a patient's detention under section 3 of the Mental Health Act 1983 was renewed for a further 6 months even though she was on unlimited leave of absence. The only relevant requirement was that she return to hospital for the ward round every Monday and OT every Friday. The High Court said it was lawful to renew the patient's

27 *The Joint Committee has criticised these proposals and recommended that more rigorous conditions be introduced for community compulsion. See, Joint Committee, Ibid, Vol I, paras 187–199. In response, the Government has said it does not propose to make any such changes. See, Department of Health, 2005, Ibid, Recommendation 33.*

28 *See, Joint Committee, Ibid, Vol II, Ev 280 (David Hewitt), para 2.6*

29 *MHA 1983 Code of Practice, para 1.1*

30 *Department of Health, Improving Mental Health Law: Towards a new Mental Health Act, September 2004, para 3.35. See also, Department of Health, 2005, Ibid, Recommendation 33*

31 *Department of Health and Home Office, Reforming the Mental Health Act – Part I: The new legal framework, December 2000, Cm 5016-I , para 2.14; emphasis added*

32 *R (DR) v Mersey Care NHS Trust, Administrative Court (Wilson J), 7 August 2002, CO/1232/2002*

detention in those circumstances, because treatment in hospital – the OT and the ward round – formed a "significant component" of the plan for her.[33]

This decision has been seen as re-introducing the 'long leash' that doctors had been asked to abjure since the case of *Hallstrom*,[34] and it has been confirmed, and possibly even extended, by the recent High Court decision in the case of *CS*.[35]

It has always been clear that, as a matter of general law, a patient may have her leave revoked, and she may be recalled to hospital, at any time by her Responsible Medical Officer ('RMO').[36] Provided she is given the relevant notice in writing, it isn't necessary for the RMO to have a good reason for revocation and recall, or for the RMO to have any reason at all.

What the *DR* and *CS* cases suggest is that by the careful use of section 17, a person who remains 'liable to be detained' in hospital may be maintained in the community indefinitely and hauled back into hospital if she acts inappropriately. There would appear to be no difference between that patient's situation and the situation of a 'non-resident patient' under the Draft Mental Health Bill.

4. The Code of Practice

Like the present Mental Health Act, the next one will have a Code of Practice.[37] However, on the face of it, the next Code will be less binding than the present one.

It would seem from the Draft Mental Health Bill that hospitals and practitioners will only need to "have regard" to the new Code.[38] The fear is that this would strip the Code of Practice of its essential force.

Whilst that may be a legitimate concern, it is questionable whether the new proposals diminish the Code of Practice at all. In the *Munjaz* case, the House of Lords held that the Code of Practice on the 1983 Act was guidance, and not binding, and that professionals and providers might lawfully depart from it if they had "cogent reason" to do so. (The Court of Appeal had earlier held that departures from the Code would be lawful where there was "*good* reason" for them.)[39]

5. An Approved Mental Health Professional

The Approved Mental Health Professional is the replacement for the Approved Social Worker ('ASW'), and the ASW role is to be abolished. The Government's proposals in this regard are perhaps the most perplexing in the whole Draft Bill.

33 *David Hewitt, There is no magic in a bed, Journal of Mental Health Law, August 2003, pp 87–101*

34 *R v Hallstrom and another, ex parte W; R v Gardner and another, ex parte L [1986] 2 All ER 306*

35 *R (CS) v Mental Health Review Tribunal [2004] EWHC 2958 (Admin). See further within this issue of the JMHL for a review of this case.*

36 *MHA 1983, s 17(4)*

37 *Department of Health, Draft Mental Health Bill, September 2004, Cm 6305-I, cl 1*

38 *Ibid, cl 1(2) & (5)*

39 *R (Munjaz) v Mersey Care NHS Trust [2005] UKHL 58; R (Munjaz) v Mersey Care NHS Trust; R (S) v Airedale NHS Trust [2003] EWCA Civ 1036. (Detailed papers on each of these cases may be found at www.hempsons.co.uk) David Hewitt, A room of one's own – seclusion is at last lawful, The Times, 26 November 2002; David Hewitt, A secluded view, New Law Journal, 153 (7090), 25 July 2003, p 1133; David Hewitt, The seclusion of psychiatric patients: trusts' position clarified, Health Care Risk Report, 10(1), November 2003, pp 17 & 18*

(a) Motive

The Government has given six main reasons for introducing a new Mental Health Act.[40] Two of them concern the ASW, and looked at from that perspective, they appear to lack logic.

(i) Up-dating principles

In 1999, the Government said it wanted to "bring up to date the principles and processes established by the 1959 and 1983 Mental Health Acts".[41]

One of the key principles of the current Act was the balancing of the 'medical model' of mental illness with the 'social model'. Because he was seen as an arch proponent of the social model, the ASW was given significant powers. However, the Draft Bill abolishes the ASW role.

In future, it is the Approved Mental Health Professional who will make an application for compulsion, and he won't have to be a social worker. He might be a community psychiatric nurse or an occupational therapist, and he might even be employed by the NHS trust that is to be responsible for subjecting a patient to compulsion.[42]

Where does that leave the 'social model' of mental illness? More generally, how far can a Government go with legislation before the principles it hopes to up-date it actually destroys?

(ii) Inadequate knowledge

The Government has said that the way the current Mental Health Act is applied varies widely between different parts of the country, and that this has something to do with a lack of knowledge amongst mental health professionals. Though they are "mostly people with professional training in clinical and social care," the Government says, "few have specialist training in or understanding of the law".[43] However, this suggestion raises more questions than it answers.

If professionals know too little about the existing Mental Health Act, why is a new Mental Health Act required? Wouldn't the answer be to provide more and better training on the existing Act? The one group of professionals that does receive specialist training in mental health law is ASWs, yet, as has been noted, the Draft Bill would abolish their role.

The Government is deeply confused about its motives for abolishing the ASW. However, it is also necessary to ask whether the Approved Mental Health Professional, or something very like him, is already a feature of psychiatric practice, more than two years before the Draft Bill is scheduled to become law.

40 *David Hewitt, Windmills, not giants, Solicitors Journal, 148 (42), 5 November 2004, pp 1271 & 1272*

41 *Department of Health, Reform of the Mental Health Act 1983: Proposals for Consultation, November 1999, Cm 4480, para 1.3. (Slightly more information may now be found in Department of Health, 2005, Ibid, Recommendation 102.)*

42 *Department of Health, Draft Mental Health Bill, September 2004, Cm 6305-I, cl 15(1), 16(3), 19(2) & 22(1)*

43 *Department of Health, Reform of the Mental Health Act 1983: Proposals for Consultation, November 1999, Cm 4480, para 2.8. See also, Department of Health, Reforming the Mental Health Act – Part I: The new legal framework, December 2000, Cm 5016-I, paras 1.14 & 2.6*

(b) Proposals

As has been indicated, it won't be necessary for an Approved Mental Health Professional to be a social worker.[44] If, in a particular case, he should turn out to be a community psychiatric nurse or an occupational therapist, there are two principal fears.

The first fear is that in that case, not only the two recommendations but also the compulsion application itself would be provided by someone whose primary allegiance was to the 'medical model' of mental health, and that as a result, the 'social model' would be ignored.

The Government has tried to address this fear. It has said, "The competence required of an AMHP will be broadly similar to that required of an ASW currently".[45] However, a nurse is not a social worker, and their perspectives, training and experience differ very widely. Therefore, the loss of the social model must remain a legitimate fear.

The second fear is about a loss of independence.[46] At the moment, the ASW is not only the sole exemplar of the 'social model'; he is also wholly independent and cannot, for example, be compelled to make an admission application.

If it will be possible in future for a compulsion application to be made by an employee of the body that is to do the compelling, the fear is that he will be more biddable than an ASW would have been and that a crucial element of independence will have been lost. That, again, is a legitimate fear. However, given what the law allows even now, is the feared position really so far away?

Here, it is necessary to consider partnership working, which perhaps reaches its culmination in the Care Trust. In most if not all of the mental health partnerships and care trusts that have been created so far great pains have been taken to keep local authority mental health functions outside the formal structure of the partnership or trust. However, the simple truth is that this is more than the law requires.

Partnership arrangements between local authorities and NHS bodies have been possible since the year 2000, when section 31 of the Health Act 1999 came into force. Under the relevant regulations, a social services authority may give nearly all of its "health related functions" (as they are defined in Schedule 1 of the Local Authority Social Services Act 1970) to the partnership, and thereby delegate the performance of those functions to its NHS partner.[47] (In fact, the only "health related functions" a local authority can't give away are the appointment of ASWs and its powers of entry and inspection).

This means that where there is a mental health partnership or care trust, a whole swathe of local authority mental health functions could pass to a NHS trust. They include: directing an ASW to consider making an admission application;[48] receiving a patient into guardianship;[49] and providing after-care once a patient has left hospital.[50]

If the relevant agreement so provides, all of these local authority functions will be performed by a NHS body, and the staff that perform them, including any ASWs, will be answerable to that NHS body.

44 *Department of Health, Draft Mental Health Bill: Explanatory Notes, June 2004, Cm 6305-II, para 36*

45 *Ibid*

46 *The Joint Committee did not share this fear. See, Joint Committee, Ibid, Vol I, para 445*

47 *The NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (SI 2000 No 617), regs 4 & 6*

48 *MHA 1983, s 13(4)*

49 *Ibid, ss 7 & 8*

50 *Ibid, s 117*

This could be seen as a positive thing. Under these arrangements the 'social model' of mental health is not left on the periphery; it is moved to the very centre of the detention process and allowed to compete on equal terms with the 'medical model'. However, there is another way of seeing it.

There is nothing in the new partnership possibilities that would allow a NHS trust to *order* an ASW to make an admission application, so that element of independence is preserved. However, where there is formal partnership working there is at least the possibility that all other functions of an ASW, and all other mental health functions of a local authority, will be under the direct control of a NHS trust.

Ultimately, of course, the social services authority will be still be liable for the way someone else performs the health-related functions it has given them. However, the new arrangements mean much more than ASWs occasionally being managed by health professionals.

Even now, long before the Draft Bill becomes a reality, the context in which a detention application is to be judged could be an avowedly medical one, and the entire statutory process – from assessment to aftercare – could be performed by practitioners whose primary fealty is owed to the NHS body that will do the detaining.

One of the other functions a social services authority can give to a partnership is the function of being a patient's Nearest Relative under the 1983 Act.[51] This means that a NHS trust that is "the managers" of a hospital for the purposes of the Act could also find that it is the Nearest Relative of a patient whom it is detaining or, where it has assumed such responsibilities, of a patient of whom it is also the Guardian. Though undoubtedly intriguing, these are also troubling possibilities.

6. Incapable patients

It is necessary to consider the case of *MH*.[52] This case concerned a young woman who was detained under section 2 of the Mental Health Act 1983. Because an application had been made to displace her mother as the 'nearest relative', the patient's detention continued long after the usual 28-day period had come to an end.

The Court of Appeal held that where a section 2 patient is 'incapable' of making an application to a Mental Health Review Tribunal, there should be a system to ensure that her case comes before a tribunal. And it said that because the current Mental Health Act doesn't provide such a system, it is incompatible with the 'right to liberty' in Article 5 of the European Convention on Human Rights.

There are at least two ways of interpreting this decision. The first interpretation says that incapable patients who are detained must have the same Mental Health Act rights as capable patients. This is the more restrictive interpretation. However, it still has some quite significant implications. It means, for example: that the current Act will have to be amended, in order to give incapable section 2 patients something like an automatic right of appeal; that section 3 patients who are

51 *MHA 1983, s 29(1)*

52 *R (MH) v The Secretary of State for the Department of Health [2004] EWCA Civ 1690. (A detailed paper on this case may be found at www.hempsons.co.uk). This paper was last revised on 16th October 2005, shortly before the House of Lords judgment in the case of MH ((2005) UKHL 60). Notwithstanding the decision of the House of Lords, the writer submits that his reasoning within this section of this paper remains sound.*

incapable will probably have to be given the same right; and that the Draft Mental Health Bill will also have to be amended, to the same effect.[53]

It may be that it is also contrary to the Human Rights Convention for *any* mental health laws to be applied differentially. In other words, incapable patients might have to have *all* the same Mental Health Act rights as capable patients. This wouldn't be limited to tribunal rights; it would apply to every aspect of compulsory treatment for mental disorder.

This idea is worthy of being explored in more detail: it might contradict recent trends and also compromise what was seen as the best hope of all those who opposed the current Draft Bill.

Drawing on the report of the Expert Committee under Professor Richardson,[54] and taking encouragement from the *obiter* comments of Lord Justice Simon Brown in the case of *Wilkinson*,[55] many have argued that capable patients should have the right to refuse medical treatment for mental disorder, even if they are subject to detention. However, that isn't a right they have claimed for incapable patients.

The *MH* judgment suggests that it's all or nothing: that incapable patients must have the *same* rights as capable patients if they are subject to detention.

The Government dismissed Professor Richardson's proposals for a capacity-based system of compulsion, and its Green Paper, White Paper and first Draft Bill didn't admit capacity as an issue at all.[56] [57]

The current Draft Mental Health Bill offers some small concessions: it gives capable patients the right to refuse ECT,[58] and to refuse to be transferred to another hospital.[59] It doesn't give similar rights to incapable patients, so maybe it too is called into question by the *MH* decision.

There might be a second, more far-reaching interpretation of the *MH* judgment. It may be that there is no justification for giving incapable patients fewer rights of *any kind* – and not just fewer *Mental Health Act* rights – than are enjoyed by capable patients. In other words, maybe incapable patients – even incapable patients who are detained in hospital – cannot be treated any differently just because they *are* incapable. This is where the *Bournewood* case comes in.

In the *HL* case,[60] the European Court of Human Rights ruled that it was unlawful, and that it would breach the right to liberty in Article 5 of the European Convention on Human Rights, to admit an incapable patient to hospital under the common law doctrine of 'necessity' if what was to be done to him there would amount to a deprivation of his liberty. And it interpreted

53 *David Hewitt, Incapacity and the right to liberty, New Law Journal, 155 (7158), 7 January 2005, pp 26 & 27*

54 *Department of Health, Review of the Mental Health Act 1983: Report of the Expert Committee, November 1999, paras 5.96 & 5.97*

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

56 *See, for example, Department of Health, Reform of the Mental Health Act 1983: Proposals for Consultation, November 1999, Cm 4480, chap 5, para 6*

57 *However, the Joint Committee suggested that one of the conditions for compulsion should be that, by reason of mental disorder, a patient's ability to make decisions about the provision of medical treatment is "significantly impaired". See, Joint Committee, Ibid, Vol I, para 156. The Government has dismissed this suggestion. See, Department of Health, 2005, Ibid, Recommendation 26.*

58 *Department of Health, Draft Mental Health Bill, September 2004, Cm 6305-I, cl 178 & 179*

59 *Ibid, cl 75–79*

60 *HL v United Kingdom, Application no 45508/99, decision of 5 October 2004. (A detailed paper on this case may be found at www.hempsons.co.uk)*

'deprivation of liberty' in such a way that most forms of confinement, treatment and control would be caught by its decision.[61]

As a result of this case, a new framework will have to be devised by which incapable patients can be 'detained' in a way that complies with Article 5.[62] Even the Government has conceded as much.[63]

At the very least, this framework will have to cover all incapable patients who need *Bournewood*-style detention. But not all incapable patients admitted to hospital under 'necessity' meet the criteria for detention under the Mental Health Act. For example, some of them are incapable because of an *acquired* brain injury; they aren't in a state of arrested or incomplete development of mind, and they don't, therefore, come within the statutory definition of 'mental impairment' or 'severe mental impairment'.[64]

So, if *they* are to be detainable the new framework will have to have a much broader conception of 'mental disorder' – or of the sorts of conditions that justify detention – than the current Act. Effectively – and to persist with the current classifications – it would be necessary to provide that a person might be detained if he suffered from mental illness, mental impairment, severe mental impairment or psychopathic disorder, *or if he was incapable in some material way*.

That, in itself would be a significant step. But might the law now require even more than that? Does the *MH* case mean that it isn't possible to use 'incapacity' as a substantive ground for confinement? Does it mean that incapable patients can only be confined if they meet the criteria that capable patients must meet in order to be confined?

That would not present an insuperable obstacle in the case of a patient whose incapacity amounted to 'mental impairment' or 'severe mental impairment' under the 1983 Act, or where an incapable patient was also suffering from 'mental illness' or 'psychopathic disorder'. Other cases, however, might prove more problematic.

If it were not possible to use 'incapacity' as a substantive ground for confinement but it were still necessary to devise a system for the confinement of the incapable, another way to do it would be to adopt a very broad definition of 'mental disorder'; a definition that was so broad that it covered everyone from people with schizophrenia to those with acquired brain injury, and, more importantly, from psychopaths to the learning disabled or dementia-impaired. The Draft Bill already contains a definition of mental disorder that is very broad – that is, perhaps, broad enough for this purpose. Hitherto, however, critics of the Bill have attacked this definition, and they've done so specifically because of its broadness. It is conceivable that they may now find themselves having to change tack.

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61 *David Hewitt, Effective, Unqualified Control, New Law Journal, 154 (7149), 22 October 2004, pp 1553 & 1554*

62 *See, Joint Committee, Ibid, Vol I, paras 179 & 180; Ibid, Vol II, Ev 281 (David Hewitt), paras 4.1 & 4.2; Ibid, Vol III, Ev 843 (W A Leason)*

63 *Department of Health, Advice on the decision of the European Court of Human Rights in the case of HL v UK (the "Bournewood" case), 10 December 2004, paras 30 & 31. See also: Department of Health, Bournewood consultation: The approach to be taken in response to the judgment of the European Court of Human Rights in the "Bournewood" case, March 2005, para 1.2; Department of Health, 2005, Ibid, Recommendation 29. The Joint Committee reported that on 22 February 2005, the Government tabled amendments to the Mental Capacity Bill that it said would have the desired effect. See, Joint Committee, Ibid, para 181 and n. 211.*

64 *MHA 1983, s 1(2)*

It is dangerous to extrapolate too far from a single High Court judgment, even one as intriguing and apparently fertile as *MH*. However, if this is where the law is leading – if, because of *Bournewood* and because of *MH*, it is necessary to have a far wider definition of 'mental disorder' – it is clear that the current position is not far removed from the one proposed in the Draft Mental Health Bill.

In any case, it may be that we are entering an odd, looking-glass world; a world where those who have so far seen a capacity-based model of compulsion as the epitome of everything good and a broad definition of 'mental disorder' as the epitome of everything bad suddenly find themselves arguing for the reverse.

7. Conclusion

In summary, then:

(a) Although the Relevant Conditions are controversial, the most extreme of them simply re-state the current position: patients who aren't a danger to others have to pose a *serious* risk to themselves if they're to be detained and almost every patient passes the 'treatability test'.

(b) With regard to 'non-resident' patients, the Government wants it both ways: it says it wishes merely to up-date the principle of the 'least restrictive alternative', so patients should be in the community unless they really *need* to be in hospital; but it also says that community treatment increases the risk to the public.

(c) Because of the *DR* case, we already have 'non-resident' patients, who can be made to reside in hospital at the drop of a hat.

(d) As for the Code of Practice, it's not as strong as many believe, so even the weak Code envisaged by the Draft Bill won't, in truth, be any weaker.

(e) The reasons given for killing off the ASW don't stack up. In any case, an ASW embedded in a mental health partnership or care trust might be an Approved Mental Health Professional in all but name.

(f) And finally, the need to improve the lot of '*Bournewood* patients' might rule out a capacity-based model of compulsion, and it might also usher in a much wider definition of 'mental disorder' than is contained in the 1983 Act.

This doesn't, of course, mean that we already have *everything* in the Draft Bill. However, the leap to there from here may not be as great as some – most – have assumed.

That's not to say that criticism should be withheld: even if a surprising proportion of the Draft Bill is, on closer inspection, quite familiar, there's still a lot of it that should give cause for concern. But that concern should not be confined to the Draft Bill.

If there's no 'treatability test' worthy of the name, it is because the courts have reasoned it out of existence. If leave patients can be kept on a long leash, that is because the High Court said it was OK. And if the Code of Practice is weak, that is because the House of Lords said it did not need to be any stronger. But the courts could only do this because the Mental Health Act allowed them to. And if the ASW is nothing more than the Approved Mental Health Professional in different shoes, that is because Parliament wanted it that way.

In making its current proposals, the Government has held up an inconvenient mirror, one in which our current mental health laws are rather alarmingly reflected. And the shapes that form in that inconvenient mirror force us to confront a worrying possibility.[65] It may be that what we would like to see – what we have until now *tried* to see – as flaws in the Draft Bill are actually something quite different: maybe they're really hard, durable, unyielding seams deep within the Mental Health Act we already have.

65 *David Hewitt, Windmills, not giants, Solicitors Journal, 148 (42), 5 November 2004, pp 1271 & 1272*

Mental Capacity Act 2005: The Statutory Principles and Best Interests Test[1]

Penny Letts[2]

Introduction

The Mental Capacity Act 2005, due for implementation in 2007, will create a new statutory framework intended to improve and clarify the decision-making process for people aged 16 and over who are unable to make decisions for themselves. Section 1 of the Act sets out five statutory principles intended to underline the provisions of the Act and guide its implementation and operation. The first part of this paper will look at the origins of each of the statutory principles. The second part will consider one of the principles – acting in the best interests of a person lacking capacity – in greater detail by looking at the requirements set out in the Act for determining a person's best interests.

Reform of the law relating to mental capacity has been a protracted process, starting in 1989 with a five-year inquiry by the Law Commission which published its report in 1995.[3] The Government undertook further consultation on the Law Commission's proposals[4], leading to a policy statement[5] and eventual publication in 2003 of a Draft Mental Incapacity Bill.[6] The draft Bill was subject to pre-legislative scrutiny by a Joint Committee of the House of Lords and House of Commons (the Joint Committee) which made a number of recommendations for improvements.[7] This paper charts the way in which these processes have influenced the new legislation.

1 *This paper is based on materials prepared for publication in G Ashton, P Letts, L Oates & M Terrell, Mental Capacity: The New Law, (Bristol: Jordans, forthcoming) and was first presented at Sweet & Maxwell's Mental Capacity Act conference on 30th September 2005*

2 *Policy Consultant, Specialist Adviser to Joint Parliamentary Scrutiny Committee on the Draft Mental Incapacity Bill*

3 *Law Commission, Mental Incapacity (Law Com No 231) (London: HMSO, 1995)*

4 *Lord Chancellor's Department, Who decides? Making decisions on behalf of mentally incapacitated adults, (London: HMSO, 1997) (Cm 3803)*

5 *Lord Chancellor's Department, Making decisions: the Government's proposals for making decisions on behalf of mentally incapacitated adults, (London: TSO, 1999) (Cm 4465)*

6 *Draft Mental Incapacity Bill, (London: TSO, 2003) (Cm 5859-I)*

7 *Report of the Joint Committee on the Draft Mental Incapacity Bill, Vol I (HL Paper 198-I, HC 1083-I) (London: TSO, 2003)*

The statutory principles

Much of the evidence submitted to the Joint Committee stressed the need for a clear statement of principles to be set out on the face of any new legislation.[8] Comparisons were made with section 1 of the Adults with Incapacity (Scotland) Act 2000 (AWI Act) which sets out five general principles to govern all "interventions" in the affairs of an adult taken under or in pursuance of the AWI Act.[9]

While some of the specific provisions of the AWI Act and the Mental Capacity Act are similar, there are significant differences in the underlying intentions and operation of both pieces of legislation as well as in the respective jurisdictions[10]. Despite those difference, the Joint Committee was persuaded that the statement of principles in the AWI Act provided not only necessary protection for people with impaired capacity and a framework for ensuring that appropriate action is taken in individual cases, but also that the specified principles were extremely helpful in pointing the way to solutions in difficult or uncertain situations.[11] In conclusion, the Joint Committee commented:

> "... we were struck by the absence of a specific statement of principles on the face of the Bill as an initial point of reference, as had been done in the Scottish Act. Although the principles of the draft Bill may be discernible to lawyers from the opening clauses of the draft Bill, they may not be so obvious to the majority of non-legal persons who will have to deal with the Bill in practice"[12]

The Joint Committee's strong recommendations[13] that a statement of principles be incorporated on the face of the Act were accepted by the Government. As a result, section 1 of the Mental Capacity Act now sets out five guiding principles designed to emphasise the underlying ethos of the Act, which is not only to protect people who lack capacity, but also to maximise their ability to participate in decision-making. Section 1 provides as follows:

> "(1) The following principles apply for the purposes of this Act.
>
> (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
>
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
>
> (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.
>
> (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."

8 *See in particular the evidence submitted by the Making Decisions Alliance in Report of the Joint Committee on the Draft Mental Incapacity Bill, Vol II (HL Paper 198-II, HC 1083-II) (London: TSO, 2003), Ev 85*

9 *Adults with Incapacity (Scotland) Act 2000, s1*

10 *See 'Reflections from Scotland: Difficult Decisions Ahead' Hilary Patrick in this issue of the JMHL*

11 *Evidence for the Law Society of Scotland, Joint Committee Report Vol II, Ev 2*

12 *Joint Committee Report, Vol I, para 39*

13 *Joint Committee Report Vol I, Recommendations 4 & 5*

The statement of principles was warmly welcomed, not only by voluntary and professional organisations involved with people who lack capacity[14], but also by MPs and Peers commenting on the principles during the Parliamentary debates. In particular, during the Bill's second reading in the House of Lords, the Lord Bishop of Worcester, said

> "The result is not just a Bill with important protections for vulnerable people; 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 believe that [the Bill] 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."[15]

Presumption of capacity

Practitioners will already be familiar with the presumption, at common law, that an adult has full legal capacity unless it is proved that he or she does not. If a question of capacity comes before a court, the burden of proof is generally on the person who is seeking to establish a lack of capacity and the matter is decided according to the usual civil standard, the balance of probabilities.

Taking account of responses to consultation and in keeping with its proposal to establish a single comprehensive jurisdiction, the Law Commission recommended that the new statutory provisions should expressly include and re-state both the common-law principle of presumption of capacity and the relevant standard of proof.[16] The presumption of capacity therefore appears in section 1(2) as the first principle relating to the Act. The Draft Code of Practice (issued in September 2004 to assist Parliamentarians in their consideration of the Mental Capacity Bill) stresses that the starting point for assessing someone's capacity to make a particular decision is always the assumption that the individual does have capacity:

> "Some people may need help or support to be able to make a decision or communicate a decision ... but the need for help and support does not automatically mean that they cannot make that decision."[17]

Capacity must then be judged in relation to the particular decision at the time that decision needs to be made, and the presumption of capacity may only be rebutted if there is acceptable evidence that the person is incapable of making the decision in question. In relation to day-to-day decisions in connection with the person's care and treatment, a "reasonable belief" that the person lacks capacity is sufficient, so long as reasonable steps have been taken to establish this.[18]

14 *See for example, Making Decisions Alliance, Briefing for 2nd Reading debate in House of Commons, 11th October 2004, pp 7–9*

15 *Hansard, HL Deb, 10 January 2005 cols 53–54, 55*

16 *Law Com No 231, para 3.2. In Scotland, the presumption of capacity is established under common law and is not re-stated in the AWI Act 2000*

17 *Mental Capacity Bill: Draft Code of Practice (DCA, 2004) http://www.dca.gov.uk/menincap/mcbdraftcode .pdf, para 3.3*

18 *Mental Capacity Act (MCA) 2005, s5(1).*

Practicable steps to help decision-making

The second of the Act's key principles[19] clarifies that a person should not be treated as unable to make a decision until everything possible – or practicable – has been done to help the person make his or her own decision. All practicable steps to enable decision-making must first be shown to be unsuccessful before the person can be assessed as lacking capacity.

The Law Commission had originally proposed that it would only be necessary for "reasonable attempts" to be made to understand a person who has difficulty in communicating a decision.[20] However, many respondents to the consultation paper made the point that the reference to "reasonable attempts" was too weak and, for people who are not simply unconscious, "strenuous steps must be taken to assist and facilitate communication before any finding of incapacity is made".[21] Other respondents stressed the need for help and support to maximise a person's potential to make their own decisions, not just those with communication difficulties. This requirement has now been translated into the Act's guiding principles in section 1(3).

There are a number of ways in which people can be given help and support to enable them to make their own decisions, and these will vary depending on the decision to be made, the timescale for making the decision and the individual circumstances of the person wishing to make it. The practicable steps to be taken might include using specific communication strategies, providing information in an accessible form, or treating an underlying medical condition to enable the person to regain capacity. The Draft Code of Practice gives a number of pointers to prompt consideration of a range of practicable steps which may assist decision-making, although the relevance of the various factors will vary depending on each particular situation.[22] As a minimum, the following steps should be considered:

- Try to minimise anxiety or stress by making the person feel at ease. Choose the best location where the client feels most comfortable and the time of day when the client is most alert.
- If the person's capacity is likely to improve, wait until it has improved (unless the decision is urgent). If the cause of the incapacity can be treated, it may be possible to delay the decision until treatment has taken place.
- If there are communication or language problems, consider using a speech therapist or interpreter, or consult family members on the best methods of communication.
- Be aware of any cultural, ethnic or religious factors which may have a bearing on the person's way of thinking, behaviour or communication
- Consider whether or not a friend or family member should be present to help reduce anxiety. But in some cases the presence of others may be intrusive.

Unwise decisions

The third principle underlying the Act, set out in section 1(4), confirms that:

> "A person is not to be treated as unable to make a decision merely because he makes an unwise decision."

19 *MCA 2005, s1(3)*

20 *Law Commission, Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction, Consultation Paper No 128 (London: HMSO, 1993) para 3.41*

21 *Law Com No 231, para 3.21*

22 *Mental Capacity Bill: Draft Code of Practice, paras 3.15– 3.22*

The right to make unwise decisions has been part of the common law since at least 1850.[23] The intention here is to reflect the nature of human decision-making. Different people will make different decisions because they give greater weight to some factors than to others, taking account of their own values and preferences. Some people are keen to express their own individuality or may be more willing to take risks than others. The diagnostic threshold requiring evidence of an impairment of, or disturbance in the functioning of, the person's mind or brain[24] will to some extent ensure that the capacity of those who are merely eccentric is not challenged unnecessarily. However, people who have mental disabilities which could affect their decision-making capacity should not be expected to make 'better' or 'wiser' decisions than anyone else.

During pre-legislative scrutiny of the draft Bill, the Joint Committee received evidence from some witnesses expressing concern that a person with apparent capacity may be able to make repeatedly unwise decisions that put him/her at risk or result in preventable suffering or disadvantage.[25] Particular concerns were raised by Denzil Lush, Master of the Court of Protection who drew attention to the distinction between decision-specific capacity and more general on-going incapacity. He gave examples of cases where people had made unwise decisions, each of which they appeared capable of making, but where they in fact lacked an overall awareness or understanding of the implications of those decisions.[26]

Some caution may therefore need to be applied in operating this principle in practice. Although as a general rule, capacity should be assessed in relation to each particular decision or specific issue, there may be circumstances where a person has an on-going condition which affects his/her capacity to make a range of inter-related or sequential decisions. One decision on its own may make sense but the combination of decisions may raise doubts as to the person's capacity or at least prompt the need for a proper assessment. But equally, an unwise decision should not, by itself, be sufficient to indicate lack of capacity.

Best interests

Section 1(5) establishes in statute the common law principle that any act done, or any decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in that person's best interests. Further details on the meaning and determination of best interests are set out in section 4 of the Act.

In seeking to establish a clear legal framework for making decisions with, or on behalf of people who lack capacity, the Law Commission proposed a single criterion to govern all decision making:

> "Although decisions are to be taken by a variety of people with varying degrees of formality, a single criterion to govern any substitute decision can be established. Whatever the answer to the question 'who decides?', there should only be one answer to the subsequent question 'on what basis?'.
>
> We explained in our overview paper that two criteria for making substitute decisions for another adult have been developed in the literature in this field: 'best interests' on the one hand and 'substituted judgment' on the other. In Consultation Paper No 128 we argued that the two were not in fact mutually exclusive and we provisionally favoured a 'best interests' criterion which would contain a strong element of 'substituted judgment'. It had been widely accepted

23 *Bird v Luckie (1850) 8 Hare 301*

24 *MCA 2005, s2(1)*

25 *Joint Committee report Vol I, paras 72, 78*

26 *Joint Committee report Vol II, Ev 184, Q495–Q496*

> by respondents to the overview paper that, where a person has never had capacity, there is no viable alternative to the 'best interests' criterion. We were pleased to find that our arguments in favour of a 'best interests' criterion found favour with almost all our respondents."[27]

It is notable that the Scottish Law Commission took a different approach in formulating proposals which led to the AWI Act:

> "We consider that "best interests" by itself is too vague and would require to be supplemented by further factors which have to be taken into account. We also consider that "best interests" does not give due weight to the views of the adult, particularly to wishes and feeling which he or she had expressed while capable of doing so. The concept of best interests was developed in the context of child law where a child's level of understanding may not be high and will usually have been lower in the past. Incapable adults such as those who are mentally ill, head injured or suffering from dementia at the time when a decision has to be made in connection with them, will have possessed full mental powers before their present incapacity. We think it is wrong to equate such adults with children and for that reason would avoid extending child law concepts to them. Accordingly, the general principles [of the AWI Act] are framed without express reference to best interests".[28]

The Joint Committee on the draft Bill compared the two approaches and came down in favour of including the concept of best interests within the Act's key principles:

> "We heard evidence that the concept of best interests has been usefully developed by the courts and that its inclusion in statute would assist in promoting awareness and good practice, thereby ensuring some consistency in approach."[29]

Least restrictive alternative

The Law Commission originally proposed that the "least restrictive alternative" principle should be included in the new legislation as one of the factors to be taken into account in determining the best interests of a person who lacks capacity.[30] The Commission considered that the principle had been developed over many years by experts in the field so as to become widely recognised and accepted.[31] The Draft Mental Incapacity Bill therefore included this principle in the proposed statutory checklist for best interests.[32] However, in response to the Joint Committee's recommendation,[33] the Government agreed to incorporate the least restrictive option as the fifth key principle to guide the use of the Act generally, rather than just one factor in the best interests checklist.[34]

Before any action is taken, or any decision is made under the Act in relation to a person lacking capacity, the person taking the action or making the decision must consider whether it is possible to act or decide in a way that interferes less with the person's rights and freedom of action. Where there is more than one course of action or a choice of decisions to be made, all possible options

27 *Law Com No 231, paras 3.24 – 3.25*

28 *Scottish Law Commission, Report on Incapable Adults, (Scot Law Com No 151) (Scottish Executive, 1995) para 2.50.*

29 *Joint Committee report, Vol I, para 82*

30 *Law Com No 231, paras 3.28, 3.37*

31 *For a discussion of the origins and development of the principle of least restrictive alternative, see Denzil Lush, 'The Mental Capacity Act and the new Court of Protection' in Journal of Mental Health Law 12, 37–38*

32 *Draft Mental Incapacity Bill, clause 4(2)(e)*

33 *Joint Committee report, Vol I, para 44*

or alternatives should be explored (including whether there is a need for any action or decision at all) in order to consider which option would be the least restrictive. However, other options need only be considered so long as the desired purpose of the action or decision can still be achieved.

Determining best interests

The principle of acting in the best interests of a person who lacks capacity has become well established in the common law and the concept has been developed by the courts in cases relating to incapacitated adults, mainly those concerned with the provision of medical treatment.[35] Section 1(5) of the Act enshrines this principle in statute as the overriding principle that must guide all actions done for, or all decisions made on behalf of, someone lacking capacity. Section 4 goes on to describe, for the purposes of the Act, what steps should be taken in determining what is in a person's best interests.

Given the wide range of decisions and acts covered by the Mental Capacity Act and the varied circumstances of the people affected by its provisions, the concept of best interests is not defined in the Act. In considering the need for a definition, the Law Commission acknowledged that:

> "no statutory guidance could offer an exhaustive account of what is in a person's best interests, the intention being that the individual person and his or her individual circumstances should always determine the result."[36]

Instead, the Law Commission recommended that statute should set out a checklist of common factors which should always be taken into account. It also suggested some important considerations as to how a statutory checklist should be framed:

> "First, a checklist must not unduly burden any decision-maker or encourage unnecessary intervention; secondly it must not be applied too rigidly and should leave room for all considerations relevant to the particular case; thirdly, it should be confined to major points, so that it can adapt to changing views and attitudes."[37]

The Joint Committee agreed with this approach:

> "We agree that no list of 'best interest' factors can ever be comprehensive or applicable in all situations. We therefore endorse the approach recommended by the Law Commission that a checklist of common factors to be considered in all cases should be set out in statute. However, it should be made clearer in the Bill that in addition to these common factors, all other matters relevant to the incapacitated individual and the decision in question must also be considered."[38]

Both as a result of recommendations made by the Joint Committee and amendments made during the Parliamentary process, the best interests checklist contained in section 4 has been extended and made more prescriptive in relation to certain types of decisions, in particular those involving end-of-life decisions.

34 *MCA 2005, s1(6)*

35 *See for example Re A (Male Sterilisation) [2000] 1 FLR 549; Re S (Sterilisation: Patient's Best Interests) [2000] 2 FLR 389; Re F (Adult Patient: Sterilisation) [2001] Fam 15*

36 *Law Com No 231, para 3.26*

37 *Law Com No 231, para 3.28*

The best interests checklist

Under the Act, a person's capacity to make the decision or take the action in question must first be assessed and section 4 only comes into play once it has been established that the person lacks capacity and needs someone else to decide or act on his/her behalf. It then sets out a checklist of factors which must be considered in deciding what is in a person's best interests, aimed at identifying those issues most relevant to the individual who lacks capacity (as opposed to the decision-maker or any other persons). Not all the factors in the checklist will be relevant to all types of decisions or actions, but they must still be considered if only to be disregarded as irrelevant to that particular situation.

Principle of equal consideration

During the Bill's Report stage in the House of Lords, an amendment was passed to make it clear that lack of capacity cannot be established merely by reference to a person's age or appearance, or any condition or aspect of his/her behaviour which might lead others to make unjustified assumptions about the person's capacity.[39] This amendment was originally proposed by the Making Decisions Alliance (a coalition of around 40 charities that campaigned for the Mental Capacity Act) as a "principle of non-discrimination and equal consideration" which the Alliance sought to have included in the Act's statement of principles, in order to ensure that people with impaired capacity are treated no less favourably than people with capacity:

> "Our concerns stem from evidence, anecdotal and otherwise, that prejudices and attitudes about the quality of life of a person with serious learning disabilities, mental health problem or a head injury or other condition that leads to loss of capacity can get in the way of supporting that person and how they are, what they want and what they need."[40]

While the Government was sympathetic to these concerns, the drafting of a broad 'equal consideration' principle proved unworkable. Instead the Government put forward two amendments, one relating to the definition of capacity and the second concerning best interests determinations in order to:

> "... reinforce the belief, shared across the House, that no-one should be assumed to lack capacity, excluded from decision-making, discriminated against or given substandard care and treatment simply, for example, as a result of disability."[41]

Therefore, section 4(1) begins with a clear statement that a determination of someone's best interests must not be based merely on the person's age or appearance, or any condition or aspect of his/her behaviour which might lead others to make unjustified assumptions about the person's best interests. The reference to "condition" covers a range of factors, including both mental or physical disabilities as well as temporary conditions. "Appearance" is also deliberately broad, covering visible medical problems, disabilities, skin colour, religious dress and so on.

This is intended to ensure that people with impaired capacity are treated no less favourably than people with capacity. Thus, decisions about best interests must not be based on any preconceived ideas or negative assumptions, for example about the value or quality of life experienced by older people or people with mental or physical disabilities who now lack capacity to make decisions for themselves.

38 *Joint Committee Report, Vol I, para 85*

39 MCA *2005, s2(3)*

40 *Making Decisions Alliance, House of Lords Briefing, Second Reading 10 January 2005, p3*

All relevant circumstances

A determination of a person's best interests involves identifying those issues most relevant to individual who lacks capacity in the context of the decision in question. The statutory checklist sets out the minimum necessary considerations but all other matters relevant in the particular situation must also be taken into account. Section 4(2) therefore requires the person making the determination to consider "all the relevant circumstances" as well as following the steps set out in the checklist.

It is recognised that the person making the determination may not be in a position to make exhaustive enquiries to investigate every issue which may have some relevance to the incapacitated person or the decision in question. Therefore relevant circumstances are defined as those:

> "(a) of which the person making the determination is aware, and
>
> (b) which it would be reasonable to regard as relevant."[42]

Regaining capacity

Following further consultation on the checklist suggested by the Law Commission for the determination of best interests, the Government proposed an additional factor – whether the person is likely to regain capacity.[43] One of the Act's key principles is that before a person is found to be incapable of making a decision, all practicable steps must be taken to help the person make that decision.[44] In keeping with this approach, when looking at best interests, it is important to consider whether the individual concerned is likely to have capacity to make that particular decision in the future and if so, when that is likely to be.[45] It may be possible to put off the decision until the person can make it him/herself. This delay may allow further time for additional steps to be taken to restore the person's capacity or to provide support and assistance which would enable the person to make the decision.

The Draft Code of Practice suggests some factors which may indicate that a person may regain capacity[46]:

- The cause of the incapacity can be treated, either by medication or some other form of treatment or therapy
- The incapacity may decrease in time (for example where caused by the effects of medication or alcohol, or following a sudden shock)
- People may learn new skills or be subject to new experiences which increase their capacity to make certain decisions, for example a young adult with learning disabilities who leaves his parental home to live in supported accommodation and gains new skills as a result
- The person may have a condition which causes capacity to fluctuate (such as some forms of mental illness) so it may be possible to arrange for the decision to be made during a lucid interval
- A person previously unable to communicate may learn a new form of communication

41 *Hansard, HL Deb, 15 March 2005, col 1318*

42 *MCA 2005, s4(11)*

43 *Lord Chancellor's Department, Making Decisions, para 1.12*

44 *MCA 2005, s1(3).*

45 *MCA 2005, s4(3)*

46 *Mental Capacity Bill: Draft Code of Practice, para 4.16*

Permitting and encouraging participation

Section 4(4) requires that, even where a person does not have capacity to make an effective decision, he or she should be both permitted and encouraged to participate, or to improve his or her ability to participate as fully as possible in the decision-making process or in relation to any act done for him or her. It will always be important to consult the person on the particular act or decision to be made and to try to seek their views, not only to encourage the development of decision-making skills, but also as an important contribution in determining best interests. The practicable steps to enable decision-making will also be relevant here.[47]

Life-sustaining treatment

A specific factor in the best interests checklist relates to decisions concerning the provision of life-sustaining treatment, which is defined as treatment which a person providing health care regards as necessary to sustainlife, usually the life of a person lacking capacity to consent to that treatment.[48] Section 4(5) clarifies that in determining whether the treatment is in the best interests of someone who lacks capacity, the person making the determination must not be motivated by a desire to bring about the individual's death.

A great deal of the debate in both Houses of Parliament concerned life and death decisions affecting people who lack capacity. In order to provide clarity and reassurance on these very difficult issues, the Government agreed to a number of amendments introducing specific statements in the legislation. In particular, section 62 confirms that the Act does not have the effect of authorising or permitting euthanasia or assisted suicide. Secondly, in relation to decisions about whether the provision or continuance of life-sustaining treatment would be in a person's best interests, section 4(5) clarifies that the decision-maker must not be motivated by a desire to bring about the person's death.

This particular factor was introduced as an amendment in the House of Lords after an undertaking was given in correspondence between the Lord Chancellor and the Roman Catholic Archbishop of Cardiff, Peter Smith, that the Act would make this point absolutely clear. Commenting on a situation where no advance decision has been made about whether treatment should be continued or refused, the Lord Chancellor said:

> "The decision about whether to continue to give life-sustaining treatment will then fall to be taken by the doctor, acting with an attorney who has relevant powers. ... In some cases a decision ... will still be taken by the court. The Bill preserves the jurisdiction exercised in the Tony Bland case and restates the principles applied in that case. These are very difficult decisions, even for a court. In making them the decision-maker must act in the best interests of the patient. Above all, he must make an objective assessment. The decision cannot simply be the personal value judgement of the decision-maker – the decision-maker cannot say "If I were in the patient's position, I would want to die" – nor can it be motivated by the desire to bring about the death of the patient."[49]

Any decision about life-sustaining treatment for a person lacking capacity will take as its starting point the assumption that it is in the person's best interests for life to continue. However, there will be some cases, for example in the final stages of terminal illness or for some patients in a

47 *See above and Draft Code of Practice, paras 3.15–3.22*

48 MCA *2005, s4(10)*

49 *Hansard, HL Deb, 10 January 2005, cols 14–15*

permanent vegetative state where there is no prospect of recovery, where it may be in the best interests of the patient to withdraw treatment or to give palliative care that might incidentally shorten life. All the factors in the best interests checklist must be considered, but the person determining best interests must not be motivated in any way by the desire to bring about the person's death.

The person's wishes and feelings, beliefs and values

A particularly important element of the best interests checklist is the consideration, so far as these can be ascertained, of:

> "(a) the person's past and present wishes and feelings (and in particular, any relevant written statements made by him when he had capacity),
>
> (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
>
> (c) the other factors that he would be likely to consider if he were able to do so."[50]

This places the focus firmly on the person lacking capacity, taking into account the issues most important to him or her and what s/he would have wanted to achieve. It also reflects the need to make every effort to find out whether the person has expressed any relevant views in the past, whether verbally, in writing or through behaviour or habits, as well as trying to seek his or her current views.

The Draft Code of Practice acknowledges that, while this factor establishes the importance of individual views, those views will not automatically determine the outcome.[51] Indeed, in some cases, there may be a conflict between the person's past and present wishes, so that these must be weighed against each other and considered alongside other factors in the checklist.

The reference to written statements in section 4(6)(a) was included as a Government amendment in the House of Lords in response to lobbying by the Making Decisions Alliance and other stakeholder organisations. Those organisations had requested that advance statements, particularly those expressing wishes about medical treatment, should be given some form of statutory recognition and should specifically be taken into account in determining a person's best interests.

The draft Mental Incapacity Bill published in 2003 made no mention of the person's "beliefs and values" but this was added to the Bill in response to a recommendation of the Joint Committee:

> "The Medical Ethics Alliance suggested to us that the factor involving the need to consider the incapacitated person's "past and present wishes and feelings" should also contain reference to that person's *values*. Others suggested that specific reference should be made to social, psychological, cultural, spiritual and religious issues. It is anticipated that the need to consider a wide range of issues, in particular religious and cultural concerns, will be spelt out in the Code of Practice. We seek reassurance that the form of words used in the Bill will require a person's values to be given due weight."[52]

The reference to factors the person "would be likely to consider" if able to do so reflects current caselaw in relation to the powers exercised by the Court of Protection to make a statutory will, where:

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50 MCA 2005, s4(6)

51 Draft Code of Practice, paras 4.19–4.22

52 Joint Committee Vol I, para 90

> "subject to all due allowances, ... the court must seek to make the will which the actual patient, acting reasonably, would have made if notionally restored to full mental capacity, memory and foresight."[53]

Section 4(6)(c) extends this notion as a factor to consider for all decisions or actions, whether or not the person concerned ever had capacity in relation to the matter in question. The Draft Code of Practice suggests that this might also include "altruistic motives and concern for others as well as duties and obligations towards dependants or future beneficiaries."[54]

The views of other people

For the first time, the Mental Capacity Act establishes the right for carers, family members and other relevant people to be consulted on decisions affecting the person. People with a right to be consulted include anyone named by the person lacking capacity as someone to be consulted, carers and anyone interested in the person's welfare, donees and deputies.[55] Any person who is determining the best interests of someone lacking capacity is required to take into account the views of these key people, but only if it is "practicable and appropriate" to consult them. The Draft Code of Practice suggests:

> "This is not intended to give absolute discretion to the decision-maker about whom to consult, rather decision-makers will need to show they have thought carefully about whom to consult and be prepared to explain why a consultation which they declined to carry out was either impracticable or inappropriate."[56]

The consultation is limited to two matters – first, what those people consider to be in the person's best interests on the matter in question, and secondly whether they can provide any information on the wishes, feelings, values or beliefs of the person lacking capacity. If prior to losing capacity, the person concerned has nominated someone whom he or she would like to be consulted, the named person is more likely to have that information. People who are close to the person lacking capacity, such as relatives, partners and other carers may also be able to assist with communication or interpret signs which give an indication of the person's present wishes and feelings.

The requirement for consultation must be balanced against the right to confidentiality of the person lacking capacity. That right should be protected so that consultation only takes place where relevant and with people whom it is appropriate to consult. For example, it is unlikely to be appropriate to consult anyone whom the person had previously indicated should not be involved. However, there may be occasions where it is in the person's best interests for specific information to be disclosed, or where the public interest in disclosure may override the person's private interest in maintaining confidentiality.[57] If professionals are involved in the determination of best interests, they will also need to comply with their own duties of confidentiality in accordance with their professional codes of conduct.

Duty to apply the best interests principle

The principle set out in section 1(5) confirms that any act done, or any decision made, on behalf of a person lacking capacity must be done in his/her best interests. Section 4(8) confirms that the

53 *Re D(J) [1982] 2 All ER 37 at 43*

54 *Mental Capacity Bill: Draft Code of Practice, para 4.22*

55 *MCA 2005, s4(7)*

56 *Mental Capacity Bill: Draft Code of Practice, para 4.23*

57 *S v Plymouth City Council and C, [2002] EWCA (Civ 388) at para 49.*

best interests principle, and the duties to be carried out in determining best interests, also apply in certain circumstances where the person concerned may not in fact lack capacity in relation to the act or decision in question. The specified situations are:

- Where a donee is acting under a Lasting Power of Attorney in relation to financial matters while the donor still has capacity
- Where someone exercising powers under the Act "reasonably believes" that the person lacks capacity

Reasonable belief

The second situation reflects the position that in most day-to-day decisions or actions involved in caring for someone, it will not be appropriate or necessary to carry out a formal assessment of the person's capacity. Rather, it is sufficient for them to "reasonably believe" that the person lacks capacity to make the decision or consent to the action in question.

This is based on the Law Commission's explanation that:

> "It would be out of step with our aims of policy, and with the views of the vast majority of the respondents to our overview paper, to have any general system of certifying people as "incapacitated" and then identifying a substitute decision-maker for them, regardless of whether there is any real need for one. In the absence of certifications or authorisations, persons acting informally can only be expected to have reasonable grounds to believe that (1) the other person lacks capacity in relation to the matter in hand and (2) they are acting in the best interests of that person."[58]

Therefore, section 4(9) confirms that, in cases where the court is not involved, carers (both professionals and family members) and others who are acting informally can only be expected to have *reasonable grounds for believing* that what they are doing or deciding is in the best interests of the person concerned, but they must still, so far as possible, apply the best interests checklist and therefore be able to point to objective reasons to justify why they hold that belief.

Section 4(9) also applies to donees and deputies appointed to make welfare or financial decisions as well as to those carrying out acts in connection with the care and treatment of a person lacking capacity. In deciding what is "reasonable" in any particular case, higher expectations are likely to be placed on those appointed to act under formal powers and those acting in a professional capacity than on family members and friends who are caring for a person lacking capacity without any formal authority.

Conclusion

It has long been recognised that complex legislation of this sort will require an accompanying Code of Practice for the guidance of practitioners using the Act and those affected by its provisions, and also to assist with interpretation and implementation of the Act.[59] In particular, the need to have regard to the Code is highly likely to be relevant to a question of whether someone has acted or behaved in a way which is contrary to the best interests of a person lacking capacity, or otherwise failed to apply the statutory principles. It will therefore be particularly important for practitioners to respond to the public consultation on the draft Code, due in spring 2006, and to make sure they are familiar with the final version when the Act comes into effect in April 2007.

58 *Law Com No 231, para 4.5*

59 *Law Com No 231, para 2.53*

The Mental Capacity Act 2005, the Mental Health Act 1983, and the Common Law[1]

Phil Fennell[2]

This paper considers what has come to be known as the 'interface' between the Mental Capacity Act 2005 and the Mental Health Act 1983. Sections 5 and 6 of the 2005 Act provide a general defence to acts of care and treatment which may involve restraint and restriction of liberty of a mentally incapacitated person. Because authority is conferred by way of a defence, there are no procedural safeguards comparable to those available under the Mental Health Act 1983 in relation to care and treatment decisions taken under the Mental Capacity Act. Sections 5 and 6 apply to any person. The defence confers powers to make decisions concerning care and treatment. Powers similar to those available under section 5 may be expressly conferred on the donee of a lasting power of attorney[3] or a deputy appointed by the Court of Protection.[4]

Until the 2005 Act comes into force in 2007, practitioners will have to be aware of the interface between powers to admit to institutional care and treat without consent under common law and those which exist under the Mental Health Act 1983. In simple terms, the interface question is 'When may the common law or, after 2007, the 2005 Act, be used to admit to institutional care and treat without consent, and when will use of the Mental Health Act be required?' The 1981 decision in *X v United Kingdom*[5] prompted significant changes to the Mental Health (Amendment) Bill then introduced. As the Mental Capacity Bill reached its final Parliamentary stages, the decision in *HL v United Kingdom*[6] prompted a major rethink of the interrelationship between mental health and mental capacity legislation. The solution was to remove deprivations of liberty from the scope of the Mental Capacity Act completely, and to leave the interface question to be dealt with under mental health or other health legislation. This article argues that there are two decisions of the European Court which need to be considered in determining how to bridge what has become the "Bournewood gap": *HL v United Kingdom* and *Storck v Germany*[7]. These will

1 *This is an amended version of a paper given at Sweet and Maxwell's Mental Capacity Act Conference, 30 September 2005, Kingsway Hall Hotel, London*

2 *Professor of Law, Cardiff Law School*

3 *Mental Capacity Act s 9(1)(a) which provides for donees to take decisions concerning personal welfare, which could include consenting to or refusing treatment.*

4 *Ibid., s 16(1)(a). Both donees and deputies may restrain an incapacitated person subject to the conditions in s 11 (donees) and in s 20(7)–(13) (deputies). In the case of deputies, authority to restrain must be expressly conferred by the court.*

5 *(1981) 4 E.H.R.R. 188*

6 *E.Ct.HR Judgment 5th October 2004*

7 *E.Ct.HR Judgement 16th June 2005*

require that the State must provide effective supervisory mechanisms to ensure that mentally incapacitated people are not deprived of their liberty (Article 5) and do not have their right of bodily integrity interfered with (Article 8) without lawful authority.

The Section 5 defence in respect of care and treatment acts done in the best interests of a mentally incapacitated person

Section 5 aims to codify, and as Richard Jones points out,[8] 'to clarify' the common law doctrine of necessity in relation to mentally incapacitated adults. Originally captioned 'The general authority to treat', this section is now titled 'Acts in connection with care and treatment.' The section provides a defence to anyone (not necessarily a health or social care professional), doing an act in connection with the care and treatment of a person ("P") who is reasonably believed to lack capacity in relation to the matter. The person, referred to in the section as "D", will have a defence to proceedings based on the absence of consent to the act[9], provided the following three conditions are met:

(1) D takes reasonable steps to establish whether P lacks capacity in relation to the matter;

(2) D reasonably believes that P lacks capacity in relation to the matter

(3) D reasonably believes that it will be in P's best interests for the act to be done

The section does not provide a defence if the act is carried out negligently, or if a criminal offence is committed. If there is a valid advance decision refusing the proposed care or treatment intervention, it may not be given.[10] A further limitation is contained in s 6(6) which provides that a decision made either by a court appointed deputy or by the donee of a lasting power of attorney acting within the scope of their authority will take priority over any decision which might be made under section 5.

The draft Code of Practice at Para 5.5 gives examples of acts in connection with care and treatment, and states that as far as medical treatment is concerned, this includes diagnosis, treatment, taking of blood or body samples, and nursing care.

Restraint

Section 6 sets a number of limitations on the scope of section 5 acts. Section 5 may only be used by D to justify an act intended to restrain P if two conditions are met. The first is that D reasonably believes that the act is necessary to prevent harm to P. The second is that the act is a proportionate response both to the likelihood of P suffering harm, and the seriousness of that harm. Restraint means the use or threat of force to secure the doing of an act which P resists, or the placing of any restriction of P's liberty of movement, whether or not P resists. The Draft Code of Practice tells us that 'Restraint may take many forms. It may be both verbal and physical and may vary from shouting threats at someone, to holding them down, to locking them in a room.'[11] Examples are given of needing to restrain a man with dementia by holding him still whilst necessary diagnostic tests are done.

8 *Mental Capacity Act Manual, Richard Jones (Sweet & Maxwell) (2005) 9–26*

9 *Mental Capacity Act s 5(2).*

10 *Ibid., s 5(4).*

11 *Mental Capacity Act Draft Code of Practice, para. 5.28.*

How does this apply to psychiatric treatment? The Draft Code clearly sees restraint as including 'chemical restraint, for example giving someone a large amount of sleeping pills in order to sedate them and thereby restrict their liberty of movement.'[12] The Act precludes giving treatment for mental disorder under any of its provisions, 'if at the time when it is proposed to treat the patient, his treatment is regulated by Part lV of the 1983 Act.'[13] In other words, the Mental Capacity Act will not apply if the patient is already liable to be detained under one of the longer term detention powers in the Mental Health Act.

Section 6(5), inserted to take account of *HL v United Kingdom*, provides that D does more than merely restrain P if he deprives P of his liberty within the meaning of Article 5, whether or not D is a public authority. The Government's interim advice[14] is that health and social services should avoid interventions of a degree and intensity which are likely to amount to deprivations of liberty, which currently require the authority of detention the Mental Health Act 1983. The Government has undertaken a consultation on the consequences of *HL v United Kingdom*, suggesting that a new form of protective care be introduced as an alternative to compulsion for compliant mentally incapacitated patients who are deprived of their liberty[15].

Section 28 Mental Health Act Matters

Section 28 provides that nothing in this Act authorises anyone –

(a) to give a patient treatment for mental disorder, or

(b) to consent to a patient's being given medical treatment for mental disorder

if at the time his treatment is regulated by Part IV of the Mental Health Act 1983.

As Richard Jones puts it, 'The effect of this section is that the consent to treatment provisions in Part IV of the 1983 Act will "trump" the provisions of the 2005 Act.' Jones states that "The 1983 Act should be invoked in respect of a mentally incapacitated person who needs to be hospitalised for treatment for mental disorder in two circumstances (assuming the criteria for compulsion are met):

1. Where there is a deprivation of liberty; and
2. Where it is considered that the provisions of a valid and applicable advance decision refusing a particular treatment for the patient's mental disorder should be overridden."

In *HL v United Kingdom* the Strasbourg Court held that factors to be taken into account in determining whether there has been a deprivation of liberty include the type, duration, effects and manner of implementation of the measure in question. 'The distinction between a deprivation of, and restriction upon, liberty', said the court, 'is merely one of degree or intensity and not one of nature or substance.'

The key factor is whether those with care of the patient exercise complete and effective control over his care and movements. This includes strict control over: assessment, treatment, contacts, (including with carers), movement, and residence. A person can still be deprived of his liberty

12 *Id.*

13 *Mental Capacity Act s. 28.*

14 *Advice on the Decision of the European Court of Human Rights in the case of HL v UK (the 'Bournewood' Case) [Gateway Reference 4269] 10th December 2004*

15 *Chapter 5 'Bournewood' Consultation Department of Health (March 2005)*

without ever having tried to leave, it is enough that there is an intention to prevent them from leaving should they attempt to do so. Similarly, it is 'not determinative' whether the ward is locked or lockable. It is the intention to prevent the patient leaving which counts. Applying these tests the Court held that HL had been deprived of his liberty.

Since the decision in *HL v United Kingdom*[16], the European Court of Human Rights has delivered a further important ruling in *Storck v Germany*[17] which contains important statements not only about the right to protection against arbitrary detention under Article 5 and but also concerning the right to physical integrity as an aspect of respect for private life under Article 8. The applicant had been admitted at age 15 to a children and young person's unit and spent seven months there in 1974–5. From July 1977 to April 1979 she was placed in a locked ward at a private psychiatric clinic (Dr Heine's Clinic), without any judicial order, as required by German law. She was brought back in March 1979 by police after she escaped. The private clinic was not entitled under German law to receive detained patients.

The Court held that there was a positive obligation for the state to take measures to protect the right to liberty under Article 5 and the right to personal integrity under Article 8 against infringements by private persons, and that both Article 5 and Article 8 had been infringed. The Court stated, at para 143, that 'Insofar as the applicant argued that she had been medically treated against her will while detained, the court reiterates that even a minor interference with the physical integrity of an individual must be regarded as an interference with the right of respect for private life if it is carried out against the individual's will.'

This statement suggests that the crucial factor in identifying a breach of Article 8 is the fact that the intervention is carried out against the individual's will, in other words that there is some resistance. However, in *HL v United Kingdom* the Strasbourg Court refused to treat compliant incapacitated patients as on a par with capable patients who were consenting. Reaffirming the importance of the right to liberty, the Court stated that:

> 'The right to liberty in a democratic society is too important for a person to lose the benefit of Convention protection simply because they have given themselves up to detention, especially when they are not capable of consenting to, or disagreeing with, the proposed action'.[18]

The Court emphatically rejected the argument that a compliant incapacitated patient should be treated on the same basis as a capable consenting patient in relation to deprivations of liberty under Article 5. The same principle must apply to interferences with physical integrity. It is too important to be lost simply because a person has given themselves up to the intervention, especially if they lack capacity to consent.

This, it is submitted, requires a gloss on Richard Jones' statement that sections 5 and 6

> '[P]rovide authority for treating P's mental disorder in a hospital setting as an informal patient, even if P's liberty was restricted, as long as P is not being deprived of his or her liberty in that hospital. The use of restraint which results in P being deprived of his or her liberty would constitute a violation of rights under Article 5'.[19]

16 *Judgment 5th October 2005*

17 *Judgment of 16 June 2005.*

18 *HL v United Kingdom Judgment of 5 October 2004, para. 90.*

19 *R.M. Jones, Mental Capacity Act Manual, 9–29. 2005 Sweet & Maxwell*

The gloss is to the effect that if the person lacks capacity and the decision-maker is assuming complete control over treatment to the extent that they are making decisions about the administration of strong psychotropic medication or even ECT to a patient, then that is assuming complete control over treatment and would be a factor tipping the balance firmly towards there being a deprivation of liberty requiring use of the Mental Health Act 1983 or at the very least use of protective care provisions such as those proposed to fill the so-called *Bournewood* Gap[20]. In *Storck*, the Court found a breach of the positive obligation under Article 8(1) because at the relevant time there was a lack of effective state control over private institutions offering protection of individuals against infringements of their personal integrity.

Where there are procedural safeguards under the Mental Health Act governing the administration of medicines and ECT, the giving of these treatments to incapacitated adults who do not resist without equivalent safeguards may well breach Article 8. So the question arises whether ECT could be given under ss.5 and 6 to an informal incapacitated patient who was not subject to control of a level of intensity to amount to a deprivation of liberty. It is submitted that the very decision to assume sufficient control of treatment to give ECT, a not inconsiderable intervention, without the consent of an incapacitated patient, would tip the balance in favour of there being a deprivation of liberty requiring use of the Mental Health Act in order to ensure effective protection of Article 5 and Article 8 rights.

Conclusion: The Scope of the Positive Obligation under Article 8 and its relationship to Deprivation of Liberty

It is important to bear in mind the statement of the scope of the positive obligation under Article 8, as outlined in of the judgment in *Storck*:

> The Court ... considers that on account of its obligation to secure to its citizens the right to physical and moral integrity, *the state remained under a duty to exercise supervision and control over private psychiatric institutions*. (emphasis added) [The court noted that in the sphere of interferences with a person's physical integrity, German law provided for strong penal sanctions and for liability in tort and went on to say that]. Just as in cases of deprivation of liberty, the Court finds that such retrospective measures alone are not sufficient to provide appropriate protection of the physical integrity of individuals in such a vulnerable position as the applicant. The above findings as to the lack of effective state control over private psychiatric institutions at the relevant time are equally applicable as far as the protection of individuals against infringements of their persona integrity is concerned. The Court therefore concludes that the respondent state failed to comply with its positive obligation to protect the applicant against interferences with her private life as guaranteed by Article 8(1).[21]

Once there is a breach of Article 8(1), then there comes the question of whether the intervention may be justified under Article 8(2). In that context the court noted that it was 'undisputed that the detention of a mentally insane person for the purpose of medical treatment required a court order *if the person did not, or was unable to, consent to his detention and treatment*' (emphasis added) and that since there was no court order, the interference was not in accordance with law.

20 *Section 58 (3) (6) Mental Health Act 1983*

21 *Storck v Germany, Judgment of 26 June 2005, para 150.*

Applying this to the interface question, a mentally incapacitated, non-resisting person detained under the Mental Health Act 1983 is entitled to a second opinion before they are given ECT at any time or medicines for more than three months[22]. These procedures will probably amount to effective supervision and control and therefore discharge the positive obligation under Article 8(1), which applies to both public and private institutions. What if the same mentally incapacitated, non-resisting person is in a hospital informally because the hospital consider that they are not subjecting him to a level of control which amounts to deprivation of liberty? If it is proposed to give him ECT, it has been argued above that this will tip the balance and make it a deprivation of liberty engaging Article 5 and an interference with personal integrity engaging Article 8. If that person is given ECT under common law, there will be no control or supervision, only potential retrospective liability, which was held not to be enough in *Storck*.

If ECT is made a 'serious treatment' for the purposes of Section 37 of the Mental Capacity Act 2005 and there is nobody other than a paid carer to consult in determining what would be in P's best interests, there would be a requirement on the relevant NHS body to appoint and consult an Independent Mental Capacity Advocate (IMCA), and the submissions made by the IMCA must be taken into account in deciding whether to provide the treatment. Section 37 does not apply to any treatment regulated by Part IV of the Mental Health Act. Treatment is only regulated by Part IV if the patient is detained or liable to be detained. As I have argued the giving of ECT to a mentally incapacitated person should tip the balance of control towards deprivation of liberty.

An equally interesting issue is the position regarding medication. ECT is viewed as a sufficiently controversial treatment to engage a higher level of safeguard than medicine under section 58 of the Mental Health Act 1983. Medicine given without consent might have a similar effect, depending on its nature and its propensity to control behaviour. This raises issues in relation to strong sedative medication, high dose neuroleptics, polypharmacy, and the administration of covert medication. We might question whether there is effective enough control and supervision of these treatments of informal patients to discharge the positive obligation under Article 8, and whether the use of such interventions might mean that a person is being deprived of his or her liberty.

The Government has estimated in its consultation on Bournewood that there may be as many as 50,000 "Bournewood" patients in residential care who might be undergoing deprivation of liberty[23]. Any new protective care provisions will not only have to ensure that there is effective review of deprivation of liberty, but that there is also adequate protection of the right of bodily integrity under Article 8.

22 *Section 58 (3) (b) Mental Health Act 1983*

23 *Paragraph 3.4. "Bournewood" Consultation Department of Health (March 2005)*

Reflections from Scotland: Difficult Decisions Ahead

Hilary Patrick[1]

Introduction

This article looks at recent developments in Scottish mental health and incapacity law.

Whilst Scotland clearly leads the way in mental health and social care law reform in the UK, its incapacity legislation is under strain. Scotland is struggling with the implications of *H.L v U.K*[2] which, because of problems with the Adults with Incapacity (Scotland) Act 2000, appear even more complex than in England and Wales.

Scotland is consulting on new laws to protect vulnerable adults, but lags behind England and Wales in its use of appropriate adults when people with mental disorders are interviewed by the police.

Problems with the Adults with Incapacity Act

Contrast with Mental Capacity Act

Like the Mental Capacity Act 2005 (MCA), the Adults with Incapacity (Scotland) Act 2000 (AWI) contains a hierarchy of measures for assisted decision making. The measures in AWI are more complex and detailed than those in MCA, including in the financial field, for example, procedures for access to bank accounts and management of finances by care homes and hospitals[3]. For medical matters Part 5 of the Act gives doctors an authority to treat, following a formal certification of incapacity, and requires second opinions or court approval for more complex medical decisions.

This approach has much to commend it. It deals with some of the concerns expressed that the MCA gives care and treatment providers too wide an authority, undermining the autonomy and dignity of adults with incapacity. Simple procedures for common or routine transactions, containing proper safeguards against abuse, fit well with the principles of minimum necessary intervention and ensuring benefit to the adult.

No general authority / indemnity

Unlike England and Wales, the specific procedures in AWI are not underpinned by a general authority or indemnity for carers[4]. The writer is not aware of any discussions prior to the passing of the Act around a possible general authority for Scotland and it is certainly not mentioned in the

1 *Honorary Fellow, School of Law, Edinburgh University*
2 *E.Ct.H.R. Judgement 5th October 2004*
3 *In Parts 3 and 4 of the Act.*
4 *Contained in Mental Capacity Act 2005, s5.*

Scottish Law Commission's consultative paper[5] or final report[6].

The suggestion of a general authority has not met with favour in Scotland, at least to date. Representatives of the Law Society of Scotland, giving evidence before the Joint Committee on the Draft Mental Incapacity Bill, expressed concern that it was too wide and even suggested it might be in breach of Article 6 ECHR. They argued that a general authority takes away an adult's right to make decisions him/herself. This is a determination of the adult's civil rights and obligations and Article 6 requires the authority of a court after a hearing[7].

Problems experienced in Scotland

However, while there may be good arguments against too wide a general indemnity, such an indemnity could have helped alleviate some of the problems experienced in Scotland over the interpretation of AWI. It has become unclear whether the Act is *enabling*, as those promoting it (including the author) had assumed, or *prescriptive*, automatically required whenever significant decisions are made in the life of an adult with incapacity.

These concerns have centred around the use of the Act for welfare interventions, where the Act contains a less well developed series of measures. Apart from the creation of welfare attorneys[8], the other remedies are court-based, the one-off 'intervention order' or full or partial welfare guardianship[9].

Use of welfare guardianship

Very early in the implementation of the AWI it became clear that there was considerable uncertainty about when it was appropriate to use a guardianship order if a significant welfare intervention (such as a change of residence) was proposed[10]. Should a guardianship or intervention order always be obtained, even if there is no evidence that any of the parties involved objects to the proposed move and there are no other reasons why an order may be necessary?

Legal advice received by some local authorities stated that a local authority which fails to obtain an order could be open to challenge. The local authority could be regarded as in breach of both its responsibilities under the Act and of its human rights obligations. Other lawyers held the equally strongly held view that it was not the intention of the Act that every welfare intervention for an adult with incapacity should require the court authority.

The Mental Welfare Commission for Scotland advised that if guardianship orders were used in all such cases, the numbers could run into thousands. Beds would be blocked by people remaining in hospital while their applications were processed and significant local authority resources (legal and social work) would be tied up in processing applications. Private carers required by local authorities to make applications for relatives could face heavy legal expenses. The courts would also be burdened with a large number of applications. This might reduce their effectiveness in those cases where there was a genuine need for court scrutiny[11].

5 *'Mentally Disabled Adults: Legal arrangements for managing their welfare and finances' Scottish Law Commission Discussion Paper No 94 1991.*

6 *'Report on Incapable Adults' Scottish Law Commission 1995*

7 *See Minutes of Evidence, Q32 and 39.*

8 *In Part 2 of the Act.*

9 *See Part 6 of the Act.*

10 *'The Adults with Incapacity (Scotland) Act 2000: Learning from Experience' Scottish Executive Social research 2004, para 3.53 ff.*

11 *See 'Authorising significant interventions for adults who lack capacity' Hilary Patrick for Mental Welfare Commission for Scotland 2004.*

Legal opinion divided

A discussion paper for the Mental Welfare Commission[12] highlighted some of the divisions, from what had previously been a broad spectrum of support for the AWI. There appeared to be a genuine difference in philosophy between those who believed that the Act should be used where necessary to provide practical benefits, and those more concerned to ensure the human rights of, and legal protections for, vulnerable people.

The discussion paper concluded that a selective approach, where use of the Act was linked to benefit to the adult and the least restrictive alternative could be justified, and guidance from the Scottish Executive has to date supported this approach[13].

Could general authority assist?

When the English Law Commission first highlighted the lack of legal clarity about what action may lawfully be taken by carers of persons without capacity[14], it could not have foreseen that it would be in Scotland that problems would first surface

AWI has given people in Scotland a greater awareness of the rights of people with mental incapacities, but lacks the tools properly to meet people's needs. Lack of an underlying authority for carers has created such absurdities as the guidance that a court order may be necessary to authorise (among other things) arrangements for respite care for an adult, the adult's attendance for medical treatment or the granting of access to certain professionals[15].

Unless legal authority under Scots law can be found to authorise such care giving these kinds of questions will remain. While it might be possible to rely on the doctrines of necessity, duty of care, or *de minimis non curat lex*[16], the interface of the common law and statute law is proving difficult to resolve.

While critics of the general authority south of the border may be concerned the general indemnity gives carers too wide a discretion, they might feel sympathy for carers in Scotland, possibly needing court authority simply to carry out their day to day caring duties.

Implications of H.L. v U.K.[17] ('Bournewood')

These problems have been exacerbated following a decision in the sheriff court in *Muldoon*[18]. This was an application for financial and welfare guardianship by the relative of an adult who had already moved to a care home. Neither the adult's mental health officer (approved social worker) nor the safeguarder appointed by the court supported the application, which they regarded as an unduly restrictive option in a situation where the adult appeared settled in the care home.

The sheriff did not specifically consider the question of whether the adult was deprived of her liberty within Article 5 of the ECHR. He noted that she was held in a locked facility but also noted that she seemed happy there and did not attempt to leave. However he ruled that the effect of

12 *See 'Authorising significant interventions for adults who lack capacity' Hilary Patrick for Mental Welfare Commission for Scotland 2004. op.cit.*

13 *'Interventions under the Adults with Incapacity (Scotland) Act 2000' Social Work Services Inspectorate 2004.*

14 *In Mental Incapacity (LC231) 1995.*

15 *'Code of Practice for local authorities authorising functions under the Adults with Incapacity (Scotland) Act 2000' Scottish Executive, March 2001, para 5.34.6. While clearly an order may be necessary if the adult appears unwilling to accept such care, the guidance suggests an order may be necessary whether or not s/he appears to object, to fill a 'legal vacuum'.*

16 *The law should not concern itself with minor matters*

17 *E.Ct.H.R. Judgment 5th 2004*

18 *Glasgow Sheriff Court, W 37/04*

H.L. v U.K. is that if an adult is legally incapable of consenting to or disagreeing with a change of residence, s/he is deprived of his/her liberty within Article 5 and in addition his/her Article 6 rights are breached. Express statutory authority should be obtained. He therefore granted the guardianship order, as the least restrictive alternative.

In a later case, *Docherty*[19], the same sheriff made it clear that a '*statutory warrant*' should be obtained for all patients lacking capacity to consent who are '*resident but compliant*', including patients already in hospital.

Conclusion: legal reform needed

The decision of the sheriff in *Muldoon* is not binding on other courts in Scotland, but clearly these decisions highlight the need for further guidance.

Reform of the law in Scotland may be necessary. Any reform should not just clarify how the AWI should deal with people who are deprived of their liberty following *H.L. v U.K.*, but should also consider the appropriate procedures for authorising significant welfare interventions for adults with incapacity in Scotland where a court order would produce no practical benefit[20].

The Scottish Executive has now issued further guidance to chief social work officers[21]. The guidance confirms that whether an adult is deprived of liberty is a matter of the facts of his/her individual case. The Executive intends to give further guidance on how to determine what constitutes detention. This will take into account not just *H.L. v U.K.*, but also *HM v Switzerland* (where detention of a person in her own interests was seen as a '*responsible measure taken by the competent authorities*'[22].)

Protection of vulnerable adults

Following its review of incapacity law, in 1997 the Scottish Law Commission produced a short report considering the way in which the law deals with the needs of vulnerable adults[23].

The report recommended that local authorities should be under a new duty to investigate whenever a vulnerable adult might be at risk. The law should give them the power to gain access to premises, to inspect papers and to arrange for the medical examination and assessment of the adult. This should include the power to remove the person from his/her home for up to seven days and, more controversially, to seek an order excluding a violent person from the home.

Powers to investigate and gain access are contained in the Adults with Incapacity Act and in the new mental health act[24]. The Scottish Executive is now consulting on extending this protection to other groups[25].

The Executive proposes limiting the definition of vulnerable adults to people who use or are in need of community care services by virtue of mental disorder, or disability, age or illness. People such as women subjected to domestic violence, for example, would not be covered. The consultation asks

19 *Glasgow Sheriff Court, AW/56/04.*

20 *For further discussion see 'Adults With Incapacity Act: When to invoke the Act' Mental Welfare Commission September 2005. (Available on the MWC website.)*

21 *'Interventions under the Adults with Incapacity (Scotland) Act' 29 September 2005*

22 *Application No 39187/98, 26 February 2002.*

23 *SLC Report 158, 1997.*

24 *Adults with Incapacity (Scotland) Act 2000, s10. Mental Health (Care and Treatment) (Scotland) Act 2003, Part 19.*

25 *'Protecting vulnerable adults – securing their safety' Consultation from Scottish Executive July 2005.*

whether and which of the Scottish Law Commission's recommendations should be implemented and it is not ruling out the most extreme remedy, the exclusion of the abuser[26].

These proposals appear to go further than the Protection of Vulnerable Adults scheme established in England and Wales under the Care Standards Act[27]. However new legal duties and powers in Scotland will be effective only if local authorities are given adequate resources to carry them out.

Police interviews of vulnerable adults

The Police and Criminal Evidence Act 1984 does not apply in Scotland. This means that, unlike England and Wales, Scotland has no legally based procedures to protect mentally disabled people being interviewed by the police.

Such protection as exists is set out in guidance from the Scottish Executive, which requires that an 'appropriate adult' is involved whenever a person who appears to have a mental disorder is interviewed by the police, whether as suspect, witness or alleged victim[28].

Research on behalf of the Scottish Executive shows that the scheme is now in operation in most of Scotland, but there are still some areas where there is no access to appropriate adults[29]. The scheme has not been widely used and this must suggest that not all those who required an appropriate adult were offered one.

In 2002 such records as were available (surprisingly not all areas kept records) showed that an appropriate adult was involved on only around 50% of the occasions that would have been expected in the light of the number of persons with a mental disorder proceeded against in court[30]. In addition, the researchers observed proceedings in one police station, where they saw high levels of mental disorder but no use of appropriate adults.

It is a matter of concern that lawyers were generally unfamiliar with the scheme, as were forensic medical advisers, despite the fact that the guidance requires them to ensure that an appropriate adult is present at any examination of the mentally disordered person.

The absence of an appropriate adult in police interviews does not necessarily render evidence received at the interviews inadmissible. The question for the court is whether the evidence has been obtained fairly[31]. If the court considers the absence of an appropriate adult has not prejudiced the fairness of the interview, it can admit the evidence. However a statutory Code would clearly have greater force. Compliance with the PACE Code in England and Wales is a critical issue in deciding whether an admission has been obtained unfairly[32].

The Scottish Executive is revising its guidance in the light of these research findings, but the current system is leaving people with mental disorders who come into contact with the criminal justice system particularly vulnerable in Scotland. If improvements are not forthcoming there will be growing calls for the scheme to be put on a statutory basis.

26 *See consultation document, para 2.2.*

27 *Department of Health, July 2004.*

28 *'Interviewing people who are mentally disordered: 'Appropriate Adult' schemes' Scottish Office June 1998.*

29 *See 'An Evaluation of Appropriate Adult Schemes in Scotland' Dr Lindsay Thomson, Viki Galt, Dr Rajan Darjee*

30 *Thomson, Galt, Darjee (above). Appropriate adults were used 827 times. The number of persons proceeded against in court estimated to have a diagnosis of schizophrenia, learning disability or dementia was 1557.*

31 *Thompson v. Crowe 2000 J.C. 173*

32 *See R v Mason (1987) 3 All ER 481; R v Absolam (1980) TLR 9 July CA; R v Walsh (1990) 91 Cr. App. R. 161; R v Keenan [1990] 2 QB 54.*

Casenotes

The House of Lords and the Unimportance of Classification: A Retrograde Step

Kris Gledhill[1]

R (B) v Ashworth Hospital Authority
House of Lords; 17 March 2005
[2005] UKHL 20, [2005] Mental Health Law Reports 47

Introduction

The issue for the House of Lords in this case was whether a patient could be treated on a ward specialising in a form of mental disorder other than the one from which he was classified for the purposes of detention. It held that the law permitted this, and in so doing disagreed with the Court of Appeal. The tensions between the two rulings reflect a fundamental difference of approach to the question of how the Mental Health Act 1983 should be interpreted.

The Facts

The facts are fairly simple. B was convicted of manslaughter in 1987; he had been acutely mentally ill at the time of the offence, showing symptoms of a florid psychotic illness. A hospital order was made together with a restriction order of indefinite duration (ss37 and 41 of the 1983 Act). The required two medical reports showed agreement that B suffered from mental illness (schizophrenia). He was placed in medium secure conditions, but transferred to high secure conditions at Ashworth Hospital in April 1988 after an incident of absconding. By this time, he was still classified as suffering from mental illness (now felt to be a paranoid psychosis), but views were expressed that there were features of personality disorder in a setting of limited intellectual ability. He was returned to medium secure facilities in October 1992 but readmitted to Ashworth in January 1994: he was now felt to be demonstrating features of "hypomanic" illness, also a mental illness, and given anti-psychotic medication. He became more stable.

During 2000, personality tests revealed a "very high" score for psychopathic disorder, a different category of mental disorder. In December 2000, he was transferred to a ward designed to address the traits of personality disorder: B felt that some aspects of the regime on this ward were less

1 *Barrister, London. Editor of the Mental Health Law Reports*

agreeable[2], and he also felt that the further therapeutic work which might be expected of him on that ward placed new obstacles in the way of his transfer to a less secure hospital, which had been recommended by his previous Mental Health Review Tribunal.

In May 2001, a Tribunal concluded that he was still suffering from a mental illness (felt to be a "schizo-affective disorder"), but did not exercise its power[3] to reclassify him as detained also on the basis of psychopathic disorder. Evidence in front of the Tribunal had included a report from an independent psychiatrist who felt that B did not suffer from a personality disorder.

In August 2001, B's solicitors wrote to the hospital to argue that B should not be on a ward for patients with psychopathic disorder. The hospital's response was that B's mental illness had been successfully controlled by ongoing medication and so the current ward within the Personality Disorder Unit was appropriate to address the remaining problems of his personality type. A new Responsible Medical Officer expressed his agreement with the view that B suffered from a mental illness and a personality disorder.

B then challenged the decision to place him on a ward within the Personality Disorder Unit and to subject him to the treatment regime within that ward: in judicial review proceedings, he sought an order quashing the decision and a declaration that his detention on a ward for those suffering from a personality disorder was unlawful. Permission was granted but the application was dismissed in a short judgment by Sir Richard Tucker: [2002] Mental Health Law Reports 336; on appeal, B was successful: [2003] Mental Health Law Reports 250; but the House of Lords then reinstated the order of the judge: [2005] Mental Health Law Reports 47.

The Legal Background

To understand the arguments put forward, the following features of the Mental Health Act 1983 should be noted. Section 1 of the 1983 Act defines "mental disorder" as being one of four different categories "and any other disorder or disability of mind". The four categories are mental illness, mental impairment, severe mental impairment and psychopathic disorder; "mental illness" is not defined further, but the other three categories are. Detention under the Act for treatment has to be on the basis of one of the four categories of mental disorder (and so the phrase "any other disorder or disability of mind" in s1 of the Act is irrelevant): see s3(2)(a) and s37(2)(a). Short-term detention for assessment under s2 requires only "mental disorder", but it is the only provision of the Act allowing detention in hospital without a formal classification.[4] The medical recommendations must agree on the form of disorder, though they do not need to agree on the precise diagnosis. It is possible to have a dual categorisation, and in this case the medical recommendations must agree on one of the categorisations.

2 *In a witness statement, it was said that B believed there were more searches on the Personality Disorder Unit, meetings with his RMO were every 3 or 4 months rather than weekly, and matters such as access to the TV were much more controlled.*

3 *Under s72(5) of the Mental Health Act 1983; in relation to those detained under ss37 and 41, only a Tribunal may reclassify a patient, whereas others may be reclassified by the Responsible Medical Officer under s16 of the Act.*

4 *A guardianship application requires one of the four classifications (s7(2)(b)); a s35 remand for a report requires one of the four classifications (s35(3)(a); a s36 remand for treatment requires either mental illness or severe mental impairment (s36(1)); an interim hospital order requires one of the four classifications (s38(1)(a)); the transfer of a prisoner under s47 is predicated on him or her suffering from one of the four classifications (s47(1)(a)) and the transfer of a remand prisoner, civil prisoner or immigration Act detainee requires mental illness or severe mental impairment (s48(1)).*

As it features in the reasoning of the House of Lords, it is also worth noting that there is an additional route into hospital detention, namely via the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, following a finding of unfitness to plead under the Criminal Procedure (Insanity) Act 1964 coupled with a finding that the accused committed the actus reus of the matter charged; or a finding of not guilty by reason of insanity. An "admission order" may be made under s5 of the 1964 Act, which allows detention in a psychiatric hospital: under para 2 of Schedule 1 to the 1991 Act, a person so admitted shall be treated "as if admitted in pursuance of a hospital order" under the 1983 Act, and a s41 restriction order may be made[5]. There is no reference to mental disorder (or any of the four categories under the 1983 Act): instead, there are separate tests. Unfitness to plead requires a finding by a jury[6] that the accused is "under a disability": this is a common law test[7] which includes those who are mute as well as those who are not sane. The special verdict of not guilty by reason of insanity requires insanity[8], which also rests on the common law test set out in M'Naghten's Case[9].

Treatment is a matter separate to detention, governed by different provisions within the Mental Health Act 1983. Section 63 provides: "The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being treatment falling within ss57 or 58 above, if the treatment is given by or under the direction of the responsible medical officer." (There is also s62, which allows urgent treatment.)

Section 58 provides that certain "forms of medical treatment for mental disorder" (which includes any medication after 3 months from the first administration of medication "for his mental disorder"[10]) shall only be given with capacitated consent of the patient or upon the certification of the Second Opinion Appointed Doctor (in practice from the Mental Health Act Commission) that the patient either has no capacity or does not consent but that the treatment should be given "having regard to the likelihood of its alleviating or preventing a deterioration of his condition". Section 57 requires both consent and a supporting second opinion and relates to psychosurgery and any other specified form of treatment[11].

B's argument was that treatment without consent within s63 for "the mental disorder from which he is suffering" was limited to treatment for the mental disorder under which he was classified for the purposes of detention. The hospital argued that the Act permitted treatment for mental disorder as diagnosed by the treating clinicians and should not be confined to the disorder or that part of the disorder classified by the Tribunal as the basis for detention.

5 *Note that the statutory provisions have now been amended by the Domestic Violence, Crime and Victims Act 2004: s24 of this Act amends s.5 of the 1964 Act to provide that the court may make a hospital order with or without a restriction order when there has been a special verdict or a finding that the accused is unfit to stand trial but committed the actus reus. The article refers to the provisions in force at the time of the judgement of the House of Lords*

6 *Under s22 of the Domestic Violence, Crime and Victims Act 2004, this is now determined by a judge without a jury*

7 *R v Pritchard (1836) C & P 303.*

8 *and also a finding that the accused committed the actus reus (s2 of the Trial of Lunatics Act 1883), otherwise a simple not guilty verdict is proper.*

9 *(1843) 10 Cl and F 200.*

10 *and also electro-convulsive therapy: see Reg 16 of the Mental Health Regulations 1983.*

11 *Extended to the surgical implanting of hormones to reduce the male sex-drive: see Reg 16 of the 1983 Regulations.*

The Administrative Court decision

Sir Richard Tucker preferred the hospital's construction. He noted that the treatment regime in place was designed to assist his transfer back to medium secure conditions and so would be to his advantage (and that of the community). It is to be noted that in the judgment, the judge first reached the conclusion that the treatment regime was to the benefit of B before he considered the question of whether it was lawful. In relation to that question, the judge concluded:

> "12. ... If Parliament had intended the mental disorder to be that classified by the Tribunal it would have said so. It is clearly a matter for the professional judgment and expertise of the clinicians in charge of B's case to decide upon the best therapeutic regime for the disorder from which they assess him to be suffering. To conclude otherwise would be to put an artificial and strange interpretation upon the words of the section."

He also dismissed any suggestion that part of the European Convention was engaged.

The Court of Appeal decision[12]

The Court of Appeal, however, took a very different view. Their conclusion was that as the context of the treatment provisions was the detention provisions, there was no need for any express limitation in the treatment provisions to the form or forms of mental disorder under which the patient was detained because that was dealt with in the detention provisions. The key to understanding the intention of Parliament as expressed in s63 of the Act was the fact that compulsory medical treatment was a serious intrusion of personal autonomy: as such Parliament could not have intended to permit compulsory treatment in the absence of clear and unambiguous language.

The Court noted two caveats which meant that their interpretation retained the necessary flexibility: first, the common law doctrine of necessity was not excluded and so emergency treatment for a non-classified disorder was possible without consent; and it would be possible to treat for a non-classified form of disorder if this was a necessary precursor to treatment for the form of disorder which justified detention.

Lord Justice Dyson, who has given a number of important judgments on mental health law[13], gave the leading judgment. He noted:

> "16. Section 63 must be construed in its statutory context. The Act provides a detailed and carefully worked out scheme for the admission of mentally disordered patients to hospital for treatment, the review of their condition from time to time, and their discharge when they are no longer liable to be detained. As I shall seek to show, a theme that runs through the Act is that the liability to detention is linked to the mental disorder from which the patient is classified as suffering, and that this disorder is considered to be treatable by the person or body making the classification. ..."

He then reviewed section 3 of the Act and the need for a classification of the disorder in order to detain, and noted that section 16 of the Act[14] provides a power for the Responsible Medical

12 *See 'The Significance of Mental Disorder Classification' Anna Harding, JMHL July 2003 pp 106–114*

13 *For example, R (Wirral Health Authority) v MHRT [2002] Mental Health Law Reports 34, R (Ashworth Hospital Authority) v MHRT [2002] Mental Health Law Reports 314, R (N) v Dr M [2003] Mental Health Law Reports 157; he was also in the Court which gave a joint opinion in R (IH) v Secretary of State [2002] Mental Health Law Reports 87.*

14 *Which also applies to a s37 patient: see Schedule 1, Part 1, paras 2 and 3.*

Officer to reclassify the patient as suffering from a different form of disorder, which has the result that the application for admission then takes effect as if the new form or forms of disorder were specified: "21. ... The reason for doing it this way is that the crucial link is maintained between the mental disorder which justifies the patient's detention and his treatment in hospital *for that disorder*."

In addition, he noted that when a s3 detention is renewed under s20, s20(9) allows reclassification:

> "23. ... So, once again, the important link is maintained between the mental disorder which justifies the patient's detention and his treatment *for that disorder*."

In relation to those detained under the criminal provisions of the Act, Dyson LJ noted that there is a mirror scheme in that the court order specifies the form of disorder: so "26. ... the essential link between a patient's mental disorder which justifies his detention in hospital and his treatment *for that disorder* is common to both." However, in relation to restricted patients, the RMO's power to reclassify under s16 or s20 do not apply, but a Tribunal may reclassify under s72(5).

Having set the statutory context, Dyson LJ dealt with the submissions which had persuaded Sir Richard Tucker to rule against B. First, there was no reference to a patient's classification anywhere in Part IV, the provisions relating to treatment, which one would expect Parliament to have made express if it were important. This was the key argument and the response of Dyson LJ was in these terms:

> "41. ... There is nothing which clearly indicates that Parliament intended Part IV to apply to *any* mental disorder from which the patient is suffering while liable to be detained in hospital, whether classified or not. Compulsory medical treatment is a serious intrusion of a person's autonomy. I would not impute to Parliament an intention to permit compulsory treatment unless this was expressed in clear and unambiguous language. It is important to underline the full reach of Mr Thorold's submission: it is that s63 authorises any forcible medical treatment for a non-classified mental disorder, even if it does not meet the emergency criteria stated in s62(1). In my judgment, s63 comes nowhere near to evincing a clear intention by Parliament to permit such treatment for non-classified mental disorder.
>
> 42. It is true that, if Part IV is considered in isolation from the rest of the Act, it might appear to apply to any mental disorder from which the patient is diagnosed as suffering, whether classified or not. But Part IV must be interpreted in its context. The Act contains detailed provisions for the admission to and detention in hospital of patients who suffer from classified mental disorders. It also contains provisions which are designed to ensure that they remain liable to be detained only so long as they continue to suffer from classified mental disorders. I have earlier set out the relevant provisions. Part IV apart, Mr Thorold was unable to draw our attention to any provision in the Act which deals with non-classified mental disorders. Part IV apart, the Act is no more concerned with non-classified mental disorders than it is with physical disorders. The Act is concerned with mental disorders which are treatable and which justify detention for their treatment. In these circumstances, I do not find it at all surprising that Part IV does not define the mental disorder for which medical treatment may be given without the patient's consent as the classified mental disorder. That is assumed. Part IV is not dealing with the definition of the mental disorder: that is determined elsewhere in the Act. Part IV is dealing with the very important ancillary question of defining the circumstances in which forcible treatment for the mental disorder may be given.

> 43. It seems to me, therefore, that the natural interpretation of s63, when construed in its context, is that treatment (other than treatment falling within s57 and 58) may be given without the patient's consent, but only for classified mental disorders. ...''

Subsidiary arguments were then put forward and it was concluded that they did not cast any doubt on this central conclusion as to the statutory meaning.

The second argument was that, in contrast to the power of administrative reclassification allowed under s16, restricted patients can only be reclassified by a Tribunal: whilst the Home Secretary can refer a case to the Tribunal at any time (under s71), this will take time, is cumbersome and so is not apt to deal with any urgent situation. This argument was predicated on the view that treatment was only possible under the Act, whereas Dyson LJ's view, which meant that this argument was not sound, was that the statutory scheme allowed treatment under the common law for the non-classified form of disorder. In short, whilst s63 governs treatment for the classified disorder, it does not deal with the non-classified disorder and so the common law doctrine of necessity has not been excluded.

The third argument was that limiting s63 would cause practical difficulties in cases of comorbidity, because it would be unfortunate to deny the patient treatment for a form of disorder which did not justify detention and it would cause major problems if this disorder aggravated that form of disorder which did justify treatment. This was also felt to be an imagined rather than real problem because, in the first place, if the disorder did not justify detention then treatment without consent could not be justified; and in the second place, if treatment was necessary in order to deal with the form of disorder which did justify detention, then it was justified as ancillary treatment for the latter form of disorder (which is authorised: see *B v Croydon Health Authority* [1995] Fam 133).

Having dealt with the hospital's arguments, Dyson LJ then considered the purpose of classification. There was, he felt, an important point in that if treatment could be given for any disorder, then there was no purpose to reclassification. The better view, he felt, was that the purpose is to identify the mental disorder for which compulsory treatment is needed: ''67. ... Were it otherwise, the carefully drafted provisions for reclassification in s16, 20 and 72(5) would serve no real purpose. Those provisions are designed to ensure that the essential link is maintained between the mental disorder which justifies the patient's detention and his treatment for that disorder, and no other.''

Scott Baker LJ gave a brief concurring judgment, as did Simon Brown LJ, who noted:

> ''74. ... If the patient can only lawfully be detained for a classified treatable mental disorder, there ought properly to be a correlation between the disorder(s) classified and the treatable disorder(s) from which the patient is suffering.''

Simon Brown LJ then referred to his own judgment in *R (Wilkinson) v Broadmoor Hospital Authority* [2001] Mental Health Law Reports 224, [2002] 1 WLR 419, at para 9, to the effect that detention was not itself sufficient to justify treatment, which was a separate matter. Since s58 of the Act authorises treatment without consent, the hospital's submissions would mean that ''77. ... patients classified as suffering only from mental disorder A could be compulsorily subjected to the sorts of severe treatment provided for by s58 with regard to mental disorder B. That is not a conclusion that I would reach except upon the clearest language and s63 does not provide it.'' For Simon Brown LJ, the key was that

> "78. ... a person suffering from a treatable mental disorder, but not one of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital, cannot be detained and treated under the Act. If the patient cannot be forcibly treated in either of those circumstances, why should he be amenable to such treatment for a non-specified mental disorder merely because he is already lawfully detained for the treatment of some other mental disorder?"

The House of Lords decision... and Comment

The House of Lords took a different view: the only reasoned judgment was given by Baroness Hale, with whom the other Lords agreed. Before describing the reasoning of her Ladyship, it is worth noting that the Court of Appeal's judgment had been distinguished in two situations. First, in *R (AL) v Home Secretary* [2005] MHLR 12, a patient was recalled on the basis of a form of disorder other than the one under which he was classified when released: the Court of Appeal held that this was acceptable. In the first place, the power of recall was not expressed to be limited; further, a restricted patient might have been reclassified several times, and while in the community might suffer a recurrence not of the form most recently diagnosed but of an earlier classified form of mental disorder, so it would be contrary to the purpose of recall to place an unnecessary restriction on the power of recall.

There is another important point to this case. The patient had been detained following a finding of not guilty by reason of insanity of a homicide. He had been discharged by a Tribunal which felt that his ongoing personality problems did not amount to psychopathic disorder. He was recalled, concern being expressed that he had a mental illness: however, by the time of his Tribunal hearing[15], the RMO was of the view that AL could not be detained on the basis of mental illness but could be detained on the basis of psychopathic disorder. The argument for him had been that once it became clear that the basis for his recall was a different form of disorder which no longer justified detention, he should have been released. The Court of Appeal noted that a patient detained as a result of the 1964 Act was admitted and detained without any reference to any form of disorder.

With respect to the Court of Appeal, this part of its reasoning is simply not so in relation to ongoing detention. It is true that there is no classification on admission: but such a patient may make an immediate application to a Tribunal[16], which will apply the criteria of s72 of the Act, which requires release unless the Tribunal is satisfied that there is one of the four classifications of disorder present so as to justify detention. Accordingly, the ongoing detention of the patient is dependent on a finding that at least one of the forms of disorder (rather than "any other disorder") is applicable. This criticism does not undermine the other part of the court's reasoning.

The second case which had distinguished the Court of Appeal's ruling in *B* was *R (SC) v MHRT* [2005] Mental Health Law Reports 31, in which Munby J held that there was no required link between the mental disorder from which the patient was classified as suffering and the grounds for believing that it was "appropriate for the patient to remain liable to be recalled to hospital for further treatment" (ie the test for any discharge being conditional as opposed to absolute under

15 *Which has to be arranged speedily after a recall: see s75 of the 1983 Act together with r29(cc) of the Mental Health Tribunal Rules 1983.*

16 *See s69(2) of the 1983 Act: the restriction applied to a s37 patient that they cannot apply until 6 months has passed does not apply.*

s73) and no reason to import such a link when a Tribunal was considering a decision under s75 as to whether to make a discharge absolute rather than conditional. As with the AL case, the valid reasoning for this is that in a case of comorbidity, it is possible that the need for ongoing supervision will be the form of disorder which had not justified detention prior to the conditional discharge.

Returning then to the reasoning of the House of Lords in *B*, the view taken by Baroness Hale was that the absence of any reference to the classified form of disorder in the statutory language relating to treatment meant that Parliament did not feel that it was important. She noted that, although patients are vulnerable, they are protected by the law of negligence and the provisions of the Human Rights Act 1998 or judicial review if treatment is in breach of a Convention right. The question in front of the House was defined as whether "21. ... the only treatment which they may be given without their consent under s63 is treatment for the particular form or forms of mental disorder from which they are recorded as suffering in the application, order or direction under which they are detained."

Baroness Hale felt that there were a "great many reasons" for concluding that s63 was not so limited. Her starting point was the language used in s63, which makes reference to the wide definition of mental disorder rather than any of the categorised mental disorders. Accordingly, "the natural and ordinary meaning of the words is that the patient may be treated without consent for any mental disorder from which he is suffering" (para 22). This, however, should be merely a starting point for the discussion because, as the Court of Appeal noted, the question is the meaning of the language in its context. Their conclusion was that as a patient was only detained on the basis of one or more of the categories of mental disorder, this meant that the question of the relevance of the category of disorder was dealt with at that stage and so did not need to be dealt with separately at the stage of treatment without consent.

Her Ladyship's second point was that the Act made plain with express language when one of the specific forms of disorder was important (using as examples the provisions relating to reclassification and the medical recommendations for a s3 or s37 order), and so the absence of such language was important. This again is a point which is valid but hardly conclusive: if it is self-evident that Parliament could not have intended to allow compulsory treatment for something which does not justify detention (which was the very point in issue), then there would be no reason for express language to state the obvious. Even if the language of the statute does not make Parliamentary intention obvious, the same point applies if the true intention of Parliament was that compulsory treatment could only follow for the classification of disorder justifying detention for treatment.

The third point noted by Baroness Hale was that s63 applies to all patients covered by Part IV of the 1983 Act and some of them are not detained on the basis of a category of disorder: rather, they merely have to be shown to be disordered. The groups covered by this are those admitted for assessment under s2 and those detained by virtue of the Criminal Procedure (Insanity) Act 1964[17]; there is also a group of military detainees under s46 of the 1983 Act. In all these cases, so the argument accepted goes, s63 must refer to any mental disorder from which the patient is suffering. Baroness Hale noted, at para 24 of her the judgment: "It would be surprising if the same words had a different meaning when the patient is detained under these provisions from the meaning it has when he is detained under the others."

17 See footnote 5 above

This can be looked at from two angles. First, assuming that s63 does allow treatment for any form of disorder for these groups of patients, it does not mean that it should apply to all other groups of patients. If it is right to conclude, as did the Court of Appeal, that those detained under treatment provisions should only be subject to forced treatment for the category of disorder which justifies their detention, it is hardly a compelling argument to suggest that because this cannot apply to all detainees, it should apply to none.

Secondly, this part of her Ladyship's argument carries little weight in reality. In relation to s2 patients, the lack of any categorisation is obviously required because the whole purpose of the section is to allow the clinical team to assess the condition of the patient and determine whether there is any need for a s3 detention to be put in place: accordingly, once it has been determined what category of disorder is suffered and that the patient needs detention under s3 of the Act, the reasoning of the Court of Appeal will apply. In short, there is a good reason why s2 patients are treated differently and it makes no difference to the validity of the reasoning of the Court of Appeal in relation to other patients.

Further, in relation to the other groups mentioned (ie those detained under the unfitness to stand trial or insanity provisions, and the military group), they are treated as if detained under s37 of the 1983 Act: accordingly, as soon as their case has been considered by a Tribunal, they will only be detained on account of one of the four specific categories of mental disorder because s72(b)(i) – which applies to both non-restricted and restricted patients – provides that a Tribunal must discharge unless the patient is suffering from one of the four categories of disorder. In other words, a patient who is suffering from "any other disorder or disability of mind" within s1 of the Act cannot be detained beyond their first Tribunal hearing. It is only if they suffer from one (or more) of the four categories of disorder that their detention can continue. In relation to the most significant number in this category, ie those detained following decisions under the Criminal Procedure (Insanity) Act 1964[18], there is an immediate right of application to a Tribunal following their admission: see s69(2). So Parliament has provided a mechanism whereby their detention continues on the basis of a categorisation imposed by a Tribunal.

A point could be made against this latter argument that it still does not ensure that there is a specified category of disorder, because s72(1)(b) simply lists all the forms of disorder. But all these patients are treated as if detained under s37 of the Act (which imports a categorisation) and s72(5), the power of the Tribunal to reclassify a patient, applies to every patient who applies to a Tribunal[19] and only makes sense if there is a categorisation of all patients other than those under s2.

The fourth point put forward by Baroness Hale was that the statutory history of the relevant provisions indicates that classification and reclassification relate to the criteria for admission and continued liability to detention rather than to the treatment which may be given while in hospital. In essence, her point here was that the different categorisations of disorder go back to the Mental Health Act 1959 (albeit expressed differently), which had no regulation as to treatment and hence no limitation of whether a patient could be treated only for the form of disorder for which they were detained. But the question in issue in the case was what was the meaning of the amendments introduced to regulate treatment and contained in s63 of the 1983 Act: it is difficult to see how this can be answered by examining an earlier statute which had no such provision in it. Parliament

18 *See footnote 5 above*

19 *The statutory language is "Where application is made ... under any provision of this Act by or in respect of a patient ..."*

grafted onto an existing system whereby detention was regulated according to categorisation some much-needed regulation of the circumstances in which treatment could be compelled: the fact that the pre-existing system dealt only with admission and detention (necessarily so as there was no regulation at all of treatment) cannot mean that categorisation issues remained limited to admission and detention rather than treatment. It is the new statutory structure which has to be considered to determine the intention of Parliament.

The fifth and final statutory construction point relied on by Baroness Hale was that the RMO cannot reclassify a restricted patient, and a Tribunal can only do so if they decide not to discharge. If treatment was restricted to the classified form of disorder, the cumbersome and time-consuming process of arranging a Tribunal hearing would have to be pursued before a patient could be treated for this new form of disorder. Her Ladyship noted (at para 28) "It is unlikely that Parliament intended that the patient could not be treated without his consent in the meantime, particularly as the patient may find ways of delaying the Tribunal hearing." Again, this is a valid point but it does not prove much because, as the Court of Appeal pointed out, any urgent treatment – which should be a rare occurrence in any event – could be provided under the doctrine of necessity and this would deal with any concerns during the delay before a Tribunal hearing.

Accordingly, none of the arguments put forward by Baroness Hale as points of construction carry sufficient weight to overturn the view of the Court of Appeal. What is noticeable as well is that she did not take any account of European Convention arguments which, pursuant to s3 of the Human Rights Act 1998, must be at the forefront of any arguments as to statutory interpretation when fundamental rights are at stake. This was relegated to the final part of her judgment and dealt with in extremely brief fashion. Given that the issue was the conditions of detention rather than the fact of detention, the relevant Convention provisions are Articles 3 and 8. On the facts, it was noted that there were no arguable breaches, and in relation to the wider principle her Ladyship simply noted that patients were offered better protection by the law of negligence and by a claim for breach of the Human Rights Act 1998 than by the construction put forward.

This part of her reasoning was clearly flavoured by her view as to whether there were any policy reasons in support of the Court of Appeal's preferred construction. Whilst noting that compulsory patients are a vulnerable group who deserve protection from being forced to accept inappropriate treatment, Baroness Hale noted that the tool of categorisation does not really provide protection because, for example, it would not prevent the wrong type of medication being given to a patient detained under the category of mental illness. But, again, this does not actually prove anything: the fact that a blunt tool cannot achieve everything that would be worthwhile does not mean that it should be rejected entirely.

The second policy matter to which Baroness Hale referred was that psychiatry is not an exact science: she noted that, as had been the case with B, a number of different diagnoses had been reached over the years. Further, given that there is often present a mental illness and a personality disorder ("comorbidity" being the medical term), it may be difficult to determine which features of the patient's presentation stem from a disease of the mind and which stem from his underlying personality traits. From this reality, Baroness Hale produced the following conclusion: "31. ... The psychiatrist's aim should be to treat the whole patient. ... Once the state has taken away a person's liberty and detained him in a hospital with a view to medical treatment, the state should be able (some would say obliged) to provide him with the treatment which he needs. It would be absurd if a patient could be detained in hospital but had to be denied the treatment which his doctor thought

he needed for an indefinite period while some largely irrelevant classification was rectified."

This is disquieting. There are two elements to compulsory treatment under the Mental Health Act 1983: one is detention and the other is treatment. Accordingly, there are two fundamental rights in play: liberty and self-determination. Psychiatric treatment – particularly medication – often involves unpleasant side-effects; our concept of self-determination is that people should make the decision about what treatment to accept even if a medical professional believes that only one decision can be sensible.

The loss of liberty does not carry with it a loss of self-determination: that was the clear principle underlying the conclusion of the Court of Appeal. That was also the basis for the decision is *Wilkinson*: the fact that treatment is separately regulated reflects an acceptance that it involves a different fundamental right, which is not subsumed in the loss of liberty. But the reasoning of the House comes close to saying that if the state takes away liberty on account of mental disorder, then any self-determination is lost: instead, the medical professionals have to do what they can to treat and put the patient back into the community.

Why is this disquieting? Admittedly, it sounds sensible in principle, but when one starts with the premise that psychiatry is an inexact science, the truth is that safeguards are required for the personal autonomy rights of the patient because the inexact nature of the science means that mistakes are a greater rather than lesser possibility. That favours not the wide licence given to psychiatrists by Baroness Hale but the restrictive interpretation favoured by the Court of Appeal. The inexact nature of the science should mean that treatment is imposable only if clear statutory language is in place. In other words, whereas section 63 of the Mental Health Act 1983 allows treatment without consent for "the mental disorder from which he is suffering", if Parliament is to be taken to have meant to allow treatment without consent for any mental disorder, including one which did not justify detention, clearer language would achieve that: for example, it could have referred to "any mental disorder from which he is suffering". The same applies to section 58: this allows treatment for "his mental disorder" but in the context of a patient being "liable to be detained"; had Parliament meant to refer to treatment for any form of mental disorder, not just the one relevant to detention, it could have said "any mental disorder".

Baroness Hale was perfectly right to say that in some instances, where the dispute is about the particular diagnosis within a given category (eg different forms of mental illness), since different specific disorders may involve different treatments, the Court of Appeal's decision offers little protection against the imposition of treatment which turns out to be wrong: but neither would the law of negligence, particularly as psychiatry is such an inexact science and accordingly a breach of the duty of care imposed is more difficult to demonstrate. And, as a matter of principle, the risk apparent from mistaken diagnoses within a category is hardly reason to take away such protection as was given by the approach of the Court of Appeal. The position now is that a person can be detained for treatment in relation to one form of disorder but also treated for a form of disorder which would not have justified his or her detention in the first place. So take two patients with capacity: patient A suffers from mental illness alone, but not sufficient to justify detention; he retains both liberty and the right to self-determination. Patient B suffers from both mental illness which does not justify detention but also mental impairment which does justify detention; he loses both liberty and all rights to self-determination, even in relation to a form of mental disorder which had it stood alone would not have justified detention.

It is true that in *B*, the additional form of disorder was a personality disorder in relation to which most treatment is psychologically based rather than chemical and so not necessarily invasive: but this is not universal and it may not be the same in the future. And the fact is that the House of Lords sets a principle applicable to different circumstances. So, a person suffering from mental impairment which justifies detention and also suffering from a psychotic illness which does not justify detention can now be treated forcibly for the latter without clear authorisation in the Mental Health Act.

It is not too much to insist that the statute be clear about this (so that at least Parliament would have had to confront the issue and reach a conclusion as to what was justified). This is consistent with the Human Rights Act 1998 and the requirement for sufficient precision in the law to meet the requirements of legal certainty. This should now be the approach to statutory interpretation: section 3 of the 1998 Act so requires when, as here, fundamental rights are at stake.

Baroness Hale was clearly concerned that by taking away from the professionals the power to treat the patient's entire range of problems, it was the patient who would suffer the indignity of longer detention. But the concept of autonomy means that it is for the patient to make the decision as to whether to accept treatment, weighing in the balance a judgment as to the consequences of non-acceptance (including that liberty may be lost for longer). For this reason, the approach of the Court of Appeal was better: but it is not the law.

The Balancing Act

Helen Kingston[1]

R (on the application of E) v Bristol City Council
Queen's Bench Division (Adminstrative Court) Bennett J., 13 January 2005
EWHC (Admin) 74

Introduction

This case involved further consideration of the difficulties created by provisions in the Mental Health Act 1983 ('the Act') relating to the nearest relative. In particular the court was asked to consider the definition of 'practicability' in the context of section 11 of the Act and paragraph 2.16 of the Code of Practice ('the Code').

The Facts

The claimant, E, had a history of mental health problems, having been detained in Broadmoor for some four years, then in a low secure unit for a two year period, followed by further periods of detention, the latest being in September 2002.

In accordance with section 26 of the Act, E's nearest relative was her sister S.

E and S had not seen each other since February 2003. E did not want S involved with her or her care. Although details of the relationship were not given in open court, in the Judge's words, they 'did not get on'.

E's consultant psychiatrist confirmed, in a letter to E's solicitors, that, in his clinical opinion, it would not be in the interests of E's mental health for S to be E's nearest relative, and, further, that consultation with S without E's consent, about E's admission to hospital, 'would further damage [E's] mental health because of the very strained relationship between the two of them'. In the proceedings, Bristol City Council (the defendant) accepted that were S to be involved, this would be 'positively harmful 'to E.

In correspondence with the defendant, E's solicitors set out her concerns, seeking assurances that S would not be notified or consulted. The defendant's response indicated that, whilst the defendant wished to respect E's wishes, section 11(3) and (4) of the Act prevented it from completely excluding S. With E's agreement, the defendant wrote to S to see if she would be

1 *Senior Lecturer, Law School, Northumbria University.* *The writer is grateful to Rob Brown, ASW Course Director S.W. England, for helpful comments*

prepared to delegate her nearest relative functions (see regulation 14 of the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983). Following S's response, that she would 'consider delegating [her] nearest relative functions to the guardianship of Social Services with Power of Attorney', whilst agreeing that this could be interpreted as S's agreement that she was prepared to so delegate, the defendant indicated that this did not, however, in its view, relieve Social Services of its legal obligations in relation to the nearest relative and that 'the fact that [S] appears to be willing to delegate her functions to Social Services does not mean it is not reasonably practicable to consult with her'.

Proceedings

Consequently E issued judicial review proceedings seeking:

- A declaration that it was unlawful for the defendant or its employee to notify/consult with S, under section 11, without E's consent
- An order prohibiting the defendant or its employees from so doing.

The defendant was not represented at the hearing, filing a skeleton argument mainly dealing with costs issues.

The Law

The Judge adopted the summary of the nearest relative's functions set out by Maurice Kay J in the case of *R (on the application of M) v Secretary of State for Health*[2]. These, as summarised, include the power to make an application for admission to hospital under sections 4, 2 or 3, and the right to be informed (section 2) or consulted (section 3), subject to 'practicability' and delay (section 3 only). Other rights include, in certain circumstances, the right to information (section 132), the right to direct discharge from section (section 23) and the right to apply to a Mental Health Review Tribunal (section 66) and to otherwise be involved in proceedings (Mental Health Review Tribunal Rules 7(d), 22(4)), 31(c).) As Bennett J concluded, '[t]hus it can be seen that the nearest relative is entitled to take actions affecting the fundamental rights of the patient and to have access to sensitive information concerning the patient'.

Section 26 of the Act sets out the process for identifying the nearest relative. This does not allow any element of choice for the patient. Once the nearest relative is identified there is then only a 'limited mechanism' for this to be changed, through a court order displacing the nearest relative, in the circumstances set out in section 29 of the Act. This does not include a situation where the patient, no matter how reasonably, objects to the person identified by the application of the provisions of section 26. The dual effect of sections 26 and 29, together with the rights and function of the nearest relative, as described, create a situation which in *JT v. the United Kingdom* (Application No.26494/95) caused *JT* to claim that her Article 8 right (to respect for private and family life, home and correspondence) under the European Convention on Human Rights and Fundamental Freedoms ('the Convention'), had been interfered with, that such interference could not be justified under 8(2), and consequently was a breach of Article 8. The claim was held admissible by the European Commission, but was subsequently settled, apparently on agreement by the Government to amend the law to allow for removal of the nearest relative in certain

2 *[2003]EWHC(Admin)1094*

circumstances. The current draft Mental Health Bill 2004 contains provisions for a 'nominated person' to 'replace' the nearest relative. In the meantime, the effect of sections 26 and 29 was declared to be incompatible with Article 8 by Maurice Kay in *Re M*.

In relation to an application for admission to hospital for assessment under section 2, section 11(3) requires the approved social worker ('ASW') before, or within a reasonable time of making the application, to 'take such steps as are *practicable*' (emphasis added) to inform the (person appearing to be the) nearest relative of the application. In relation to an application for admission for treatment under section 3, section 11(4) states that no such application shall be made ....except after consultation with ...the nearest relative...unless it appears to that social worker that in the circumstances such consultation is *not reasonably practicable* or would involve unreasonable delay' (emphasis added). Section 11(4) prevents such an application being made where the nearest relative objects. The Code at paragraph 2.16, comments on the '[c]ircumstances in which the nearest relative need not be informed or consulted' and states (emphasis added) '[p]*racticability* refers to the *availability* of the nearest relative and *not to the appropriateness of* informing or consulting the person concerned.'

Section 3 of the Human Rights Act 1998 requires the court to interpret, so far as possible, legislation in such a manner so as to be compatible with rights under the Convention.

Issue

Against this legal background the question in this case was the extent to which the defendant's hands were tied by the obligation to inform and/or consult S, in her role as nearest relative, prior to any application under section 2 or 3 being made, even where it was contrary to E's capable wishes, could be harmful to her, and could breach E's Article 8 rights.

Court's Findings

The Judge concluded that there was credible evidence that 'significant distress' would be caused to E if S were to exercise functions of the nearest relative role, namely being involved in decisions relating to E's admission to hospital or taking any 'action' herself in this regard. Bennett J stated '[i]t would seem clear to me that Mrs S is not an appropriate person to carry out the many powers and responsibilities given to her as the Claimant's nearest relative under the Mental Health Act 1983. I say that because (i) the claimant does not want her as her nearest relative, (ii) it might be positively harmful to the patient's mental and emotional well being for Mrs S to act, and (iii) Mrs S it seems, does not wish to so act. Indeed if it is necessary I would go so far as to find that it is not in the best interests of the claimant for Mrs S to be involved in any way with the claimant and, in particular, with the assessment and/or treatment of the claimant's mental health problems' (paragraph 9).

In indicating that E's Article 8 rights had been, or were in 'real danger' of being, interfered with, Bennett J went on to consider the provisions of section 11(3) and 11(4). Acknowledging the obligation on the court imposed by section 3 of the Human Rights Act 1998, in fact Bennett J found that it was 'perfectly possible' to interpret the words of section 11(3) and (4) in a way which was compatible with E's rights, by interpreting the words so as to take into account E's 'wishes and/or health and well-being'. Whilst noting that the Code is issued for guidance, the Judge went on to state that the relevant guidance in paragraph 2.16 is wrong, falling 'into the trap of confusing

the different concepts of 'possibility and 'practicability'' and 'contrary to ...common sense'.

The question, in the particular circumstances of the case, whether or not it was 'practicable' to inform and/or consult, involved a 'balancing act'. Parliament's intention that the nearest relative plays a 'significant role' should 'not lightly be removed by invoking impracticality. On the other hand, to confine practicability, as does the Code..., is far too restrictive and could lead to positive injustice in the breach of the claimant's right under Article 8'. In this case Bennett J held that the 'balance' came down in favour of E and that it was not practicable for the defendant to inform/consult for the purposes of section 11(3) and (4).

Conclusion

The Judge declared that it was not practicable for the defendant to carry out its duties to inform the nearest relative under section 11(3) and /or to consult under section 11(4) and ordered that the defendant pay E's costs.

It is worth noting that Bennett J did not grant the declarations in the terms requested by E, but in effect relieved the ASW from having to consult/inform in these particular circumstances. If the ASW did decide to contact S the judge said E could return to court. This seems to be very helpful (if contentious from an ASW point of view) because it allows a judgement to be made by the ASW on ''practicability''.

Comment

Does the decision mean that a matter of some debate and concern for some time is now finally resolved? Jones has long argued that the Code's interpretation is in conflict with Article 8. Drawing on the same authorities as subsequently relied upon by Bennett J, he has contended that caselaw ''strongly suggest[s] it would not be 'practicable' for an approved social worker applicant to consult with a nearest relative if such consultation would have an adverse effect on the patient's situation by, for example, causing significant emotional distress to the patient or by placing the patient at risk of physical harm''. He has concluded that ASWs 'should therefore be advised not to interpret this provision in the manner advocated by the Code...'[3]. For some time, understandably, ASWs have been concerned about their position. No doubt many will have agonised over to whether to follow Jones or the Code, with the prospect of acting unlawfully exacerbating what is often already a difficult decision. This case provides a welcome answer on this point. The Department of Health, in a legal briefing following the decision (gateway reference 4606) accepts that the advice given in paragraph 2.16 of the Code, referred to above, is no longer correct.

This, however, is the easy bit. What are the practical implications for the ASW? As before, in the absence of impracticability or (in the case of a proposed s.3) unreasonable delay the ASW must inform/consult the nearest relative, who will still, of course be 'automatically' identified by section 26, and who can still not be removed other than within the narrow provisions of section 29. The incompatibility declared by Maurice Kay J remains. In considering whether it is 'practicable' to inform/consult, the ASW will now have to consider the wider definition of 'practicable' and the patient's Article 8 rights. This will involve the 'balancing act' as described by Bennett J. This is surely the tricky part. The Department of Health briefing suggests that ASWs should not 'lightly

3 *Most recently, Jones, Mental Health Act Manual 9th edition (2004; Sweet & Maxwell) paragraph 1–124*

invoke 'impracticality' as a reason for excluding [the nearest relative]'. '[K]ey factors', in the Department's view, in this case, were the very strong objections by E, the fact that S did not want to be involved and the likelihood that S's involvement would have been distressing for E. The Department gives other possible examples where impracticality might arise, which may include a situation 'where the nearest relative is known intensely to dislike the patient and/or would not act in the patient's best interests or where the involvement of the nearest relative might adversely affect the patient's health (e.g. by causing the patient severe distress)'. The Department goes on to stress that 'it is very unlikely that the fact that a nearest relative is expected to object to admission or to seek the patient's discharge would, of itself, make their involvement impracticable and therefore relieve ASWs of the duty to inform or consult them'.

What about the impact of the patient's capacity? How may/should this affect the ASW's assessment of whether or not consultation is 'practicable'? What about risk and thus the dilemma for the ASW of competing duties, where, for example, the nearest relative may have important information relating to risk which the ASW has to assess?

Reflecting on the variety of different circumstances an ASW may face, and issues that may arise, and attempting to analyse when and how this may lead to a conclusion that it will not be practicable to inform/consult, only serves to illustrate in reality how difficult this 'balancing act' may be. In E's case there was time to consider and understand E's views, to seek S's views, to obtain a medical opinion and legal advice, and ultimately to ask the court itself to carry out the 'balancing act'. Clearly this is not often going to be the case. In reality, time may well be short and information limited. In relation to court involvement, it is notable that the defendant, whose reasonableness throughout was praised by the judge, and who did not bring the matter to court through 'any unjustified act' (paragraph 41) ultimately had to bear the costs of the application.

As long as the tension created by the incompatibility of sections 26 and 29 remains, it would seem that, what will often be a precarious balancing act by the ASW, will have to continue. It remains a matter of considerable regret that the Government has failed to act on its undertaking in JT and in response to the declaration of incompatibility in *Re* M.

"Hospital" Treatment Further Refined

Susan Thompson and Stuart Marchant[1]

R (on the application of CS) v Mental Health Review Tribunal; Managers of Homerton Hospital (East London and the City Mental Health NHS Trust) (Interested Party)

Queen's Bench Division, (Administrative Court), Pitchford J., 6 December 2004

EWHC (Admin) 2958

The decision of a Mental Health Review Tribunal under section 72(1) Mental Health Act 1983 not to discharge a patient on section 17 leave from hospital was not unlawful. The link between hospital and treatment may be "gossamer thin" but still a "significant component" to justify renewal of detention

Introduction

CS was a patient liable to be detained on leave of absence from hospital (leave).[2] She challenged the decision of the Tribunal which had confirmed the lawfulness of her detention following renewal[3] on the grounds that she was no longer receiving hospital treatment which justified continued detention. The court, whilst restating that hospital treatment must be "*a significant component*" of the treatment plan to be lawful under the Mental Health Act 1983 (the Act), found that, although the Responsible Medical Officer's (RMO) grasp on the patient was "*gossamer thin*", it was a "significant component" sufficient to justify continuing detention. As a patient liable to be detained, CS could be recalled to hospital for treatment if she refused or failed to take her medication in the community which introduced an element of compulsion that she accept treatment in the community.

The Facts

CS, who had a clinical history of paranoid schizophrenia, and repeated admissions to hospital, was detained in hospital for treatment in May 2003. Her detention was renewed on 29 October 2003. On 5 November 2003 she applied for review of her detention to a Tribunal which confirmed that she should remain liable to be detained at a hearing on 2 February 2004. She had in fact been on leave since 5 November 2003.

Her treatment in hospital comprised attending ward rounds at the hospital once every 4 weeks. These were described by her RMO as an opportunity to discuss how leave was progressing, to discuss her medication and how it was suiting her and to provide her with supportive and motivational work to help her move from a hospital-based model of care to community-based care with the assertive outreach team. The latter included support for compliance with medication as part of treatment.

1 *Solicitors who acted for the interested party. Susan Thompson is a partner at Beachcroft Wansbroughs. Stuart Marchant is a solicitor at Bevan Brittan.*

2 *section 17 Mental Health Act (MHA) 1983*

3 *under section 20 MHA 1983*

Further leave was negotiated at each ward round. Additionally, CS had weekly sessions with the ward psychologist. Her hospital-based care was also described by Counsel on behalf of the detaining authority, as the continued provision of a place of refuge and stability, a reference point for CS in her attempts to disengage with treatment in hospital and engage with treatment in the community. By the time the court considered her case in December 2004, CS had been discharged from detention and her care was continuing in the community without compulsion.

The issue

...was CS's mental illness of a nature or degree which made it appropriate for her to receive treatment, a significant and justified component of which was treatment in a hospital?[4]

CS challenged the decision of the Tribunal that she should remain liable to detention and recall (rather than directly challenging the detaining hospital following renewal), claiming its decision was disproportionate and in breach of her human rights under Article 5 ECHR, her right to liberty, as her treatment plan indicated that she was not receiving any hospital treatment. Broken down, she argued that the Tribunal failed to properly exercise its powers by:

a) failing to order her immediate discharge, or

b) even if it accepted the need for further phasing of her discharge incorporating a continuing element of liability to detention, by failing to name a day on which discharge should take effect, or

c) failing to consider less restrictive (and more proportionate) options including the use of guardianship under section 7 of the Act or supervised discharge pursuant to section 25 (A–J).

Joining in East London and the City Mental Health NHS trust as an interested party, CS initially argued that the decision to renew her detention by her RMO was also unlawful because the RMO was not seeking her actual admission to hospital, but in the course of the proceedings Counsel for CS conceded that treatment in a hospital under section 3 can take place daily without overnight stays in hospital.

The Law

(1) Section 17 leave

Section 17 provides the only lawful authority for a detained patient to be absent from the detaining hospital.[5] A person on leave remains liable to be detained and subject to consent to treatment under Part IV of the Act. The RMO can *"grant .....leave to be absent from the hospital subject to such conditions (if any) as that officer considers necessary in the interests of the patient."*[6] This can include a condition that the patient lives in a particular place including a care home[7] or that the patient accepts medication or attends for medical treatment. Leave can be granted *"indefinitely or on specified occasions or for any specified period"*[8] and the period may be extended. Leave can be revoked and the patient recalled to hospital by the RMO where *"it appears to the RMO that it is necessary to do so in the interests of the patient's health or safety or for the protection of other persons."*[9]

4 *Judgment at para 39*

5 *Jones, R. Mental Health Act Manual, 9th edition, (Sweet & Maxwell, 2004) at para. 1–172*

6 *section 17(1) MHA 1983*

7 *See note under Conditions in Jones, R. 9th edition, (Sweet & Maxwell, 2004) at para 1 – 176*

8 *section 17(2) MHA 1983*

9 *section 17(4) MHA 1983*

(2) Duration of detention

A person cannot be recalled to hospital once he has ceased to be liable to be detained.[10] It is unlawful for a patient to be recalled to hospital to facilitate renewal of detention under section 20 of the Act.[11] It will, however, be lawful if the treatment plan contains an element of hospital treatment.[12] This finding marked a departure from the position that had stood since *Hallstrom*[13] that a patient on leave could not have his detention renewed. Developing this theme in *R (on the application of DR) v Mersey Care NHS Trust*, the lawfulness of continued detention was held to depend on

> ". . . whether a significant component of the plan for the claimant was for treatment in hospital. It is worth noting that, by section 145(1) of the Act, the words 'medical treatment' include rehabilitation under medical supervision. There is no doubt, therefore, that the proposed leave of absence for the claimant is properly regarded as part of her treatment plan. As para 20.1 of the Code of Practice states, 'leave of absence can be an important part of a patient's treatment plan'. Its purpose was to preserve the claimant's links with the community; to reduce the stress caused by hospital surroundings which she found particularly uncongenial; and to build a platform of trust between her and the clinicians upon which dialogue might be constructed and insight on her part into her illness engendered."[14]

In setting boundaries to the limits of "hospital treatment" the discharge by an MHRT of detention of a person on leave to a nursing home where it was acknowledged that hospital treatment would arise at some point in the future, but its timing was uncertain, has been held to be lawful.[15]

(3) The Powers of the Tribunal

Section 72(1) and (2) require the Tribunal to direct the discharge of a patient detained under section 3 if it is not satisfied that

> "he is then suffering from mental illness . . . of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or that it is necessary for the health or safety of the patient . . . that he should receive such treatment[16] having regard (a) to the likelihood of medical treatment alleviating or preventing a deterioration of the patient's condition; and (b) in the case of a patient suffering from mental illness . . . to the likelihood of the patient, if discharged, being able to care for himself, to obtain the care he needs or to guard himself against serious exploitation."[17]

The Argument

The court was invited by Kristina Stern, Counsel representing both the MHRT and the Trust, to consider CS's treatment holistically, incorporating in-patient, out-patient and community treatment, subject to constant assessment of each element. The significance of the element of

10 *section 17(5) MHA 1983*

11 *R (on the application of W) v Hallstrom [1986] QB 1090, [1986] 2 All ER 306*

12 *section 20(4) MHA 1983; R v Barking Havering and Brentwood Community Healthcare NHS Trust[1999] 1 FLR 106*

13 *above, [1986] QB 1090, [1986] 2 All ER 306*

14 *[2002] EWHC 1810 at para 30*

15 *R (on the application of Epsom and St Helier NHS Trust) v Mental Health Review Tribunal [2001] EWHC 101(Admin)*

16 *Section 72(1) (i) and (ii) MHA 1983*

17 *Section 72(2) MHA 1983*

treatment received at hospital was directly related to CS's response to the other elements and liability to be detained should be maintained whilst hospital treatment remained a significant part.

In response, it was argued by CS that what was happening was merely a method of enforcing co-operation with the outreach team. There was no in-patient treatment. Furthermore, the Tribunal's powers[18], as Steven Simblet, Counsel, submitted on behalf of CS, represent *"the reverse side of the section 3 coin: in other words, if the Tribunal is not satisfied that the patient any longer satisfies the conditions for detention under section 3, then the patient must be discharged."*[19]

The Decision

Pitchford J accepted that the test for continuing liability for detention was whether a significant component of the plan was for the patient to receive medical treatment in a hospital.[20] Finding the contention on behalf of CS that what was happening was merely a method of enforcing co-operation with the Outreach Team to be too crude an analysis, Pitchford J supported the difficult role of the RMO in managing a patient back into the community in a manner designed to avoid the revolving door syndrome:

> "Viewed as a whole the course of treatment should be seen..... as a continuing responsive programme, during which the need for treatment in hospital and on leave was being constantly reassessed depending upon the circumstances, including CS's responses to AOT and the ward round. Until such time as the transition was complete, the element of treatment at hospital remained a significant part of the whole.[21]
>
> It is clear to me that the RMO was engaged in a delicate balancing exercise by which she was, with as light a touch as she could, encouraging progress to discharge. Her purpose was to break the persistent historical cycle of admission, serious relapse and readmission. It may be that in the closing stages of the treatment in hospital her grasp on the claimant was gossamer thin, but to view that grasp as insignificant is, in my view, to misunderstand the evidence."[22]

Each of the challenges against the Tribunal were dismissed. On failing to order her immediate discharge, Pitchford J accepted the evidence of the RMO that :

> "It is not appropriate to abruptly discharge a patient who has been subject to compulsory admission and treatment as an in-patient for a number of months. I would strongly disagree with an assertion that it is better for a patient to be discharged straight into the community without adequate phasing of care and then re-sectioned if the patient suffers a relapse. Such a statement shows little insight into modern means of engaging and treating patients with severe mental illness... To allow CS's section to lapse or bring it to an abrupt end only to re-section her would greatly upset CS and damage the relationship between her and the clinical team. It would also mean that mental health services were only able to engage once CS has suffered a significant deterioration..."[23]

18 *under section 72(1) and (2) MHA 1983*

19 *Judgment at para 29*

20 *R(on the application of DR) v Mersey Care NHS Trust [2002] EWHC 1810 at para 29; R (on the application of CS) v MHRT [2004] EWHC 2958 at para 45*

21 *Judgment at para 44*

22 *Judgment at para 46. It should be noted that Pitchford J ended this paragraph by stating that he was not convinced by Ms Stern's submission that "the mere existence of the hospital and its capacity to be treated by the patient as a refuge and stability is part of the treatment of the patient at that hospital"*

23 *Judgment at para 46*

On failing to name a day on which discharge should take effect, Pitchford J again found in favour of the medical evidence:

> "That course could, as Miss Stern pointed out, have been disastrous. The RMO was not in a position to know from one day to the next what CS's prospects in the community could ultimately be. Only upon the successful completion of the carefully laid plan of treatment could discharge be risked".[24]

Finally, on failing to consider less restrictive (and more proportionate) options, Pitchford J accepted the medical evidence that CS's personality would not be amenable to supervised discharge as it was unlikely she would remain compliant with treatment. Whilst the Tribunal was not asked to consider guardianship, Pitchford J was in no doubt that guardianship was not appropriate. The new regime would have brought with it significant upheaval for CS, including a whole new group of professionals. Arguably more relevant to practice, Pitchford J agreed with Kristina Stern that "*there was no power available under either regime to require the patient to take medication*". He further commented that "*CS's knowledge of the RMO's powers was a significant element in her willingness to accept the treatment plan.*"[25]

The Court found that the Tribunal members had also addressed the issue of proportionality stating in their written decision that they had "*taken into account R (on the application of H) v Mental Health Review Tribunal North and East London Region [2001]*[26] *and from the evidence are satisfied that detention is a proportionate response having regard to the risks on discharge.*"

On the issue whether a decision to continue detention under section 72 (1) required a proportionate response under Article 5(1)(e) ECHR, Pitchford J applied the Court of Appeal's judgment in *Nadarajah v Secretary of State for the Home Department*[27]: A challenge to the proportionality of the Tribunal's exercise of its powers in CS's case would not have been made out in any event:

> "the question is whether or not domestic law permits the arbitrary detention of those in the position of the claimant. It seems to me that manifestly it does not. Accordingly, there is no dimension further to s 72 of the 1983 Act which needs to be added to the statutory right to discharge and the exercise of the residual discretion. The application of the principle of proportionality to this case leads in any event, in my view, to only one conclusion: the interference with the claimant's freedom of movement and choice were minimal in the context of the object to be achieved, namely her satisfactory return to community care.[28]

Comment

(a) Section 17 leave

CS reaffirms that a patient on leave at the time of a tribunal decision not to discharge the patient did not make the tribunal decision unlawful.[29] The cases of *DR* and *CS* have liberalised what is permissible where the patient no longer requires in-patient treatment but require an element of compulsion to give effect to their treatment plan. A hospital bed may be unnecessary[30] but the link

24 *Judgment at para 49*
25 *Judgment at para 48*
26 *[2001] EWCA Civ 415*
27 *[2003] EWCA Civ 1768*
28 *Judgment at para 52*
29 *above, R (on the application of CS) v MHRT [2004] EWHC 2958(Admin)*
30 *above, R (on the application of DR) v Mersey Care NHS Trust [2002]EWHC 1810 (Admin)*

between the treatment plan and hospital must be more than speculative.[31] It must be a significant component. The degree of custodianship or actual physical control over a patient's movements as part of a treatment plan may not be determinative.[32] The decision in CS supports the position promulgated in *Barker* that rehabilitation under medical supervision can include assessment or monitoring of progress of a patient on leave.[33] It can also include leave as part of a treatment plan.[34] The Code of Practice acknowledges that *"leave of absence can be an important part of a patient's treatment plan."*[35] As Lord Woolf MR in *Barker* commented *"this appears to be just the type of treatment contemplated by the second half of the definition of treatment contained in section 145 of the Act."*[36] Whilst adopting the test in DR, a more holistic view was taken by the court when considering treatment and rehabilitation of CS, by reference to the continuing and responsive programme. The emphasis or weight given to hospital treatment as a "significant component"[37] of treatment becomes more intangible when the whole of the programme is viewed in this way. How is one element of an holistic plan more significant than another? It is no doubt true, as this case shows, the exploration of the definitions of "hospital," "medical treatment," "in-patient" in the context particularly of leave is evidence of the complexity of current law.[38]

A further conclusion to be drawn is that, whilst admission to hospital (and a bed) for treatment surely remains a necessary pre-requisite to initial detention and application of the compulsory treatment provisions of Part IV of the Act[39], it is no longer necessary when judging the lawfulness of renewal of detention. In this sense a different test is developing which requires only a connection between hospital and treatment. That connection can be *"gossamer thin"* so long as it can be shown to be a significant component of treatment. Logically, if different tests are being applied on admission compared with renewal, can this be justified in the context of an individual's human rights? Have the courts gone too far in keeping pace with clinical practice and exposed an inherent weaknesses in their decisions by discarding the requirement for in-patient treatment for renewal of detention required in *Hallstrom* and *Barker*? Only time will tell.

(b) The future for guardianship and supervised discharge?

This question is posed in the context of the *obiter* views in CS[40] and in *DR*.[41] Both claimants failed in their arguments that a less restrictive regime than remaining "liable to be detained" should have been considered. In CS the RMO felt that her patient would not benefit from supervised discharge because she would find it difficult to comply given her personality. The judge agreed.[42] Guardianship was also dismissed.

31 *above, R(on the application of Epsom and St Helier NHS Trust) v MHRT [2001] EWHC 101 (Admin)*

32 *Judgment at para 40*

33 *B v Barking, Havering and Brentwood Community Healthcare NHS Trust [1999] 1 FLR 106 at 114*

34 *R (on the application of DR) v Mersey Care NHS Trust [2002] EWHC 1810, para. 30 per Wilson J and adopted in R(on the application of CS) v MHRT [2004] EWHC 2958 at para. 39*

35 *Mental Health Act Code of Practice revised 1999, para. 20.1*

36 *above, B v Barking NHS Trust [1999] 1 FLR 106 at 112*

37 *above, B v Barking, Havering and Brentwood Community Healthcare Trust [1999]; R (on the application of DR) v Mersey Care NHS Trust [2002]*

38 *Hewitt, D. There is no magic in a bed – the renewal of detention during a period of leave, Journal of Mental Health Law July 2003, p 87*

39 *See Jones R Mental Health Act Manual at para 1-042 9th Edition, (Sweet & Maxwell, 2004)*

40 *above, R (on the application of CS) v MHRT [2004] EWHC 2958*

41 *R (on the application of DR) v Mersey Care NHS Trust [2002] EWHC 1081 at para 32*

42 *ibid at para. 48*

Both powers fall short of permitting compulsory medical treatment in the community, unlike leave which offers a more flexible, less structured framework for a person regardless of age. They can assist in persuading the persuadable, but not the non-compliant, patient where the only available sanctions are recall or admission to hospital. Whether the threat of compulsion offers an effective carrot or stick will depend very much on the individual perceptions of what can be achieved by patient and practitioner. Claims of their coercive effect and better outcomes without damage to the therapeutic relationship are realised in some cases.[43] Supervised discharge can work well for a number of "difficult to engage" patients to ensure improved medication compliance[44]. Whilst scrupulous about explaining that it does not permit a practitioner to force medication on a patient, it binds patient and practitioner together *"in a mutual obligation to work together with a frankly articulated statement and care plan of the rationale based on objective risks and losses."*[45]

(c) Policy Context

The focus of the Mental Health Act 1983 is compulsory treatment in hospital. Overall, numbers of admissions to hospital for mental illness have fallen[46] but use of compulsion has increased in the last 10 years by nearly 30%.[47] The key community powers are supervised discharge,[48] guardianship[49] and leave[50] (and, of course, for restricted patients, conditional discharge[51]). National statistics are not collated of the number of patients granted leave from hospital. The Mental Health Act Commission has suggested numbers in the region of 13,500 patients at any one time,[52] a much greater uptake than for other powers.[53]

The NSF set out an ambitious programme.[54] Its major components were the creation of assertive outreach teams (AOTs)[55] for "difficult to engage" people living in the community with the most complex health and social needs, crisis resolution teams (CRTs)[56] to work as an alternative to hospital admission for individuals experiencing acute crisis in their mental health and early intervention teams.[57] The NHS Plan launched specific clinical initiatives aimed at making community care work by introducing these teams.[58] Described as the two most influential policy documents in the lifetime of anyone currently working in mental health they signify

43 *Bindman, Pinfold et al, National Evaluation of Supervised Discharge and Guardianship, September 2001*

44 *Franklin, Pinfold et al, Consultant Psychiatrists' Experiences of using Supervised Discharge. Psychiatric Bulletin (2000) 24, 412–415*

45 *Mike Firn, Chair, National Forum for Assertive Outreach, Evidence to the Joint Parliamentary Scrutiny Committee on the Draft Mental Health Bill 2004.*

46 *DH: Hospital Activity Data, DH Publications, London*

47 *Department of Health (2003) Statistical Bulletin 2003/22; DH: Korner Returns, DH Publications, London*

48 *Mental Health Act 1983 section 25A-J inserted by the Mental Health (Patients in the Community) Act 1995*

49 *Mental Health Act 1983 sections 7–10*

50 *Mental Health Act 1983 section 17*

51 *Mental Health Act 1983 sections 42(2), 73(2)*

52 *DMH (Memo) Submissions by the Mental Health Act Commission to the Joint Parliamentary Scrutiny Committee, November 2004*

53 *Department of Health(2004) Guardianship under the Mental Health Act 1983,England,2004*

54 *Department of Health (1999) National Service Framework for Mental Health: Modern Standards and Service Models, London DH.*

55 *above, see also Department of Health, (2004) 2004/0457,National Service Framework for Mental Health – Five Years On, p 20 reported of the 170 AOTs envisaged by 2003 more than 263 teams were in place by March 2004.*

56 *above, NSF for Mental Health – Five Years On, p 21 reported of the 335 teams proposed in the NHS Plan by 2004 168 were in place by March 2004*

57 *CRTs generally work with individuals for a few weeks whilst AOTs can work with their clients for many months and even years providing support from the management of medication to daily living skills and psychological therapies.*

58 *Department of Health, (2000) NHS Plan, London, DH*

transformational change in the status of mental health in the NHS and how services are being delivered to patients.[59]

In a review of the NSF five years on, Professor Louis Appleby noted the progress made as services become more responsive to the needs and wishes of the people who use them, and identified the need for action for the care of long-term mental disorders with a new model of mental health in primary care.[60] This includes new models of in-patient provision to reflect its multiple purposes – acute care, rehabilitation, crisis admission and specialist treatment and a more flexible division of responsibilities between primary and secondary care with reduction in emergency admissions through better continuing care.[61] The lawfulness of continuing to detain patients liable to be detained in hospital for treatment but on leave in the community is of increasing importance given the policy shift.

Given the current rumours that the Mental Health Bill has stalled yet again[62] where does this leave treatment in the community? Arguably, on the boundary of the hospital. The courts in *DR* and *CS* have not sanctioned compulsory treatment in the community, and arguably have gone as far as a civilised society should in compelling treatment within a hospital-based regime for the relatively small number of patients with complex needs living in the community. Compulsory treatment has been described as "deeply discriminatory."[63] With neither consent nor capacity being particularly relevant factors, this is unlikely to change. Individuals will continue to be denied autonomy where treatment for mental disorder is perceived to be in their best interests. The hope is that more enlightened practice will result in fewer compulsions. The Care Programme Approach has done much to deliver a comprehensive plan of care for individual patients and improve choice. Better choice should mean less compulsion.

The challenge for practitioners will be to ensure that leave is used appropriately as part of a rehabilitative programme towards discharge and not as a method of enforcing co-operation under compulsion. Practitioners will need to show that any compulsory treatment plan is facilitating a process of careful and staged discharge from hospital to community treatment to be lawful and that the plan is not an alternative to discharge.[64]

59 *Chisholm, A and Ford, R Transforming Mental Health Care: Assertive Outreach and Crisis Resolution in Practice, The Sainsbury Centre for Mental Health/NIMHE 2004; above, DH, NSF for Mental Health – Five Years On, December 2004 at p66 per Professor Louis Appleby*

60 *DH 2004/0457 The National Service Framework for Mental Health – Five Years On, 20 December 2004.*

61 *Ibid at p 73*

62 *For example see Guardian Newspaper 31/10/05*

63 *Scott-Moncrieff, L. Capacity Choice and Compulsion, Journal of Mental Health Law, September 2004 at p146*

64 *above, R (on the application of CS) v MHRT [2004]; Mental Health Act 1983 Code of Practice revised 1999, Chapter 20.2*

Book review

Offenders, Deviants or Patients? by Herschel Prins (3rd edition)

Published by Taylor & Francis Ltd (2005) £19.99

Prins was obviously sufficiently pleased with the reception of the first two editions of this book (25 and 10 years ago respectively) to think that another would be welcome. He is probably right: as he points out, the last decade has seen an avalanche of criminal justice legislation, in the context of, in his view, "an almost morbid governmental preoccupation with, and over-reaction to, the need for public protection". In this climate, the market for books such as his is extremely healthy, with potential readers – he lists them – in the fields of forensic psychiatry and psychology (including trainees), the police, advocates, probation officers, prison and hostel staff, mental health nurses, social workers, the voluntary sector, the Parole Board, Mental Health Review Tribunals and the civil service. Not forgetting, of course, members of the public, who are "very puzzled about and may be made very anxious by" the behaviour of some of their fellow citizens.

Prins acknowledges that the presence of the word "deviants" in the title may be offensive to some. His defence is captured in the words of the late Dr. Peter Scott: these are the "unrewarding, degenerate, not nice offenders". Prins points out that those who work with such individuals, like the public, can be reluctant to face up to "issues of treatment versus punishment ... and the dilemmas inherent in distinguishing between normality and abnormality, sickness and sin, care and control".

In part, this book provides an overview of some of the major topics relevant to mentally disordered offenders. Although other writers have dealt with these at greater length, the author's analysis of some of the uncertainties and ambiguities both in the law and in clinical practice is shrewd. There are chapters on legal aspects of responsibility; sentencing options; the evidence for a link between different types of mental disorder and crime; sexual offending; arson; and on "bloody deeds" of violence towards others (the book is peppered with quotes from Shakespeare, no doubt a result of the author's acknowledged debt to the late Dr. Murray Cox). In the latter chapter, Prins critically examines the government's response to violence as a public health issue, including the controversial guide issued by the Department of Health in 2001, entitled: "Withholding Treatment from Violent and Abusive Patients in NHS Trusts: We Don't Have to Take This". In postulating that some staff could actually be responsible for provoking some incidents – and providing evidence that this might be so – he is challenging those of us who work in allegedly caring institutions to face up to difficult truths.

Prins also proposes a new, "socio-legal" classification with 13 categories of unlawful killing, although the basis for it is unclear, with motive, international politics, mental disorder, marital status, childhood and sex all potentially playing a part. He has a particular objection to Harold Shipman being labelled a serial killer, in the light of what is known about the behavioural and other characteristics of those he believes to be the genuine article. In his own typology, Shipman was guilty of "carer killings", sometimes committed by those with severe personality disorders, as in the case of the former nurse Beverley Allitt.

Recent and proposed legislation are usefully – and briefly – outlined. However, Prins also provides us with a personal and thoughtful commentary on some of the difficulties and dilemmas inherent in this field of work. Often these are illustrated by rich case vignettes, which bring alive the dangers both of over-optimistic clinicians who fail to spot warning signs, and of those who remain in denial – and therefore unconscious of – their distaste and even hatred for some of the patients they have to treat. Prins is frank in his critique of the growing dominance of the clinical governance culture and its' preoccupation with ticking the boxes: "such clinical oversight has its uses but, increasingly, one suspects that it may be sapping individual initiative and activity. It also tends to lower professional morale and engender a 'looking over one's shoulder' attitude".

The chapter on personality disorder gives a theoretically broad and informed account of the origins of the concept, and adds three key characteristics to the 16 famously outlined by Cleckley: "super-ego lacunae" rather than a total lack of conscience; a greater than usual need for excitement and arousal; and a "capacity to create chaos among family, friends and those involved in trying to manage or contain them." Again, it is in the clinical sphere that Prins offers his most interesting insights: he is very aware of the serious impact that personality-disordered patients can have upon professionals, and of "the need to tolerate, without loss of temper, the hate, hostility, manipulation and 'splitting' shown by such individuals, and an ability not to take such incidents as personal attacks". This is not an area of work, warns Prins, that "should be characterised by 'prima donna' activities ... for there are dangerous workers as well as dangerous patients".

Also discussed are some of the legal, moral and clinical challenges presented by the government's new proposals for the legal and clinical management of personality-disordered offenders. One of the most significant of these is the prospect that individuals with severe personality disorder could be detained in hospital on an indeterminate basis, on the grounds of the risks they pose to others. What happens, asks Prins, if staff in one of the new specialist units consider that such a person is "untreatable"? The question, in this book at least, remains unanswered.

A later chapter on risk gives a number of useful definitions, and discusses the growing use of structured risk assessment tools, pointing out that these may say much about groups, but less about individuals. While Prins has comments to make about the prevalent "culture of risk and blame", he also points out that failures of communication often lie behind tragedy. These have been listed repeatedly by those conducting Homicide Inquiries into killings by the mentally disordered, but with an emphasis on the faults of individual professionals rather than any attempt at a more sophisticated analysis. There is a need, Prins argues, for improved communication between clinician and patient: ambivalence, hostility, fear and denial are not the sole prerogative of the latter. Also for improved communication between professionals: "case conferences and public protection committees sometimes fail to work as effectively as they could because of the mistaken belief that multi-agency is synonymous with multidisciplinary, when, in terms of role perceptions and territorial boundaries, it clearly is not."

The author acknowledges that "issues of confidentiality are prominent in relation to inter-agency functioning and often impede it", but merely refers the reader to another author's writings on the subject. A discussion about confidentiality would have been a useful addition to this chapter, since this is a topic on which the General Medical Council, the National Health Service, the medical defence unions, and a number of other bodies all give different – and sometimes conflicting – advice.

This is an extremely perceptive book, which provides a good overview of the literature as well as challenging professionals to improve their practice, and government to improve its law-making. The references are drawn from a broad spectrum of thought and research. I will be buying a copy for the staff library in our service.

Dr Celia Taylor

Consultant Forensic Psychiatrist, North East London Forensic Personality Disorder Service