

UNITED KINGDOM

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Executive summary

Definitions

- [1]. Both of the terms used by this Study – mental disorder and intellectual disability (‘learning disability’) - are familiar in the UK.
- [2]. In all jurisdictions the term ‘mental disorder’ encompasses both mental illness and intellectual disability and also covers personality disorders.

Anti-discrimination

- [3]. The UK has ratified the *Convention on the Rights of Persons with Disabilities* and its *Optional Protocol*. The UK has a programme based on the areas identified by the *EU Disability High Level Group*.
- [4]. A comprehensive legislative framework to prevent disability discrimination is found in the *Disability Discrimination Act 1995*. The term ‘disability’ applies to both persons with mental illness and with intellectual disability.
- [5]. State bodies and agencies are under a duty to promote equality.

Specific fundamental rights

- [6]. The *Human Rights Act 1998* incorporated most of the rights protected by the European Convention on Human Rights into UK law. These rights are enforceable in the courts and must also be observed by central and local government activities and policies.
- [7]. The *Data Protection Act 1998* provides a right to access confidential medical data.
- [8]. All those subject to involuntary placement in a psychiatric facility are entitled to vote in all elections, except mentally disordered offenders. The voting rights of persons in this group are currently under review.

Involuntary placement and involuntary treatment

- [9]. There is a comprehensive legislative framework providing for involuntary placement and treatment in all jurisdictions in the UK.
- [10]. Involuntary placement without treatment is not possible in any part of the UK, although a detained patient may, rarely, remain in hospital even though not treatable, on grounds of public protection.
- [11]. Public protection, along with the health or safety of the patient, are interchangeable reasons for instigating an involuntary placement. All placements must follow a diagnosis, by at least one and usually two psychiatrists, confirming that involuntary placement is necessary.
- [12]. An application for admission is made by a social work professional, except in Scotland where all applications for involuntary placement must be made to a Tribunal. A placement must only be made after alternatives have been considered and rejected as unsuitable.
- [13]. Most placements are ended by the doctor in charge of the patient's treatment. A patient may apply to a Tribunal with powers to order the patient's release. Free legal support is available to all applicants.
- [14]. Patients are encouraged to participate as fully as possible in their treatment but treatment may be given without consent, subject to a system of safeguards and requirements for second opinions.
- [15]. Other coercive measures are regulated only by state guidance rather than statutory limitation.
- [16]. Aftercare is available in all parts of the UK. Special provision is made for child patients within the general legislative framework.

Competence, capacity and guardianship

- [17]. There is a statutory test of incapacity in the UK.
- [18]. A proxy decision-maker may be appointed by a person before he or she loses capacity or may be appointed by a court. Courts may make decisions on behalf of persons lacking capacity and declare authoritatively on a person's capacity in a particular context.
- [19]. Often court orders or the use of formal schemes of management will not be necessary there are general powers to do acts for a person lacking capacity in the best interests of that person.

- [20]. There is an Office of Public Guardian in each jurisdiction, tasked with supervising and policing the systems of care and individual carers.

Miscellaneous

- [21]. In England and Wales legislation was enacted in 2007 to establish a statutory regime providing for the deprivation of liberty of persons lacking capacity otherwise than under mental health legislation in their best interests and to prevent harm to such persons.

1. Definitions [11a].

- [22]. In England and Wales there are two relevant terms. The *Mental Health Act 1983*,¹ as amended in 2007, uses the terms ‘mental disorder’ and ‘learning disability’.
- [23]. In Scotland, the same terms are used by the *Mental Health (Care and Treatment) (Scotland) Act 2003*.² Unlike England and Wales, however, Scotland does provide sub-definitions of mental disorder. Section 328(1) *Mental Health (Care and Treatment) (Scotland) Act 2003* provides that ‘mental disorder means ‘mental illness’, ‘personality disorder’ or ‘learning disability’.
- [24]. In Northern Ireland, Article 3(1) *Mental Health (Northern Ireland) Order 1986*³ also uses the term ‘mental disorder’, and also provides sub-definitions of the terms ‘mental illness’, ‘mental handicap’, “severe mental handicap” and “severe mental impairment”.
- [25]. *The meaning of the terms in their national context [11b]*. In England and Wales, ‘mental disorder’ is defined broadly:⁴ it means ‘any disorder or disability of the mind’. The term is understood to encompass both mental illness and intellectual disability, as well as personality disorders and indeed any other disorder or disability. ‘Learning disability’ ‘means a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning’.⁵ ‘Learning disability’ equates very closely to the FRA’s preferred term ‘intellectual disability’.
- [26]. In Northern Ireland, ‘mental disorder’ is framed in similarly wide terms. It ‘means mental illness, mental handicap and any other disorder or disability of mind’.⁶ Specific terms are then further defined. Accordingly, “‘mental illness” means a state of mind which affects a person's thinking, perceiving, emotion or judgment to the extent that he requires care or medical treatment in his own interests or the interests of other persons; “mental handicap” means a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning; “severe mental handicap” means a state of arrested or incomplete development

¹ UK/Mental Health Act 1983 c.20.

² UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13
http://www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030013_en_1 (10.10.09).

³ UK/Mental Health (Northern Ireland) Order 1986 SI 1986/595 (NI 4)
http://www.opsi.gov.uk/RevisedStatutes/Acts/nisi/1986/cnisi_19860595_en_1 (10.10.09).

⁴ UK/Mental Health Act 1983 c.20, s1(2).

⁵ UK/Mental Health Act 1983 c.20, s1(4).

⁶ UK/Mental Health (Northern Ireland) Order 1986, art 3(1).

of mind which includes severe impairment of intelligence and social functioning; and “severe mental impairment” means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned’.

- [27]. The reason for having the three terms ‘mental handicap’, ‘severe mental handicap’ and ‘severe mental impairment’ is to distinguish not between species of mental disorder but to distinguish between the severity and consequences of an individual’s disorder, as it is only when a person’s severe mental impairment ‘is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned’ that involuntary placement in a psychiatric hospital is possible.⁷ Again, these terms equate very closely with the FRA’s preferred term ‘intellectual disability’. The main points which distinguishes the legislation in Northern Ireland from that elsewhere in the UK are that there is a statutory definition of mental illness and the definition of mental disorder does not currently encompass personality disorder.⁸
- [28]. In Scotland, ‘mental disorder’ is defined more narrowly than in England, Wales and Northern Ireland in that it does not extend to any disorder or disability of the mind. However, it is also defined more widely than the definition which applies in Northern Ireland in that the term includes personality disorder as well as mental illness and learning disability.⁹
- [29]. In all jurisdictions, ‘mental disorder’ is defined specifically to exclude those who may be clinically diagnosed as mentally disordered by reason of dependence on drugs or alcohol.¹⁰ In Scotland and Northern Ireland, sexual deviancy is also excluded from the scope of the definition. In Scotland alone, ‘behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person, or acting as no prudent person would act’ are also excluded.
- [30]. The current definition of mental disorder in England and Wales dates from 2007, the one in Scotland from 2003. To date there is no caselaw

⁷ UK/Mental Health (Northern Ireland) Order 1986, art 12(1)(a).

⁸ The Northern Ireland Assembly does intend to bring personality disorder within the statutory definition when the law is reformed: see Department of Health, Social Services and Public Safety (2009) ‘Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland’, para. 8.1 <http://www.dhsspsni.gov.uk/legislative-framework-for-mental-capacity.pdf> (10.10.09).

⁹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp.13, s328(1).

¹⁰ UK/Mental Health Act 1983 c.20, s1(3) (England and Wales); UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp.13, s328(2) (Scotland); UK/Mental Health (Northern Ireland) Order 1986, art 3(2) (Northern Ireland).

concerning the scope or extent of these terms. There is no significant caselaw in Northern Ireland where, in any case, the intention is to simplify the definition so that it is more closely aligned to those which operate elsewhere in the UK.¹¹

2. Anti-discrimination

- [31]. The UK Government has been active for over a decade in enacting increasingly greater protection from discrimination and harassment for disabled persons. The current legal situation is discussed at 2.2 below. The UK has also been a full participant in the international movement, spear-headed by the Office of the United Nations High Commissioner for Human Rights and, in Europe, the EU Disability High Level Group. As detailed below, the UK has ratified both the Convention on the Rights of Persons with Disabilities and its Optional Protocol.

2.1. Incorporation of United Nations standards [12].

- [32]. The UK was not amongst the ten or so European states to contribute to the one-day consultation undertaken by the Office of the United Nations High Commissioner for Human Rights on 24 October 2008.
- [33]. The EU Disability High Level Group identified seven priority areas for EU states in order effectively to implement the *UN Convention on the Rights of Persons with Disabilities* in its first Report in May 2008.¹² Its second Report, in June 2009,¹³ gives information about steps taken by EU Member States to take action in these priority areas. Pages 206-214 of the second Report give information on steps taken by the UK. Topics dealt with include accessibility of rights, legal capacity, access to justice, independent living, voting rights, monitoring mechanisms, and empowerment of people with disabilities. Many of the topics are discussed elsewhere in this Review.
- [34]. Shortly after the second Report was issued the UK ratified the CRPD and Optional Protocol (see below). This has necessitated the UK nominating as the monitoring mechanism to ensure the

¹¹ Department of Health, Social Services and Public Safety (2009) 'Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland', para. 8.1.

¹² Available at <http://ec.europa.eu/social/main.jsp?catId=431&langId=en> (15.10.09).

¹³ Available from the same address.

implementation of the CRPD in the UK the Equality and Human Rights Commission, the Scottish Human Rights Commission, the Northern Ireland Human Rights Commission and the Equality Commission for Northern Ireland, as detailed at page 212 of the High Level Group's second Report.

- [35]. [13]. The UK signed the CRPD on 30 March 2007 and the Optional Protocol on 26 February 2009. The Convention was ratified by the UK on 8 June 2009 and the Optional Protocol on 7 August 2009. To date, the ratification procedure has not been followed by amendments of relevant UK legislation. However, in April 2009 a new *Equality Bill* was published and had reached the Committee Stage in the House of Commons by summer 2009.¹⁴ If passed, this Bill will repeal all existing discrimination legislation and replace it with one statute. It is proposed that discrimination law will be amalgamated into a unitary regime covering all forms of discrimination. With particular reference to disability discrimination, the Bill proposes to extend the reach of protection from direct discrimination and introduce the concept of indirect discrimination into this area.¹⁵

2.2. The anti-discrimination national framework

2.2.1. Anti-discrimination/equality legislation [15][a,b].

- [36]. There is no written Constitution in the UK, and so there are no rules regarding equality or anti-discrimination at this level.
- [37]. At the legislative level, the *Disability Discrimination Act 1995*,¹⁶ which applies in all jurisdictions in the UK, is the main statute in the area. This has been amended, and the legal protection provided for disabled persons extended, by a number of subsequent laws, the most important of which are the *Disability Discrimination Act (Amendment) Regulations 2003*,¹⁷ the *Disability Discrimination Act 2005*¹⁸ (in

¹⁴ For the text of the Equality Bill and information on its progress, see <http://services.parliament.uk/bills/2008-09/equality.html> (10.10.09).

¹⁵ UK/Equality Bill 2009, c113, 19.

¹⁶ UK/ Disability Discrimination Act 1995 c.50
http://www.opsi.gov.uk/acts/acts1995/ukpga_19950050_en_1 (15.10.09).

¹⁷ UK/ Disability Discrimination Act 1995 (Amendment) Regulations 2003 SI 2003/1673 (1 October 2004) <http://www.opsi.gov.uk/si/si2003/20031673.htm> (15.10.09).

Northern Ireland, the *Disability Discrimination Order 2006*),¹⁹ and the *Equality Act 2006*.²⁰

- [38]. As mentioned above, in April 2009 a new *Equality Bill* was published and had reached the Committee Stage in the House of Commons by summer 2009. If passed, this Bill will also repeal all existing discrimination legislation and replace it with one statute.
- [39]. The 1995 Act as amended protects disabled persons from discrimination in the areas of employment (part II), access to services, premises (including the disposal and management of land and premises), and private clubs (part III), and education (part IV).
- [40]. The 1995 Act protects against
- Direct discrimination (in some areas), for which there can in law be no justification
 - Less favourable treatment which cannot be justified (disability-related discrimination)
 - Failure to comply with a duty to make reasonable adjustments²¹
 - Harassment/victimisation.
- [41]. Direct discrimination is prohibited in the employment field²² and in relation to further and higher education establishments²³ and academic qualification bodies.²⁴ Direct discrimination is committed by a person ‘if, on the grounds of the disabled person’s disability, he treats the disabled person less favourably than he treats or would treat a person not having that particular disability whose relevant circumstances, including his abilities, are the same as, or not materially different from, those of the disabled person’.²⁵
- [42]. ‘Less favourable treatment’ is a key concept in the 1995 Act. It is unlawful to treat a disabled person less favourably than a person

¹⁸ UK/Disability Discrimination Act 2005 c.13

http://www.opsi.gov.uk/Acts/acts2005/ukpga_20050013_en_1 (15.10.09)

¹⁹ UK/Disability Discrimination Order 2006 <http://www.opsi.gov.uk/si/si2006/20060312.htm> (15.10.09).

²⁰ UK/Equality Act 2006 c.3 http://www.opsi.gov.uk/acts/acts2006/pdf/ukpga_20060003_en.pdf (15.10.09).

²¹ This is considered at paras 81-90 below.

²² UK/ Disability Discrimination Act 1995 c.50, s3A(5).

²³ UK/ Disability Discrimination Act 1995 c.50, s28S(10).

²⁴ UK/ Disability Discrimination Act 1995 c.50, s31AB(8).

²⁵ UK/ Disability Discrimination Act 1995 c.50, s3A(5). This definition applies in relation to the employment field.

without that particular disability unless that differential treatment can be justified.²⁶

- [43]. The test for whether less favourable treatment has occurred varies according to context. Less favourable treatment in the employment field, for example, can be justified ‘if, but only if, the reason for it is both material to the circumstances of the particular case and substantial’.²⁷ This form of words appears throughout the Act, but various specific factors will sometimes also be relevant.
- [44]. In relation to the provision of goods, facilities and services, for example, less favourable treatment can only be justified for a limited range of reasons. The differential treatment must be necessary in order not to endanger the health or safety of any person;²⁸ or because the disabled person cannot give a requisite informed consent;²⁹ or because otherwise the provider of a service to members of the public would be unable to provide it;³⁰ or because it would otherwise not be economically viable for the provider to provide the service in question or to provide it to appropriate standards or on feasible terms.³¹ Similar limited justifications for less favourable treatment are found elsewhere in the Act in relation to premises,³² schools,³³ further and higher education establishments³⁴ and qualification bodies.³⁵
- [45]. It is unlawful for a public authority to discriminate against a disabled person when carrying out its functions.³⁶ For these purposes, a ‘public authority’ ‘includes any person certain of whose functions are functions of a public nature’.³⁷ This is a broad definition which covers all government and quasi-governmental bodies, subject only to specified exclusions on grounds of national security.³⁸ Courts and legislative bodies are also excluded from the scope of this duty.³⁹ A similar duty not to discriminate is placed on education authorities.⁴⁰

²⁶ UK/ Disability Discrimination Act 1995 c.50, s3A(1) (the employment field), s20(1)(b) (goods, facilities and services), s24(1) (premises), s28B(1) (schools), s28S(1) (further and higher education establishments), s31AB(1) (qualification bodies).

²⁷ UK/ Disability Discrimination Act 1995 c.50, s3A(3).

²⁸ UK/ Disability Discrimination Act 1995 c.50, s20(4)(a).

²⁹ UK/ Disability Discrimination Act 1995 c.50, s20(4)(b).

³⁰ UK/ Disability Discrimination Act 1995 c.50, s20(4)(c).

³¹ UK/ Disability Discrimination Act 1995 c.50, ss20(4)(d), (e).

³² UK/ Disability Discrimination Act 1995 c.50, s24(3).

³³ UK/ Disability Discrimination Act 1995 c.50, ss28B(5)-(8).

³⁴ UK/ Disability Discrimination Act 1995 c.50, ss28S(5)-(10).

³⁵ UK/ Disability Discrimination Act 1995 c.50, ss31AB(3)-(7).

³⁶ UK/ Disability Discrimination Act 1995 c.50, s21B(1).

³⁷ UK/ Disability Discrimination Act 1995 c.50, s21B(2).

³⁸ UK/ Disability Discrimination Act 1995 c.50, s21B(3).

³⁹ UK/ Disability Discrimination Act 1995 c.50, s21C.

⁴⁰ UK/ Disability Discrimination Act 1995 c.50, s28F.

- [46]. Harassment of a disabled person by an employer or potential employer,⁴¹ any person appointed by a UK government to any office or post,⁴² any member of a partnership,⁴³ barrister,⁴⁴ Trade Union,⁴⁵ professional⁴⁶ or educational⁴⁷ qualification body, local government body,⁴⁸ or further or higher education establishment,⁴⁹ is unlawful.
- [47]. The 1995 Act also, in Part V, provides for equality of access to public transport. Providers of taxi and private hire vehicles⁵⁰ and other transport services (such as minibuses and coaches) provided by means of private contract,⁵¹ and those providing public service vehicles (bus service providers)⁵² and rail service providers⁵³ must all ensure that their services are accessible to disabled persons. This Part of the 1995 Act is not yet generally in force, although certain elements, such as the requirement that persons in wheelchairs⁵⁴ or accompanied by guide dogs⁵⁵ must be carried by taxis, are.
- [48]. Enforcement of disability discrimination law is achieved through various means. Discrimination or harassment in the employment field may be the subject of an application to an employment tribunal.⁵⁶ The burden of proving absence of discrimination is on the respondent if the disabled person is able to provide facts which allow the tribunal to form a preliminary view that there has been an instance of discrimination.⁵⁷ If a case is proven, the tribunal has powers to order the payment of compensation to the complainant by the respondent, and to require the respondent to take reasonable steps within a reasonable period of time to obviate or reduce the cause of the adverse effect on the complainant.⁵⁸
- [49]. The parents of a child may make an application to an education tribunal in cases of alleged discrimination by a school. This tribunal has similar powers to that of the employment tribunal to order that

⁴¹ UK/ Disability Discrimination Act 1995 c.50, s4(3).

⁴² UK/ Disability Discrimination Act 1995 c.50, s4D.

⁴³ UK/ Disability Discrimination Act 1995 c.50, s6A.

⁴⁴ UK/ Disability Discrimination Act 1995 c.50, s7C.

⁴⁵ UK/ Disability Discrimination Act 1995 c.50, s13.

⁴⁶ UK/ Disability Discrimination Act 1995 c.50, s14A.

⁴⁷ UK/ Disability Discrimination Act 1995 c.50, s31AA(2).

⁴⁸ UK/ Disability Discrimination Act 1995 c.50, s15B.

⁴⁹ UK/ Disability Discrimination Act 1995 c.50, s28SA.

⁵⁰ UK/ Disability Discrimination Act 1995 c.50, s32.

⁵¹ UK/ Disability Discrimination Act 1995 c.50, s33.

⁵² UK/ Disability Discrimination Act 1995 c.50, s40.

⁵³ UK/ Disability Discrimination Act 1995 c.50, s46.

⁵⁴ UK/ Disability Discrimination Act 1995 c.50, s36.

⁵⁵ UK/ Disability Discrimination Act 1995 c.50, s37.

⁵⁶ UK/ Disability Discrimination Act 1995 c.50, s17A.

⁵⁷ UK/ Disability Discrimination Act 1995 c.50, s17A(1C).

⁵⁸ UK/ Disability Discrimination Act 1995 c.50, s17A(2).

reasonable remedial steps are taken by the respondent if a claim of discrimination is upheld,⁵⁹ except that an education tribunal may not order a payment of money compensation.⁶⁰

- [50]. Claimed discrimination by a further or higher education provider,⁶¹ or by a qualification body,⁶² or by a provider of goods, facilities or services⁶³ may be subject to a claim in civil proceedings for breach of statutory duty.
- [51]. Central government Ministers also have powers to require compliance with a duty placed on education providers under the Act when satisfied that a child has been denied admission to, or excluded from, a school in a discriminatory manner.⁶⁴
- [52]. The *Equality Act 2006*,⁶⁵ which applies to England, Wales and Scotland, established the Commission for Equality and Human Rights.⁶⁶ The Commission has various tasks allocated to it. It must promote understanding of and good practice in respect of equality and diversity, enforce equality and discrimination protection law and work towards the elimination of unlawful discrimination and harassment.⁶⁷ It must also promote respect for human rights, particularly on the part of public bodies.⁶⁸
- [53]. The Commission also has powers of enforcement. It may investigate whether an unlawful act of discrimination has occurred⁶⁹ and require any person found to be in breach of discrimination law to take steps to remedy that breach. That person must prepare an action plan,⁷⁰ and submit it to the Commission for approval.⁷¹ The plan must then be implemented by that person within six weeks. If it is not, the Commission may apply to the court for an order that the person in question comply with the plan. The Commission may also make agreements with any person that that person avoid any act of discrimination, and may seek a court order to enforce that agreement if it is not voluntarily complied with.⁷²

⁵⁹ UK/ Disability Discrimination Act 1995 c.50, s28I.

⁶⁰ UK/ Disability Discrimination Act 1995 c.50, s28I(4)(b).

⁶¹ UK/ Disability Discrimination Act 1995 c.50, s28V.

⁶² UK/ Disability Discrimination Act 1995 c.50, s31ADA.

⁶³ UK/ Disability Discrimination Act 1995 c.50, s25.

⁶⁴ UK/ Disability Discrimination Act 1995 c.50, s28M.

⁶⁵ UK/Equality Act 2006 c.3.

⁶⁶ The Commission runs a website: <http://www.equalityhumanrights.com> (11.10.09).

⁶⁷ UK/Equality Act 2006 c.3, s8(1).

⁶⁸ UK/Equality Act 2006 c.3, s9(1)(d).

⁶⁹ UK/Equality Act 2006 c.3, s20 and schedule 1.

⁷⁰ UK/Equality Act 2006 c.3, s21.

⁷¹ UK/Equality Act 2006 c.3, s22.

⁷² UK/Equality Act 2006 c.3, s24.

- [54]. In Scotland the Scottish Human Rights Commission,⁷³ and in Northern Ireland the Human Rights Commission and the Equality Commission for Northern Ireland,⁷⁴ established under the *Northern Ireland Act 1998*⁷⁵ have similar powers.⁷⁶

2.2.2. Anti-discrimination/equality caselaw [15c].

- [55]. The leading case is *Lewisham LBC v Malcolm* [2008] 1 UKHL 43; 1 AC 1399. The House of Lords held that a local authority was not in breach of its obligation not to discriminate against M, a disabled person (diagnosed with schizophrenia) to whom it provided social housing. M was in breach of his tenancy agreement because he had sublet his local authority-provided apartment, contrary to its terms. This rendered M liable to be given notice to quit, which was given. M resisted the attempt to evict him, arguing that his breach of his tenancy agreement was caused by his schizophrenia, and that the local authority was consequently in breach of section 22(3)(c) of the 1995 Act, which provides that it is unlawful for a person managing premises to discriminate against a disabled person occupying those premises in various ways, one of which is 'by evicting the disabled person'.
- [56]. The House of Lords held that there could be no discrimination because Section 24(1)(a) of the Act requires that the discrimination be 'for a reason which relates to the disabled person's disability', and as the local authority did not know that M was disabled it could not be suggested that his disability was the reason that he was given notice to quit. The court further held that the appropriate comparator in determining whether a person in M's position had been treated less favourably because of his discrimination is a person without disability who had also sublet his or her accommodation in breach of the tenancy agreement. As such a person would also have received notice to quit, there had been no discrimination.
- [57]. In taking this approach, the court overruled the earlier caselaw, in which the appropriate comparator was said to be a person in respect of whom the disability-related reason for the treatment did not apply. Applied to the present case, that would mean a person who had not sublet their accommodation.

⁷³ The Commission website may be found at <http://scottishhumanrights.com> (10.10.09).

⁷⁴ Which maintain websites at <http://www.nihrc.org> and <http://www.equalityni.org/site/default.asp?secid=home> respectively (10.10.09).

⁷⁵ UK/Northern Ireland Act 1998 c.47, s73
http://www.opsi.gov.uk/Acts/acts1998/ukpga_19980047_en_1 (10.10.09).

⁷⁶ UK/Northern Ireland Act 1998 c.47, s74.

- [58]. The controversial nature of *Malcolm* is illustrated by the finding of one of the judges in the House of Lords, Lord Bingham, that ‘I would accept that, but for his mental illness, Mr Malcolm would probably not have behaved so irresponsibly as to sublet his flat and moved elsewhere.... But Lewisham's reason for seeking possession—that Mr Malcolm had sublet the flat and gone to live elsewhere—was a pure housing management decision which had nothing whatever to do with his mental disability’.⁷⁷ In other words, although the court accepted that M’s breach of his tenancy agreement was caused by his mental illness, because the local authority’s decision was not motivated by it, and because it would have treated a non-disabled person in breach of their tenancy agreement in the same way, there was in law no discrimination. Had the pre-existing test been applied to this fact situation, there would have been a greater chance of a finding in favour of Mr Malcolm. It is for this reason that the Equality and Human Rights Commission has described the decision in this case as ‘worrying’.⁷⁸
- [59]. It was not clear after *Malcolm* if the ruling in that case applied only to cases involving discrimination in the context of premises, but it has subsequently been applied in cases of claimed employment discrimination⁷⁹ and discrimination by a school.⁸⁰

2.2.3. Preferential Treatment Arrangements [16a,b].

- [60]. Section 49A, *Disability Discrimination Act 1995* requires public authorities, when carrying out their functions, to have due regard to a number of factors. These include ‘the need to promote equality of opportunity between disabled persons and other persons’,⁸¹ and ‘the need to take steps to take account of disabled persons’ disabilities, even where that involves treating disabled persons more favourably than other persons’.⁸²
- [61]. In addition, the Commission for Equality and Human Rights is enabled, in its pursuit of the eradication of discrimination and harassment, to ‘in particular, promote the favourable treatment of disabled persons’.⁸³ The Commission has issued Codes of Practice for

⁷⁷ *Lewisham LBC v Malcolm* [2008] 1 UKHL 43; 1 AC 1399 per Lord Bingham at para 11.

⁷⁸ <http://www.equalityhumanrights.com/legislative-framework/legal-updates/recent-developments-in-disability-discrimination-cases> (10.10.09).

⁷⁹ *Stockton on Tees BC v Arlott* [2009] ICR 872.

⁸⁰ *R (on the application of N) v Independent Appeal Panel of Barking and Dagenham LBC* [2009] EWCA Civ 108.

⁸¹ UK/ Disability Discrimination Act 1995 c.50, s49A(1)(c).

⁸² UK/ Disability Discrimination Act 1995 c.50, s49A(1)(d).

⁸³ UK/Equality Act 2006 c.3, s8(3).

England and Wales and Scotland relating to the equality duty.⁸⁴ The Equality Commission for Northern Ireland has published a Guide to Best Practice on the equality duty.⁸⁵

- [62]. Regulations have been issued by the Secretary of State.⁸⁶ These require public authorities, defined very broadly,⁸⁷ to prepare and publish a Disability Equality Scheme, laying out how the authority intends to fulfil its disability equality duty.⁸⁸ Local disabled persons must be involved in the construction of the Scheme⁸⁹ and their involvement detailed by the authority.⁹⁰ Schemes had to be in operation within three years of their making.⁹¹ The latest date for making a Scheme was 3rd December 2007,⁹² so all Schemes should be in operation by December 2010.

2.2.4. Preferential Treatment Caselaw [16c].

- [63]. Section 49A has not generated a great deal of caselaw, and none specifically on the question of preferential treatment. Only one case has reached the Court of Appeal to date. In *R (on the application of Domb) v Fulham and Hammersmith LBC* [2009] EWCA Civ 941 the local authority wished to reduce the amount of council tax it collected from residents in its area by three per cent. In order to achieve this, it intended, amongst other things, to introduce charges (as it was lawfully entitled to do) for at home services for disabled persons. The council consulted on this proposal and carried out an equality impact assessment, and at length the policy was introduced. D, a disabled person in receipt of the relevant services sought judicial review of the decisions of the council arguing, amongst other things, that the council had not given due regard to its equality duty under section 49A of the 1995 Act in their implementation. Lord Justice Rix emphasised that

⁸⁴ Both Codes are available at <http://www.equalityhumanrights.com/search-results/index.html?q=code+of+practice> (11.10.09).

⁸⁵ Equality Commission for Northern Ireland (2007) *A Guide for Public Authorities* <http://www.equalityni.org/archive/pdf/ECNIDisPlan.pdf> (10.10.09).

⁸⁶ UK/Disability Discrimination (Public Authorities)(Statutory Duties) Regulations 2005 SI 2005/2966 <http://www.opsi.gov.uk/si/si2005/20052966.htm> (15.10.09).

⁸⁷ UK/Disability Discrimination (Public Authorities)(Statutory Duties) Regulations 2005 SI 2005/2966, sched 1.

⁸⁸ UK/Disability Discrimination (Public Authorities)(Statutory Duties) Regulations 2005 SI 2005/2966, para 2(1).

⁸⁹ UK/Disability Discrimination (Public Authorities)(Statutory Duties) Regulations 2005 SI 2005/2966, para 2(2).

⁹⁰ UK/Disability Discrimination (Public Authorities)(Statutory Duties) Regulations 2005 SI 2005/2966, para 2(3).

⁹¹ UK/Disability Discrimination (Public Authorities)(Statutory Duties) Regulations 2005 SI 2005/2966, para 3.

⁹² UK/Disability Discrimination (Public Authorities)(Statutory Duties) Regulations 2005 SI 2005/2966, para 2(6)(b).

‘the duty is to have due regard, not to achieve results or to refer in terms to the duty; that due regard does not exclude paying regard to countervailing factors, but is “the regard that is appropriate in all the circumstances”; that the test of whether a decision maker has had due regard is a test of the substance of the matter, not of mere form or box-ticking, and that the duty must be performed with vigour and with an open mind; and that it is a non-delegable duty’.⁹³

- [64]. The Court of Appeal nevertheless upheld the decision of the first instance judge, that there was no evidence that the council had failed to have due regard to its equality duty in making the decisions that it had. The impact assessment carried out demonstrated that the council had given due regard to its equality duty and power to treat disabled persons more favourably throughout the relevant period.
- [65]. The only decision of the High Court which concerns a person with mental disorder is *R (on the application of Chavda) v Harrow LBC* [2007] EWHC 3064 (Admin). In this case a local council proposed to restrict the provision of community care services to people with critical needs. It consulted widely and carried out an equality impact assessment, although that assessment did not refer to the disability equality duty. C, who suffered from mental illness, judged to be ‘substantial’ but not ‘critical’, was one of 500 people who would be affected by the decision. She sought judicial review, arguing amongst other things that the council was in breach of its duty under section 49A of the 1995 Act. The court examined the nature of the consultation process and the council’s deliberations based on it, and found ‘no evidence that this legal duty and its implications were drawn to the attention of the decision-takers who should have been informed not just of the disabled as an issue but of the particular obligations which the law imposes’.⁹⁴ The court therefore found a breach of section 49A.

2.2.5. The definition of disability and compliance with the Employment Equality Directive (Directive 200078/EC) [17].

- [66]. The Employment Equality Directive was implemented in national law by the *Disability Discrimination Act 1995 (Amendment) Regulations*

⁹³ *R (on the application of Domb) v Fulham and Hammersmith LBC* [2009] EWCA Civ 941 per Rix LJ at para 52.

⁹⁴ *R (on the application of Chavda) v Harrow LBC* [2007] EWHC 3064 (Admin), per Judge Mackie at para 40.

2003.⁹⁵ However, the concept of ‘disability’ in Article 1 of the Directive was already part of substantive UK law. Section 1(1) *Disability Discrimination Act 1995* provides that a person has a disability if experiencing ‘physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities’. Schedule 1 of the 1995 Act elaborates on the meaning of the terms used in this definition. Specific conditions may be included or excluded through the mechanism of Regulations.⁹⁶ The Regulations in force exclude addiction to alcohol, nicotine or any other substance from the definition of impairment.⁹⁷

- [67]. The 1995 Act also provides for the Secretary of State to issue Guidance on the scope of ‘disability’.⁹⁸ The most recent Guidance came into force on 1 May 2006.⁹⁹ This provides that ‘mental impairment’ includes ‘learning difficulties’ (intellectual disability), mental health conditions and mental illnesses.¹⁰⁰
- [68]. ‘Disability’ also covers past disabilities for the purposes of protection from discrimination under the 1995 Act,¹⁰¹ as well as an impairment currently in abeyance, if it is ‘likely to reoccur’.¹⁰²

2.2.6. The definition of ‘disability’: caselaw

- [69]. In July 2009 the House of Lords decided the case of *SCA Packaging v Boyle* [2009] UKHL 37, a case on appeal from the Northern Ireland industrial tribunal but which is relevant across the UK. This was a case of discrimination because of a physical disability rather than mental disorder or intellectual difficulty, but the decision is relevant to all forms of disability.

⁹⁵ UK/Disability Discrimination Act 1995 (Amendment) Regulations 2003, SI 2003/1673 <http://www.opsi.gov.uk/si/si2003/20031673.htm> (28.09.09).

⁹⁶ UK/Disability Discrimination Act 1995 c.50 s1(1) and sched 1, para 1(2).

⁹⁷ UK/Disability Discrimination (Meaning of Disability) Regulations 1996/1455, para 3(1).

⁹⁸ UK/Disability Discrimination Act 1995 c.50, s3(A1).

⁹⁹ Secretary of State (2006) *Disability Discrimination Act Guidance on matters to be taken into account in determining questions relating to the definition of disability* http://83.137.212.42/sitearchive/drc/the_law/legislation_codes_regulation/guidance.html (28.09.09)

¹⁰⁰ Secretary of State (2006) *Disability Discrimination Act Guidance on matters to be taken into account in determining questions relating to the definition of disability*, para A6. Those listed comprise ‘depression, schizophrenia, eating disorders, bipolar affective disorders, obsessive compulsive disorders, as well as personality disorders and some self-harming behaviour.’ This list is not necessarily exhaustive.

¹⁰¹ UK/Disability Discrimination Act 1995 c.50, s2.

¹⁰² UK/Disability Discrimination Act 1995 c.50, sched 1, para 2(2).

- [70]. In this case B claimed that she had been discriminated against because of her disability, which comprised nodules on her vocal chords which significantly reduced her powers of speech, thus affecting her ability to attend meetings, answer telephone calls, and comply fully with other elements of her employment. Although the nodules had been successfully treated and had not returned this was because, in B's opinion, she had maintained a strict management regime, which involved minimum use of her vocal chords. B made various claims of discrimination, the most important of which was that she was made redundant because of her disability, but her employer claimed she was not disabled for the purposes of the *Disability Discrimination Act 1995* because her disability had been removed by the treatment. The case went to the House of Lords on the preliminary question of whether B was to be classified as disabled for the purposes of the 1995 Act, and it is the judgment of the House of the scope of the concept of disability which renders this case relevant to this Report.
- [71]. The House of Lords held that B was disabled as defined by section 1(1) of the 1995 Act because, although her disability was absent at the time of the alleged discrimination against her, this was only because of the ongoing management regime. She thus had an 'impairment' for the purposes of section 1(1), determined by reference to para 6(1) of Schedule 1 to the 1995 Act. This provides that 'an impairment which would be likely to have a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day duties, but for the fact that measures are being taken to treat or correct it, is to be treated as having that effect'.
- [72]. The key issue was how to understand the requirement in para 6(1) that the presumed substantial adverse effect must be 'likely'. The House of Lords agreed with the Court of Appeal that this means 'may well happen'. The real importance of this case for persons with mental disorder is that the control, for instance of schizophrenia by drug treatments, such that the person in question's disability is not apparent to those around them, does not remove that person from the scope of the protection offered by the 1995 Act. As long as it can be said that, without ongoing treatment, their disorder 'may well' manifest again, and provided that the other elements of the definition of disability are satisfied (namely, that the disability in question would, without management or treatment, have 'a substantial and long-term effect' on the abilities of the disabled person to carry out 'normal day-to-day activities') that person is protected by the 1995 Act.

2.2.7. The application of the definition of disability, and protection from discrimination, in fields other than employment [18].

[73]. The definition of disability found in the previous paragraphs does not apply only in the field of employment. As detailed earlier in this Report,¹⁰³ the *Disability Discrimination Act 1995* as amended also covers the provision of goods, facilities and services, and primary, secondary, further and higher education. Providers of health care, education and housing are all therefore covered by the existing legislation. The extent of the protection for disabled persons will be extended in the ways explained above¹⁰⁴ if and when the *Equality Bill 2009* is enacted in its current form.

2.2.8. The obligation to make 'Reasonable Accommodation' to secure equality between individuals [19].

[74]. The *Disability Discrimination Act 1995*, as amended, makes provision for the reasonable accommodation of the needs of persons with disability, including those disabled by reason of mental disorder (including intellectual disability).

[75]. The Act does this by placing duties on a wide range of persons to make 'reasonable adjustments' to accommodate the needs of disabled persons. Those on whom this duty falls include: employers,¹⁰⁵ office holders,¹⁰⁶ those who run occupational pension schemes,¹⁰⁷ business partnerships,¹⁰⁸ barristers and advocates,¹⁰⁹ trade unions,¹¹⁰ professional qualification bodies,¹¹¹ those offering work experience,¹¹² service providers,¹¹³ public authorities,¹¹⁴ private clubs having 25 or

¹⁰³ Para 41 above.

¹⁰⁴ Para 35 above.

¹⁰⁵ UK/Disability Discrimination Act 1995 c.50, s4A.

¹⁰⁶ UK/Disability Discrimination Act 1995 c.50, s4E.

¹⁰⁷ UK/Disability Discrimination Act 1995 c.50, s4H.

¹⁰⁸ UK/Disability Discrimination Act 1995 c.50, s6B.

¹⁰⁹ UK/Disability Discrimination Act 1995 c.50, ss7B, 7D.

¹¹⁰ UK/Disability Discrimination Act 1995 c.50, s14.

¹¹¹ UK/Disability Discrimination Act 1995 c.50, s14B.

¹¹² UK/Disability Discrimination Act 1995 c.50, s14D.

¹¹³ UK/Disability Discrimination Act 1995 c.50, s21.

¹¹⁴ UK/Disability Discrimination Act 1995 c.50, s21E.

more members,¹¹⁵ schools,¹¹⁶ further and higher education providers,¹¹⁷ and general qualification bodies.¹¹⁸

[76]. The duty to make reasonable adjustments is triggered when a disabled person is put at ‘substantial disadvantage’. The precise nature of the duty varies from context to context. For example, when an employer applies a ‘provision, criterion or practice’ which places a disabled person at substantial disadvantage, or where any physical feature of the premises occupied by the employer has that effect, the employer must take such steps as are reasonable in the circumstances, to prevent that effect.¹¹⁹ The duty only comes into effect when the employer knows or could reasonably be expected to know that the person in question has a disability such that he or she is likely to be affected by the provision, criterion, practice or design of premises.¹²⁰ This pattern is repeated in each of the other contexts in which a duty to make reasonable adjustments applies.

[77]. Monitoring and enforcement of the duty to make reasonable adjustments is done through the mechanism of the various Commissions listed at paragraphs 48 and 49 above. The various Commissions have issued Codes of Practice.¹²¹ The Code of Practice issued by the Equality and Human Rights Commission, gives examples¹²² of steps that may be taken by way of reasonable adjustments. These include, for example in the context of employment discrimination:

- Adjustments to premises
- Allocating the disabled person’s duties to another by employers
- Transferring the disabled person to fill a vacancy
- Altering that person’s working hours
- Providing training
- Acquiring or modifying equipment
- Providing supervision or other support

¹¹⁵ UK/Disability Discrimination Act 1995 c.50, s21H.

¹¹⁶ UK/Disability Discrimination Act 1995 c.50, s28C.

¹¹⁷ UK/Disability Discrimination Act 1995 c.50, s28T.

¹¹⁸ UK/Disability Discrimination Act 1995 c.50, s31AD.

¹¹⁹ UK/Disability Discrimination Act 1995 c.50, s4A(1).

¹²⁰ UK/Disability Discrimination Act 1995 c.50, s4A(3).

¹²¹ These are available at the websites listed above, fn 73-75.

¹²² Equality and Human Rights Commission (2004) *Disability Discrimination Act 1995 Code of Practice: Employment and Occupation* para 5.18

http://www.equalityhumanrights.com/uploaded_files/drc_employment_code.pdf (10.10.09)

2.2.9. Reasonable accommodation: caselaw

- [78]. In *Archibald v Fife Council* [2004] IRLR 651 the council had dismissed A from its employ as a manual labourer by reason of her disability, acquired following medical treatment. The council had attempted and failed to redeploy A in a non-manual labour position, despite automatically short-listing her for some posts. The House of Lords held that the council had not done enough to satisfy the requirement of reasonableness, and the tribunal from which the appeal had come should have considered whether it was reasonable for the employer to simply have transferred A to a non-manual post for which she was suitably qualified rather than subject A to a competitive interview procedure.
- [79]. In *Governing Body of X Endowed Primary School v Special Educational Needs and Disability Tribunal, Mr. and Mrs. T, The National Autistic Society* [2009] EWHC 1842 (Admin) a 10 year-old boy with Attention Deficit and Hyperactivity Disorder (ADHD) was expelled from school by reason of his violent behaviour. His parents successfully argued that his exclusion from school constituted unlawful discrimination by reason of disability; and that the school had failed to make reasonable adjustments for pupils suffering from ADHD, in that it had not sought support from an expert as to how to provide an education to a pupil with ADHD.
- [80]. In *Fareham College v Walters* [2009]¹²³ W was a college lecturer. For reasons relating to both physical and mental disability (acute stress) she was unable to perform her duties, had been away from work for several months and would continue to be so for several further months. She was dismissed from her employment because she was unable to comply with her terms of employment. The Employment Appeal Tribunal headed by Mr. Justice Cox upheld the decision of an employment tribunal that W had been dismissed in breach of the 1995 Act.
- [81]. Although her dismissal was not of itself discriminatory – the approach of the House of Lords in *Malcolm* being followed, leading to the conclusion that a non-disabled person unable to comply with her duties would also have been dismissed – it was nevertheless rendered discriminatory by the failure of the employer to make reasonable adjustments to accommodate W. The college had a policy on phased return to work for employees who had been ill. This amounted to a ‘provision, criterion or practice’ for the purposes of the 1995 Act.¹²⁴ It declined to apply this policy to W, for reasons concerned with the

¹²³ *Fareham College v Walters* [2009] Appeal No. UKEAT/0396/08/DM UKEAT/0076/09.

¹²⁴ UK/Disability Discrimination Act c.50, s4A(1).

management of the college, the accommodation of teaching staffs' wishes and reasonable expectations regarding teaching hours (W expressed a wish, based on her medical condition, to teach in the middle of the day rather than the early morning or evening, which meant that other staff would have to take these, less popular, hours of work). In essence, the college decided that it could not accommodate W within its existing human resource management structures.

[82]. The Appeal Tribunal decided that the test for comparator explained by the House of Lords in *Malcolm* did not apply to the question of whether reasonable adjustments had been made. Instead, for these purposes, 'the comparator group is other employees of the Respondent who are not disabled and who are able forthwith to attend work and to carry out the essential tasks required of them in their post'.¹²⁵ As the college policy on phased return to work made only brief mention of the relevance of disability discrimination law, and because in fact the college had not sought to modify its general policy to take account of W's disability, the Appeal Tribunal upheld the employment tribunal's finding that reasonable adjustments had not been made.

[83]. In *Eastern and Coastal Kent PCT v Grey* [2009]¹²⁶ the issue was the scope of section 4A(3) of the *Disability Discrimination Act 1995*. This provides that an employer is not under a duty to make reasonable adjustments in relation to a person if it does not know or could not reasonably be expected to know that the person in question has a disability. In this case the Employment Appeal Tribunal said that to be protected by this provision an employer must be able to demonstrate that it:

- does not know that the disabled person has a disability; and
- does not know that the disabled person is likely to be at a substantial disadvantage compared with persons who are not disabled; and
- could not reasonably be expected to know that the disabled person had a disability; and
- could not reasonably be expected to know that the disabled person is likely to be placed at a substantial disadvantage in comparison with persons who are not disabled.

¹²⁵ *Fareham College v Walters* [2009] Appeal No. UKEAT/0396/08/DM UKEAT/0076/09, para 59.

¹²⁶ *Eastern and Coastal Kent PCT v Grey* [2009] Appeal No. UKEAT/0454/08/RN.

2.2.10. Competency of the equality body to deal with cases of discrimination on grounds of intellectual disability [20].

- [84]. The law described in this section of the Report applies to persons with a mental disorder, defined to include both those who are mentally ill and those with an intellectual disability. Both groups therefore already come within the jurisdiction of the equality body in the relevant UK jurisdiction.¹²⁷ Each Commission has jurisdiction to hear complaints from persons with intellectual disability that they have been discriminated against.
- [85]. For an example of a successful intervention by the Commission for Human Rights and Equality to prevent discrimination against a person with intellectual disabilities, see the story of Jack Thomas, a young boy from Swansea who was caught up in a ban on persons with intellectual disabilities on competing in the Paralympics. The ban was applied in Jack's school and in many others. Following intervention by the Commission, the ban was lifted, thus enabling an estimated 300,000 young people with intellectual disabilities to participate in sports at school.¹²⁸

¹²⁷ These are detailed at paras 53 and 54 above.

¹²⁸ Equality and Human Rights Commission (2009) *One Year, Ten Stories* <http://issuu.com/equalityhumanrights/docs/oneyearstoriories?mode=embed&layout=http%3A%2F%2Fskin.issuu.com%2Fv%2Fflight%2Flayout.xml&showFlipBtn=true> (15.10.09).

3. Specific Fundamental Rights

- [86]. Although there is no written formal Constitution in the UK, all persons present in the UK are entitled as a matter of UK domestic law to the protection of most of the substantive rights found in the European Convention on Human Rights.¹²⁹ Courts in the UK must take into account the jurisprudence of the European Court of Human Rights, as well as opinions of the former European Commission of Human Rights (in a report made under Article 31) and decisions of the Commission (taken under Articles 26 or 27(2)) or the Committee of Ministers of the Council of Europe (taken under Article 46).¹³⁰
- [87]. Courts must also interpret national legislation wherever possible in a manner consistent with the protection of Convention rights.¹³¹ The UK's legislative bodies must confirm that new legislation is compatible with the Convention.¹³² Central and local government, and other 'public authorities' and their employees, including for example those working in psychiatric facilities or otherwise providing services to persons with mental disorder or learning disability, must act at all times in a manner compatible with the Convention, unless primary national legislation precludes them from so acting.¹³³
- [88]. The protection by national law of the rights to be considered in this section has been developed largely in terms of the application, interpretation or extension of principles enunciated or decisions made by the European Court of Human Rights.

3.1. The Right to life [22].

- [89]. The right to life has substantive application to persons with mental disorder or intellectual disability when housed in hospital or other state-provided accommodation, and imposes positive obligations on service providers. The right to life has recently been held by the House of Lords to be the source of both a general positive obligation

¹²⁹ UK/Human Rights Act 1998 c.42 http://www.opsi.gov.uk/ACTS/acts1998/ukpga_19980042_en_1#pb1-11g2 (08.10.09). The Articles of the Convention incorporated by s 1(1) of this Act into UK national law are Articles 2 to 12, 14, Articles 1 to 3 of the First Protocol (subject to the U.K.'s reservation in relation to Article 2 of that Protocol), and Article 1 of the Thirteenth Protocol.

¹³⁰ UK/Human Rights Act 1998 c.42, s2.

¹³¹ UK/Human Rights Act 1998 c.42, s3.

¹³² UK/Human Rights Act 1998 c.42, s19.

¹³³ UK/Human Rights Act 1998 c.42, s6.

on the part of the state to have systems in place to prevent harm, including self-harm, to psychiatric hospital patients; and of an operational obligation, to do what is reasonable in the circumstances, when there is a real and immediate risk to life about which the authorities knew or ought to have known at the time (*Savage v South Essex Partnership NHS Trust Foundation* [2008] UKHL 74).

- [90]. In *R (Wilkinson) v Broadmoor Special Hospital Authority* [2002] 1 WLR 419, a detained patient in poor health had been forcibly treated with anti-psychotic medication, immediately after which he had suffered an angina attack. It was accepted as arguable by the Court of Appeal that Article 2 was relevant to proposals further to medicate the patient, again by force and again with the risk of serious consequences for his health. Thus Article 2 applies to the administration of medical treatment for mental disorder, and can in a suitable case be pleaded as a mechanism to prevent unwanted treatment. The occurrence of such cases, however, is likely to be rare.
- [91]. Article 2 also imposes an obligation to conduct an inquiry into deaths, or injuries sustained, in state custody. The *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* investigates and reports on all such suicides and homicides in the UK, not just those in hospital, and on any sudden deaths in hospital. The Inquiry issues reports annually in England and Wales. The most recent such Report was published in July 2009.¹³⁴ The Inquiry also issues five-yearly Reports on the UK, England and Wales, and Scotland.¹³⁵ The purpose of the National Confidential Inquiry is to provide information to service providers in order to allow improvements to be made into the quality of care and prevent avoidable deaths of persons with mental disorder.

3.2. The right to freedom from torture or cruel, inhuman or degrading treatment or punishment [23].

- [92]. There are no decided cases in the UK in which an infringement of Article 3 of the Convention on grounds of intentional cruelty or maltreatment of patients has been argued. Caselaw instead focuses

¹³⁴ Available at

<http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/inquiryannualreports/AnnualReportJuly2009.pdf> (05.10.2009).

¹³⁵ These are available from the Inquiry website at

http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/inquiry_reports/ (05.10.09). The first five-yearly Report on Northern Ireland is expected in 2010.

on the ability of Article 3 to protect patients from unwanted medical treatment which their treatment providers insist is administered to them. On this question, the caselaw in the UK, as elsewhere in Europe, is founded on the decision of the European Court in *Herczegfalvy v Austria* (1992) 15 EHRR 437. As is well known, in that case the Court acknowledged the vulnerable position of persons with mental disorder subject to involuntary placement and treatment in a psychiatric facility. It then went on to hold that the non-consensual but necessary medical treatment of such a patient would not breach Article 3 of the Convention: ‘The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist’.¹³⁶

- [93]. UK law is prima facie vulnerable to a successful action under Article 3 because it provides blanket permission for the doctor in charge to treat a detained patient with drug treatments without consent for three months, and, with some exceptions, to continue treatment thereafter if able to secure a second opinion as to its desirability from a government-appointed psychiatrist.¹³⁷ There is, with one exception,¹³⁸ no absolute right to refuse treatment in domestic law, however unwarranted it may be in terms of its impact on the patient as torture, or as cruel, inhuman or degrading treatment.
- [94]. To remedy this lacuna, UK courts have used *Herczegfalvy* to fashion a right to refuse on the basis of Article 3 (and Article 8). The leading case is *R (Wilkinson) v Broadmoor Special Hospital Authority* [2002] 1 WLR 419. In this case a patient who, it was claimed by doctors commissioned by him, had capacity (although this was disputed by the doctors treating him) refused to consent to the administration of medication for a psychotic disorder. It was necessary to use force to administer the treatment and the patient, who suffered from coronary heart disease, suffered an angina attack shortly afterwards. The patient then sought to prevent further administration of the treatment.
- [95]. The issue was whether the professionals involved in the patient’s treatment could be compelled to appear before the court for cross-examination. The Court of Appeal held that they could, on the basis that the patient’s rights under Article 3 (and Articles 2 and 8), in particular, the requirement laid down in *Herczegfalvy* that the need for treatment must be ‘convincingly shown’, must be upheld.

¹³⁶ *Herczegfalvy v Austria* (1992) 15 EHRR 437, para 82.

¹³⁷ See paras 240-254 below.

¹³⁸ See paras 241, 248 below.

Although the court was not required to consider the legality of the treatment in question, one of the judges, Lord Justice Simon Brown, did say that ‘[i]f in truth this claimant has the capacity to refuse consent to the treatment proposed here, it is difficult to suppose that he should nevertheless be forcibly subjected to it... its impact on the claimant's rights above all to autonomy and bodily inviolability is immense and its prospective benefits (not least given his extreme opposition) appear decidedly speculative’.¹³⁹

[96]. In the later Court of Appeal decision in *R v Dr M and others, ex parte N* [2003] 1 WLR 562 the Court of Appeal gave some guidance as to factors to be taken into account by a court charged to determine whether or not the medical evidence favouring treatment is convincing.¹⁴⁰ These factors are:

- certain is it that the patient does suffer from a treatable mental disorder
- how serious a disorder is it
- how serious a risk is presented to others
- how likely is it that, if the patient does suffer from such a disorder, the proposed treatment will alleviate the condition
- how much alleviation is there likely to be
- how likely is it that the treatment will have adverse consequences for the patient
- how severe may they be

[97]. To date, no court in the UK has categorically found that non-consensual treatment of a person for mental disorder is or would be in breach of Article 3. This may be because the *Herczegfalvy* framework defers unduly to medical opinion as to the necessity of treatment and its assumed beneficial or therapeutic effect. This undermines the safeguards established in *Wilkinson*. For example, in the *ex parte N* case, and in the later decision of *R v RMO and SOAD, ex parte JB* [2006] EWCA Civ 961 the Court of Appeal declined to accept that the patient’s ability to produce professional witnesses holding the opinion that the necessity of treatment had not or could not be convincingly shown did not preclude the court, as it did in both cases, from holding that the case for treatment had been convincingly made out. In the *JB*

¹³⁹ *R (Wilkinson) v Broadmoor Special Hospital Authority* [2002] 1 WLR 419 at para 30.

¹⁴⁰ *R v Dr M and others, ex parte N* [2003] 1 WLR 562 at para 19.

case, the court held that in order for the case for treatment to be convincingly shown, those wishing to treat had to persuade the court of ‘the satisfaction of medical necessity on a balance of probabilities’, or of the ‘likelihood’ of therapeutic benefit’.¹⁴¹ Thus, in the UK at present, the ‘convincingly shown’ test operates with a relatively low threshold and seems some distance away from, and to offer less protection to patients than, the test as originally intended and enunciated by the Court in *Herczegfalvy*.

3.3. The right to freedom from exploitation [24].

- [98]. The *Mental Capacity Act 2005*,¹⁴² which applies in England and Wales, and the *Adults with Incapacity (Scotland) Act 2000*,¹⁴³ which applies in Scotland, seek to provide a comprehensive regime to protect the best interests of persons lacking capacity. This legislation is discussed below at part 5 of this Report. The Northern Ireland Assembly intends to enact comparable legislation by 2011.
- [99]. The capacity legislation, however, does not extend to all issues. The courts in all jurisdictions have inherent powers to protect vulnerable persons from abuse or exploitation. These powers have been used on several occasions in recent years to protect persons with intellectual disabilities from exposure to exploitative events or situations.
- [100]. In *Sheffield City Council v E* [2005] Fam 326 the English High Court issued injunctions preventing the marriage of E, a 21 year-old woman with intellectual disabilities, to a man of 37 with a history of sexual offences. This was partly on the basis that E lacked capacity to marry, but also because it was found not to be in the best interests of E to marry the man in question. There was a similar outcome in *M v B* [2005] EWHC 1681 (Fam);¹⁴⁴ and in *Local Authority X v M* [2007] EWHC 2003 (Fam) [2009] 1 FLR 443¹⁴⁵ the same powers were used to regulate the relationship between a 39 year-old woman who suffered from paranoid schizophrenia and moderate learning difficulties, and her long-term partner, in pursuit of the best interests of the woman.

¹⁴¹ of *R v RMO and SAOD, ex parte JB* [2006] EWCA Civ 961 per Auld LJ at para 42.

¹⁴² UK/Mental Capacity Act 2005 c.9

http://www.opsi.gov.uk/ACTS/acts2005/ukpga_20050009_en_1 (15.10.09).

¹⁴³ UK/Adults with Incapacity (Scotland) Act 2000 asp. 4

http://www.opsi.gov.uk/legislation/scotland/acts2000/asp_20000004_en_1 (15.10.09).

¹⁴⁴ See para 130 below.

¹⁴⁵ See para 135 below.

3.4. The right to liberty and security [25].

- [101]. In all jurisdictions in the UK, the *Winterwerp*¹⁴⁶ criteria for involuntary admission and continued detention are satisfied by the national legislation in question.¹⁴⁷ The relevant legislation also protects the liberty and security of patients in other ways, for example by placing duties on hospital managers to inform those involuntarily placed in their hospital of their rights to challenge detention.¹⁴⁸
- [102]. This, however, assumes that legal detention is coterminous with detention in fact. In *R v Bournewood Community and Mental Health NHS Trust, ex parte L* [1999] AC 481 the House of Lords held that L, a patient with very significant intellectual disability who had been provided with accommodation as an inpatient on an informal basis, was not being deprived of his liberty even though, had he attempted to leave the hospital, he would have been prevented from doing so through the use of powers of compulsory detention.
- [103]. The court was of the view that informal admission to a hospital of patients lacking capacity to consent or refuse, and so who could merely acquiesce to that admission, was permitted by the *Mental Health Act 1983* without the need to use the powers under the Act to institute an involuntary placement. The court also decided that there could be no claim for wrongful detention in this case as the patient, L, had not in fact attempted to leave the hospital.
- [104]. The case went to the European Court,¹⁴⁹ which disagreed with the House of Lords and found a breach of Article 5(1) of the Convention. The true test of whether there had been a deprivation of liberty in such circumstances is ‘whether the hospital exercised complete control over his care and movements’.¹⁵⁰ As L would have been prevented from leaving had he attempted to do so, he was detained for the purposes of Art 5.¹⁵¹
- [105]. Moreover, the UK national law, which places no formal requirements on an informal admission to hospital, was found not to provide sufficient procedural protection to allow the court to find that the detention of L was in accordance with Article 5(1)(e). The court ‘found striking the lack of any fixed procedural rules by which the

¹⁴⁶ *Winterwerp v The Netherlands* (1979-1980) 2 EHRR 387.

¹⁴⁷ See paras 159-175 below.

¹⁴⁸ UK/Mental Health Act 1983 c.20, s132 (England and Wales); UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s260 (Scotland); UK/Mental Health (Northern Ireland) Order 1986 SI 1986/595 NI 4, Art 237.

¹⁴⁹ *HL v UK* Application Number 45508/99 (2005) 40 EHRR 32.

¹⁵⁰ *HL v UK* Application Number 45508/99 (2005) 40 EHRR 32, para 91.

¹⁵¹ *HL v UK* Application Number 45508/99 (2005) 40 EHRR 32, para 91.

admission and detention of compliant incapacitated patients is conducted'.¹⁵² The decision in this case prompted new legislation in England and Wales to provide appropriate safeguards and procedural clarity for the deprivation of liberty of persons lacking capacity. This is discussed at 6.1 below.

- [106]. The right to liberty has also been influential on the time taken to hear an application by a patient to a review tribunal with powers to order release, as required by Article 5(4) of the Convention. In *R v MHRT, ex parte KB and seven others* [2002] EWHC Admin 639, eight patients challenged the legality of waiting periods of four weeks (for a patient held for assessment, which can last for a maximum of 28 days) and between nine and 27 weeks, for patients held for treatment under civil or criminal law powers. All eight patients were successful, the court finding that the delays in tribunals hearing applications were caused by systemic failures in the administration of the tribunal system. All were paid damages of various amounts to compensate for the breach of their human rights.¹⁵³
- [107]. In the earlier case of *R v MHRT London South and West Region, ex parte C* [2001] MHLR 110 the Court of Appeal found that a standard eight week delay between application and hearing for patients detained for treatment was in breach of Article 5(4). The procedural rules governing applications provide for a three week limit on the detaining hospital providing medical reports on a newly detained patient.¹⁵⁴ The court found no justification for the apparently arbitrary extension of this period to eight weeks by those government officials who administered the tribunal referral system in the local area. The court indicated that 4-5 weeks should be the time taken in a standard case.

3.5. The right to fair trial [26].

3.5.1. Rights of mentally disordered accused persons in the criminal justice system.

- [108]. The following mechanisms are available in the UK to ensure a fair trial in respect of mentally disordered persons in the criminal justice system.

¹⁵² *HL v UK* Application Number 45508/99 (2005) 40 EHRR 32, para 120.

¹⁵³ UK/Human Rights Act 1998, s9 provides for this.

¹⁵⁴ UK/Mental Health Review Tribunal Rules 1983 SI 1983/942, r.6(1)(a), (b).

- [109]. *The ‘Appropriate Adult’ scheme.* This scheme applies throughout the UK. It applies whenever a mentally disordered person¹⁵⁵ or one who is ‘mentally vulnerable’ (defined as ‘any detainee who, because of their mental state or capacity, may not understand the significance of what is said, of questions or of their replies’)¹⁵⁶ is detained in a police station or interviewed by a police officer. The rights and interests of that person must be protected by the presence of an independent third party, the ‘appropriate adult’.
- [110]. The role of the appropriate adult is to advise the person being detained or interviewed; observe whether the interview is conducted fairly; and facilitate communication between the mentally disordered person and the investigating officers.¹⁵⁷ The absence of an appropriate adult does not mean that any evidence obtained cannot be used in subsequent court hearings, but the trial judge must warn of the dangers of convicting a person with learning difficulties¹⁵⁸ (but not a person who is mentally ill) on the basis of that person’s uncorroborated confession evidence if made in the absence of an appropriate adult.¹⁵⁹
- [111]. *At trial.* A person cannot be tried unless he or she is fit to stand trial. In *R v M(John)* [2003] EWCA Crim 3452 the English and Welsh Court of Appeal held that for a person to be fit for trial he or she must be capable of: ‘(1) understanding the charges; (2) deciding whether to plead guilty or not; (3) exercising his right to challenge jurors; (4) instructing solicitors and counsel; (5) following the course of the proceedings; (6) giving evidence in his own defence’.¹⁶⁰ A finding of unfitness must be based on medical evidence.¹⁶¹

¹⁵⁵ As defined by UK/Mental Health Act 1983 c.20, s1(2): see UK/Police and Criminal Evidence Act 1984 c.60, Code of Guidance C, para 1(G) <http://police.homeoffice.gov.uk/operational-policing/powers-pace-codes/pace-code-intro/> (15.10.09).

¹⁵⁶ UK/Police and Criminal Evidence Act 1984 c.60, Code of Guidance C, para 1(G).

¹⁵⁷ UK/Police and Criminal Evidence Act 1984 c.60, Code of Guidance C, para 1(G). This legislation applies only to England and Wales. The Northern Ireland scheme is in all important respects identical to this: see UK/Police and Criminal Evidence (Northern Ireland) Order 1989, Code C. In Scotland, the scheme has no statutory basis but operates in the same way as it does elsewhere in the UK. See The Scottish Government (2004) *An Evaluation of the Appropriate Adult Scheme in Scotland* <http://www.scotland.gov.uk/Publications/2004/11/20253/46679> (09.10.09).

¹⁵⁸ The relevant legislation - UK/Police and Criminal Evidence Act 1984 c.60, s77(1) – uses and defines the term ‘mental handicap’, but there is no substantive difference between this term and ‘intellectual disabilities’.

¹⁵⁹ UK/Police and Criminal Evidence Act 1984 c.60, s77(1) <http://www.statutelaw.gov.uk/content.aspx?parentActiveTextDocId=1871554&ActiveTextDocId=1871558> (15.10.09).

¹⁶⁰ *R v M(John)* [2003] EWCA 3452, para 20.

¹⁶¹ *R v Borkan* [2004] EWCA Crim 1642.

- [112]. If a person is found to be unfit, a ‘trial of the facts’ will follow.¹⁶² A trial of the facts does not consider the question of guilt or innocence, merely whether the accused person did the act he or she is accused of. If so, the court has various options. It may order that the defendant be detained in a hospital, be provided with treatment in the community, or be discharged absolutely.¹⁶³ Unless the court makes a hospital order and a ‘restriction order’; the disposal is final and that person will not be required to stand trial at any point in the future.¹⁶⁴
- [113]. The compatibility of the ‘trial of the facts’ procedure with Article 6 of the Convention was litigated in *R v H and Secretary of State for the Home Department* [2003] UKHL 1. It was argued in this case that a trial of the facts, just like a full trial, is unfair to a person unfit to plead as he or she will not be able to take any active part in the proceedings. It was also argued that there was a contravention of Article 6(2), in that a trial of the facts should be construed as a criminal trial and therefore infringed that provision because it departed from the presumption of innocence. It was claimed too that Article 6(3) was infringed because a trial of the facts does not, as that provision demands, allow a defendant adequate time and facilities to prepare a defence.
- [114]. The House of Lords held that no element of Article 6 was infringed by the trial of the facts procedure. Applying the judgment of the European Court in *Engel v The Netherlands* [1976] 1 EHRR 647, the court decided (i) that a trial of the facts, which cannot result in a conviction, is not a criminal trial, but rather comes into operation instead of a criminal trial and (ii) provided that the proceedings are conducted with ‘scrupulous regard for the interests of the accused person’ it is fair.¹⁶⁵
- [115]. This decision applies directly only to the trial of the facts procedure which operates in England and Wales. However, the procedure in Scotland¹⁶⁶ and Northern Ireland¹⁶⁷ is to all intents and purposes the same as that in England and Wales and it is therefore highly probable that the decision of the House of Lords in this case accurately states the law in all jurisdictions within the UK.

¹⁶² UK/Criminal Procedure (Insanity) Act 1964 c.84, s4A
http://www.opsi.gov.uk/RevisedStatutes/Acts/ukpga/1964/cukpga_19640084_en_1
 (15.10.09).

¹⁶³ UK/Criminal Procedure (Insanity) Act 1964 c.84, s5.

¹⁶⁴ UK/Criminal Procedure (Insanity) Act 1964 c.84, s5A(4).

¹⁶⁵ *R v H and Secretary of State for the Home Department* [2003] UKHL 1, para 20.

¹⁶⁶ UK/Criminal Procedure (Scotland) Act 1995 c.46, Part VI
http://www.opsi.gov.uk/Acts/acts1995/ukpga_19950046_en_1 (09.10.09).

¹⁶⁷ UK/Mental Health (Northern Ireland) Order 1986, SI 1986/595 (NI 4), art 49.

- [116]. *Psychiatric Reports at the sentencing stage*. Before passing any sentence other than a fine, or in respect of which the court is obliged by law to pass a sentence of life imprisonment, a sentencing court in England and Wales must consider all the circumstances of the offence and offender.¹⁶⁸ If the defendant is mentally disordered, the court must also obtain a medical report from a psychiatrist appointed for this purpose unless the court considers it unnecessary to do so, and must consider any medical information available to it (obtained by a medical report or otherwise) and the likely effect of a custodial sentence on the defendant's medical condition and any treatment options which may be available.¹⁶⁹
- [117]. The situation is exactly the same in Northern Ireland,¹⁷⁰ and there is a similar requirement to consider information relating to the mental condition of a convicted person placed on sentencing judges in Scotland.¹⁷¹

3.5.2. Rights to a fair trial in hearings under mental disorder legislation.

- [118]. The *Mental Health Act 1983* in its original form provided that, in order to be eligible for release from an involuntary placement, it was for a patient to persuade a Tribunal that the conditions for continued detention no longer applied. In *R v Mental Health Review Tribunal, North and East London, ex parte H* [2001] EWCA Civ 415 it was held that this position was in breach of Articles 5(1) and 5(4) of the Convention. It is for those seeking to continue the placement to persuade the Tribunal that the criteria for detention continued to be met. The burden of proof was accordingly reversed by statutory means.¹⁷²
- [119]. In *Wilkinson*¹⁷³ the Court of Appeal held that Article 6 did not apply to the administration of treatment to a detained patient without consent on the authority of a doctor appointed for the purposes of giving a second opinion, as provided for by the Mental Health Act 1983, on the

¹⁶⁸ UK/Criminal Justice Act 2003 c.44, s156
http://www.opsi.gov.uk/acts/acts2003/ukpga_20030044_en_1 (09.10.09).

¹⁶⁹ UK/Criminal Justice Act 2003 c.44, s157.

¹⁷⁰ UK/Criminal Justice (Northern Ireland) Order 2008, SI 2008/1216, Article 10
http://www.england-legislation.hmso.gov.uk/si/si2008/em/uksiem_20081216_en_1
 (09.10.09).

¹⁷¹ UK/Criminal Procedure (Scotland) Act 1995, s204(2).

¹⁷² UK/Mental Health Act 1983 (Remedial) Order 2001 SI 2001/3712
<http://www.opsi.gov.uk/si/si2001/20013712.htm> (09.10.09).

¹⁷³ *R (Wilkinson) v Broadmoor Special Hospital Authority* [2002] 1 WLR 419.

basis that it was established in that case that there is a right to go to court to challenge that decision on human rights ground.¹⁷⁴

3.6. The right to privacy, including the access to one's own confidential medical records [27].

- [120]. *Privacy rights* have historically been protected in the UK through the imposition of duties of confidentiality on those holding information. Increasingly these days, however, UK lawyers tend to think in terms of the privacy rights protected by Article 8 of the Convention. The UK implemented *Council Directive 95/46/EC of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data* in the form of the *Data Protection Act 1998*.¹⁷⁵ This Act also provides for rights to access confidential personal information about oneself, such as that held in medical records.
- [121]. There is guidance on the need to respect the privacy in hospital inpatients in the English,¹⁷⁶ Welsh¹⁷⁷ and Scottish¹⁷⁸ Codes of Practice. Issues dealt with include searches of patients, access to telephones including mobile telephones, and privacy of correspondence. The English Code also discusses the need for lockable space for the private property of patients.¹⁷⁹
- [122]. In *W v Egdeell* [1989] 1 All ER 1089 a patient with a diagnosis of paranoid schizophrenia, W, was detained following his manslaughter of five persons. Several years later, when in the view of W's treatment providers his schizophrenia has been brought under control by drugs, thus diminishing his dangerousness to others, W sought release by way

¹⁷⁴ *R (Wilkinson) v Broadmoor Special Hospital Authority*, para 34.

¹⁷⁵ UK/ Data Protection Act 1998 c.29

http://www.opsi.gov.uk/Acts/Acts1998/ukpga_19980029_en_1 (15.10.09).

¹⁷⁶ Department of Health (2008) *Mental Health Act 1983 Code of Practice*, Ch 16

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597 (15.10.09).

¹⁷⁷ Welsh Assembly (2008) *Mental Health Act 1983 Code of Practice for Wales*, paras 2.44, 7.5, 7.8, 18.17, 18.22, 19.5, 19.11, 19.42, 20.4, 21.3, 21.9, 22.43, 25.23-26, 26.18, 26.20-21, 33.6 <http://www.assemblywales.org/bus-home/bus-guide-docs-pub/bus-business-documents/bus-business-documents-doc-laid/gen-ld7209-e.pdf?langoption=3&ttl=GEN-LD7209%20-%20Mental%20Health%20Act%201983%3A%20Code%20of%20Practice%20for%20Wales> (15.10.09).

¹⁷⁸ The Scottish Executive (2005) *Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice* Volume 1, Ch 12

<http://www.scotland.gov.uk/Publications/2005/08/29100428/04431> (15.10.09).

¹⁷⁹ Department of Health (2008) *Mental Health Act 1983 Code of Practice* Ch 16.8.

of an application to a mental health review tribunal. He commissioned a report from a psychiatrist, E, to support his application.

- [123]. E's report was to the effect that W was not yet safe for release. E had concerns, that had not previously been given much weight, that W had a worrying interest in chemical explosives. E also reported concerns that W suffered from paranoid psychosis rather than schizophrenia, and in consequence drug treatments were less likely to be effective than W's treatment providers supposed. In viewing the report, W abandoned his application to the tribunal, which meant that E's report was not seen by it, nor by the doctors treating W. E was concerned about this and so sent his report to the detaining hospital, to the tribunal, and also, as W was a restricted patient, to the Home Secretary. W thereupon sued E for breach of confidence.
- [124]. The Court of Appeal held that although W's confidence had clearly been breached, the breach was justified. This was on the basis that it is in the public interest for those treating persons who are mentally ill and have a history of significant danger to others should have access to all relevant information about the patient. Although this case was decided before the Human Rights Act 1998 brought the right to respect for privacy into UK law, it is likely that the same substantive outcome would be reached now as in 1989.
- [125]. In *Ashworth Hospital v Mirror Group Newspapers* [2002] UKHL 29 the House of Lords upheld the judgment of the lower courts that hospital authorities have their own independent right of privacy in medical records, which continues to exist and be enforceable even if the patient (in this case, a notorious child murderer who had talked to the press about his treatment in hospital) has put some of the information found in his medical records into the public domain.
- [126]. *Access to medical records* is governed by the *Data Protection Act 1998*.¹⁸⁰ Any individual is entitled to access the information held in his or her medical records.¹⁸¹ This general right of access is subject to limitations. If the data disclosed would include information relating to another person it may not be disclosed without the consent of that person, unless it is reasonable to provide the information sought without the consent of that person.¹⁸²
- [127]. Regulations made under the 1998 Act allow for medical data to be withheld from the data subject if disclosure 'would be likely to cause serious harm to the physical or mental health or condition of the data

¹⁸⁰ UK/ Data Protection Act 1998 c.29.

¹⁸¹ UK/ Data Protection Act 1998 c.29,s7(1)(c)(i).

¹⁸² UK/ Data Protection Act 1998 c.29, s7(4).

subject or any other person'.¹⁸³ The person who withholds data must be the medical professional most recently in charge of that person's treatment or, if not, must consult that person before withholding data.¹⁸⁴

- [128]. If the data subject lacks capacity, such that he or she cannot manage his or her own affairs, access to his or her medical records may be instead applied for by a person appointed by a court to manage those affairs.¹⁸⁵ This means a court-appointed Deputy (in England and Wales) or Guardian (in Scotland).¹⁸⁶ Such a person cannot access medical information about a data subject who has provided it to medical professionals in circumstances in which the data subject expected or expressly provided that it should not be disclosed to any other person.¹⁸⁷

3.7. The right to marry, to found a family and to respect of family life [28].

- [129]. *Capacity and the Right to Marry* The right to marry is dependent on having capacity to marry. The test for capacity was discussed in the case of *Sheffield City Council v E* [2005].¹⁸⁸ The High Court considered two hundred years worth of precedents, concluding that in order to be able validly to enter a marriage the following considerations apply: '(i) It is not enough that someone appreciates that he or she is taking part in a marriage ceremony or understands its words. (ii) He or she must understand the nature of the marriage contract. (iii) This means that he or she must be mentally capable of understanding the duties and responsibilities that normally attach to marriage. (iv) That said, the contract of marriage is in essence a simple one, which does not require a high degree of intelligence to comprehend. The contract of marriage can readily be understood by anyone of normal intelligence'. It will be a question of fact whether any given individual satisfies this test.

- [130]. This test was applied in *M v B* [2005] EWHC 1681. In this case the parents of a woman, M, in her early 20s with severe intellectual disability, domiciled in the UK, intended to take her to Pakistan. The parents claimed that the purpose of the visit was a holiday, but the

¹⁸³ UK/Data Protection (Subject Access Modification) (Health) Order 2000/413, para 5(1) <http://www.opsi.gov.uk/si/si2000/20000413.htm> (12.10.09).

¹⁸⁴ UK/ Data Protection (Subject Access Modification) (Health) Order 2000/413, para 5(2).

¹⁸⁵ UK/ Data Protection (Subject Access Modification) (Health) Order 2000/413, para 5(4).

¹⁸⁶ See paras 290-302 below.

¹⁸⁷ UK/ Data Protection (Subject Access Modification) (Health) Order 2000/413, para 5(3).

¹⁸⁸ *Sheffield City Council v E* [2005] Fam 326, para 68.

local social services authority was able to persuade the court that the real purpose of the visit was so that M could be married to a Pakistani man selected by her parents. The court further found (i) that M clearly lacked capacity to marry and (ii) marriage, and departure from the UK, would not be in her best interests. It therefore issued injunctions forbidding her parents to arrange for a marriage to take place or to take M out of the jurisdiction.

- [131]. This test was also applied in *Local Authority X v M* [2007] EWHC 2003 (Fam) [2009] 1 FLR 443. This case is discussed at paragraph 142 below in relation to respect for family life.
- [132]. If a person lacks capacity, he or she can not marry. Section 27 of the Mental Capacity Act 2005,¹⁸⁹ which applies in England and Wales, provides that no other person may consent to marriage, or to the formation of a civil partnership, on behalf of a person lacking capacity. In Scotland, a Guardian appointed by a Sheriff¹⁹⁰ may be given powers to defend a decree of nullity or divorce,¹⁹¹ but there is no scope for a Guardian to be given powers to consent to marriage on behalf of a person lacking capacity.
- [133]. *Marriage in Hospital* It is not normally possible for a marriage to be celebrated in a hospital. However, special provision is made for persons detained (other than under the short-term sections) under the *Mental Health Act 1983* by the *Marriage Act 1983*.¹⁹² Section 1(1), which applies to England and Wales, and section 3(1), which applies to Northern Ireland, provide that the marriage of a detained patient may take place in the hospital in which he or she is detained. In Scotland, section 18 *Marriage (Scotland) Act 1977* c.15¹⁹³ provides that a civil marriage may be celebrated other than at a registry office or approved premises if one of the parties is unable to attend a registry office or approved premises.
- [134]. *The Right to Found a Family* There is no right to conjugal visits for those involuntarily placed in hospital. In *Dickson v UK* (2008) 46 EHRR 41 the European Court found that the policy of the UK Government towards the provision of facilities for artificial insemination for those in prison was in breach of Article 8 of the Convention. This was because that policy failed adequately to weigh

¹⁸⁹ UK/Mental Capacity Act 2005 c.9.

¹⁹⁰ See para 290 below.

¹⁹¹ UK/Adults With Incapacity (Scotland) Act 2000 asp. 4, s64.

¹⁹² UK/Marriage Act 1983 c. 32

http://www.opsi.gov.uk/RevisedStatutes/Acts/ukpga/1983/cukpga_19830032_en_1
(10.10.09).

¹⁹³ UK/ Marriage (Scotland) Act 1977 c.15

http://www.opsi.gov.uk/RevisedStatutes/Acts/ukpga/1977/cukpga_19770015_en_1
(10.10.09).

up the competing considerations and was not sufficiently proportionate in its approach.

[135]. *The Right to Respect of Family Life In Local Authority X v M* [2007] EWHC 2003 (Fam) [2009] 1 FLR 443 M, aged 39 years, had moderate intellectual disabilities (IQ score 56) and also suffered from paranoid schizophrenia. She had been in a relationship with her partner, K, for 15 years, involving several years of off and on cohabitation. K suffered from a psychopathic personality disorder and alcoholism. M had accepted an offer from her local social services authority to reside in supported accommodation. However, under the influence of K, she often left the accommodation and failed to take medication. K had in the past encouraged M to disengage from social service support and had been violent towards her. When K announced that he intended to move to another part of the country and take M with him, the social services authority sought injunctions to the effect that M should reside in the supported accommodation and have only limited and supervised contact with K.

[136]. The court found that M lacked capacity for various things: to decide where she should live, to marry, to litigate, and with whom she had contact. However, it was found that M had capacity to consent to sexual relations,¹⁹⁴ and that contact with K improved her mental well-being. The court proceeded to make various orders, concerning residence and contact between M and K. However the court also referred specifically to Article 8 of the Convention and the right to respect for private and family life,¹⁹⁵ expressing the view that orders which interfered with the private lives of M and K respectively must be in compliance with it. The requirement of proportionality meant that '[t]he court should intervene only where there is a need to protect a vulnerable adult from abuse or the real possibility of abuse'.¹⁹⁶ This, therefore, puts in place a higher threshold for intervention than the customary 'best interests' criterion, in order to respect the privacy and family rights of persons suffering from a mental disorder from unwarranted interference by the state.

[137]. The cases discussed at paragraph 100 above are relevant here also.

¹⁹⁴ The test for this is found in *X City Council v MB, NB and MAB (by his litigation friend the Official Solicitor)* [2006] EWHC 168 (Fam), [2006] 2 FLR 968. The test is whether the person in question has the ability to choose whether or not to engage in sexual activity, which involves a rudimentary understanding of what that activity entails.

¹⁹⁵ *Local Authority X v M* [2007] EWHC 2003 (Fam) [2009] 1 FLR 443 at para 101 et seq.

¹⁹⁶ *Local Authority X v M* [2007] EWHC 2003 (Fam) [2009] 1 FLR 443 para 118.

3.8. The right to have children and maintain parental rights [29].

- [138]. *The right to have children* In UK law there is no substantive positive right to have children. However, the state does provide, through the National Health Service, access to IVF treatment free of charge. In *Dickson v UK* (2008) 46 EHRR 41¹⁹⁷ the European Court held that this entails some degree of access to those treatments for persons in prison and also, by implication, those subject to involuntary placement by reason of mental disorder.
- [139]. *The right to maintain parental rights* In the UK the concept of parental rights has been replaced to a large extent by the concepts of parental duties and responsibilities. Involuntary placement or involuntary treatment does not of itself trigger any change to a person's legal duties and responsibilities as a parent. Any 'right' to maintain contact with one's children, when continued contact is in dispute, depends on an application of the welfare principle found in the relevant legislation in all jurisdictions.¹⁹⁸ Having said that, it is generally accepted that the best interests of children is to have continued continuing contact with their parents. And of course it is possible to find in the UNCRC (which the UK has ratified) various relevant rights.¹⁹⁹
- [140]. In domestic law, visitors to premises are bare licensees (i.e. entry onto the property is only lawful with the permission of those who run or manage the property in question, and permission may be refused or withdrawn). However, hospital patients are regarded as having a right to be visited anyone of their choice,²⁰⁰ and '[t]he decision to prohibit a visit by any person whom the patient has requested to visit or agreed to see should be regarded as a serious interference with the rights of

¹⁹⁷ See para 134 above.

¹⁹⁸ UK/Children Act 1989, s1(1) (England and Wales)

http://www.opsi.gov.uk/acts/acts1989/Ukpga_19890041_en_1.htm (09.10.09); UK/Children (Scotland) Act 1995 c.36, s16(1)

http://www.opsi.gov.uk/acts/acts1995/ukpga_19950036_en_1 (09.10.09); UK/Children (Northern Ireland) Order 1995 SI 1995/755 (N.I. 2)

http://www.opsi.gov.uk/si/si1995/uksi_19950755_en_1 (09.10.09).

¹⁹⁹ See for example Article 5 (States Parties shall respect the responsibilities, rights and duties of parents), Article 7 (the right to know and be cared for by his or her parents), Article 8 (States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference), Article 9(3) (States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests).

²⁰⁰ Department of Health (2008) *Mental Health Act 1983 Code of Practice*, para 19.2.

the patient’.²⁰¹ Visitors will only be denied access to or excluded from hospital premises, or conditions placed on their visits, if there is a clinical or security-based need to so do.²⁰² Visits by children may also be prohibited on the grounds that it is not in the best interests of the child to allow a visit to take place.

- [141]. Although there is no legal right in the domestic legislation regarding the maintenance of parental rights, the issue is dealt with in the Codes of Practice which have been published under section 118 *Mental Health Act 1983* in England and Wales. The Welsh Code, which is typical, requires hospitals to have sufficiently flexible arrangements so as to allow regular visiting of their inpatients.²⁰³ Regarding visits by children, hospitals are required to have child-friendly visiting arrangements. The Code advises those who operate the hospital system that ‘the child’s rights in relation to private and family life should be protected, and their wishes taken into account in the decision-making process’.²⁰⁴
- [142]. The Welsh Code also requires that ‘[i]n planning and preparing for visits by children to parents, relatives or carers, mental health professionals must consider the needs of the child and should make appropriate and safe arrangements for them to visit, including appropriate facilities. Although it is important to maintain relationships, a visit by a child should only take place after a risk assessment and full multi-agency agreement that the visit would be in the child’s best interests. Decisions to allow such visits should be regularly reviewed’.²⁰⁵
- [143]. The same policy applies whether a hospital placement is involuntary or informal. However, if a visit to an informal patient is denied, consideration should be given to utilising the deprivation of liberty safeguards found in the Mental Capacity Act 2005.²⁰⁶
- [144]. In Scotland, section 278 *Mental Health (Care and Treatment) (Scotland) Act 2003*²⁰⁷ places an explicit legal duty on persons having functions under the Act to ‘take such steps as are practicable and appropriate to m.
- [145]. Oitigate the impairment or diminution’ of a parent/child relation by reason of either the parent or the child being subject to compulsory measures under the Act.

²⁰¹ Department of Health (2008) *Mental Health Act 1983 Code of Practice* para 19.11.

²⁰² Department of Health (2008) *Mental Health Act 1983 Code of Practice* paras 19.9-19.11.

²⁰³ Welsh Assembly (2008) *Mental Health Act 1983 Code of Practice for Wales* para 20.6.

²⁰⁴ Welsh Assembly (2008) *Mental Health Act 1983 Code of Practice for Wales* para 20.8.

²⁰⁵ Welsh Assembly (2008) *Mental Health Act 1983 Code of Practice for Wales* para 20.9.

²⁰⁶ See paras 324-329 below.

²⁰⁷ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13.

3.9. The right to property [30].

[146]. There is no right to property as such in the UK. However, UK law has long protected property rights, including the rights of those who lack capacity to manage their own property and affairs by reason of mental disorder or intellectual disability, through various mechanisms such as the trust. The contemporary schemes for managing the property of those lacking capacity are found in the *Mental Capacity Act 2005*²⁰⁸ (which applies in England and Wales) and the *Adults with Incapacity (Scotland) Act 2000*²⁰⁹ (which applies in Scotland). The Northern Ireland Assembly intends to legislate for a similar scheme in the near future. These schemes are described in detail in Part 5 below. To date, no significant caselaw has been generated by either of the existing schemes.

3.10. The right to vote [31].

[147]. All patients who are informally accommodated in hospital or detained under civil law powers are entitled to vote in all elections in the UK. A person who is likely to be living in hospital accommodation for some time may register to vote using the hospital as his or her home address.²¹⁰

[148]. The situation is different for those detained under criminal powers.²¹¹ Such persons may not vote.²¹² The legality of this situation is open to question following the decision of the European Court in *Hirst v UK* (2005),²¹³ in which it was held that a blanket ban on the ability of convicted criminal prison inmates to vote violates Article 3 of Protocol 1.²¹⁴ The same argument applies, if anything with greater force, to those detained under legislation which provides for the detention of mentally disordered offenders in psychiatric hospitals.

[149]. At the time of writing the UK Government has not responded to the decision in *Hirst*, although it has consulted twice, in 2006-07 and

²⁰⁸ UK/Mental Capacity Act 2005 c.9.

²⁰⁹ UK/Adults With Incapacity (Scotland) Act 2000 asp. 4, s64.

²¹⁰ UK/Representation of the People Act 1983 c.2, s7.

www.opsi.gov.uk/RevisedStatutes/Acts/ukpga/1983/cukpga_19830002_en_1 (10.10.09).

²¹¹ These are found in UK/Mental Health Act 1983 c.20, Part III (England and Wales); UK/Criminal Procedure (Scotland) Act 1995, Part VI (Scotland); UK/Mental Health (Northern Ireland) Order 1986, Part III (Northern Ireland).

²¹² UK/Representation of the People Act 1983 c.2, s3A.

²¹³ *Hirst v UK* (No.2) (2004) 38 E.H.R.R. 40.

²¹⁴ This provides that 'The High Contracting Parties undertake to hold free elections at reasonable intervals by secret ballot, under conditions which will ensure the free expression of the opinion of the people in the choice of the legislature'.

again this year (the consultation period ended on 29th September 2009).²¹⁵ The first consultation asked questions about those detained in hospitals following contact with the criminal justice system, but it has now been decided that the voting rights of persons in this group will be the subject of a separate consultation.²¹⁶

- [150]. The *Representation of the People Act 2000*²¹⁷ gives all electors suffering from blindness, physical incapacity or incapacity to read (which would encompass a number of people with intellectual disability) the right to vote with the assistance of a companion.²¹⁸ The *Electoral Administration Act 2006* contains provision²¹⁹ requiring local authorities to review access to voting stations for all persons, including those who are disabled. It also abolished the common law rule that a person lacks legal capacity to vote by reason of mental disorder.²²⁰

²¹⁵ Ministry of Justice (2009) *Voting Rights of Convicted Prisoners Detained within the United Kingdom: Second stage consultation* available at <http://www.justice.gov.uk/consultations/docs/prisoner-voting-rights.pdf> (15.10.09).

²¹⁶ Ministry of Justice (2009) *Voting Rights of Convicted Prisoners Detained within the United Kingdom: Second stage consultation*, page 13.

²¹⁷ UK/Representation of the People Act 2000 c.2.

²¹⁸ UK/Representation of the People Act 2000 c.2, s13.

²¹⁹ UK/Electoral Administration Act 2006 c.22, s18
http://www.opsi.gov.uk/ACTS/acts2006/ukpga_20060022_en_1 (15.10.09).

²²⁰ UK/Electoral Administration Act 2006 c.22, s73.

4. Involuntary placement and Involuntary Treatment

[151]. The UK was covered in the Report on *Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in EU-Member States*. However, as already mentioned in this Review, there has been significant reform of the law in England, Wales and Scotland in the years following the publication of that Report, and in Northern Ireland substantial reform is expected in the next two years. Moreover, the information given in that Report focuses almost entirely on the situation in England and Wales.

[152]. In England and Wales, the main changes from the situation described in the 2002 Report are:

- The abolition of the sub-categories of mental disorder mentioned on page 139 of the Report. This was the Government's preferred way to parry the controversy about its proposal to introduce particular controls over those with a 'dangerous and severe personality disorder', discussed at pages 145-6 of the Report. The new definition is non-specific but broad enough to cover those judged to have this disorder.
- 'Immoral conduct' and 'sexual deviancy' have been removed from the list of disorders which can not alone justify involuntary placement for mental disorder²²¹
- The removal of the requirement of admission for treatment, that treatment in hospital would be 'likely to alleviate or prevent a deterioration' of the patient's condition. The new criterion²²² is that 'appropriate medical treatment is available'.
- The introduction of new Community Treatment Orders to allow greater control over patients leaving an involuntary hospital placement, and the corresponding repeal of the Mental Health (Patients in the Community) Act 1995 mentioned on page 142 of the Report.
- The introduction of greater safeguards against the inappropriate use of ECT.²²³

²²¹ See para 29 above.

²²² See para 188 below.

²²³ See para 243 below.

- The provision of greater rights to refuse treatment to some young people who have been made subject to an involuntary placement.²²⁴
- Greater flexibility about which professionals may undertake various functions under the Act.
- It should be noted that although the author of the UK Chapter in the Report was able to state, at page 144, that the use of compulsory powers is ‘balanced by a comprehensive system of safeguards and independent checks on their use’, there has been subsequently a number of significant judicial decisions finding various aspects of that system deficient in terms of human rights protection.

[153]. In Scotland, the main changes from the situation described in the 2002 Report are:

- The introduction of new Community Treatment Orders to allow greater control over patients without the need for involuntary hospital placement.²²⁵
- The establishment of the Mental Health Tribunal for Scotland, to which all applications for long-term detention must be made. The Tribunal has taken over that responsibility from Sheriffs, as described at page 143 of the Report. The Tribunal also now hears appeals against, and reviews of, detention.
- Greater flexibility in disposal options for criminal courts, including a new Assessment Order.²²⁶

[154]. *Summary of the main and most relevant findings of the United Nations Committee Against Torture related to involuntary placement and involuntary treatment in the UK [33].* The most recent set of findings of the CAT²²⁷ are concerned with the prohibition of torture, anti-terrorism measures, and prison conditions. There are no findings relevant to involuntary placement or treatment of persons for mental disorder.

²²⁴ See para 179 below.

²²⁵ See paras 162, 167 below.

²²⁶ See sections 52B-52J UK/Criminal Procedure (Scotland) Act 1995, inserted by UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s130.

²²⁷ United Nations Committee Against Torture (2006) *Consideration of Reports Submitted by State Parties under Article 19 of the Convention: Comments by the Government of the United Kingdom of Great Britain and Northern Ireland to the conclusions and recommendations of the Committee against Torture* CAT/C/GBR/CO/4/Add. 18 June 2006
[http://www.unhcr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/a425c34563cf26f3c1257195002985b8/\\$FILE/G0642534.pdf](http://www.unhcr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/a425c34563cf26f3c1257195002985b8/$FILE/G0642534.pdf) (15.10.09).

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- [155]. *Summary of the main and most relevant findings of the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment related to involuntary placement and involuntary treatment in the UK [34].* The CPT visited the UK most recently in November 2008.²²⁸ However, this visit focussed on prison conditions, the situation of persons deprived of their liberty by the police, and the conditions in which those held in immigration centres are kept. These topics were also the main focus of the reports made by the CPT in 2007 and 2005. The most recent visit in which the situation of those subject to involuntary placement or treatment for mental disorder was considered took place from 12 to 23 May 2003.²²⁹
- [156]. The CPT visited the State (High Security) hospital in Carstairs, Scotland. The CPT emphasised that its delegation received no complaints about ill treatment and found the atmosphere in the hospital to be relaxed and staff-patient relations good.²³⁰ The delegation did receive information about ill-treatment, mainly in relation to the use of restraint and although very few complaints made by patients were upheld the delegation considered that the need for managerial action, for example in terms of better training for staff, was indicated.²³¹ The delegation found no examples of over-medication, and that the staff at the hospital organised activities and events which improved or maintained patient morale, and generally adopted a holistic approach to patients' treatment. Although the delegation did find living conditions generally satisfactory, concern was expressed about sanitary facilities in parts of the hospital, particularly those made available for female patients.²³² The

²²⁸ See <http://www.cpt.coe.int/documents/gbr/2008-12-05-eng.htm> (10.10.09).

²²⁹ European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (2005) *Report to the Government of the United Kingdom on the visit to the United Kingdom and the Isle of Man carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 12 to 23 May 2003* <http://www.cpt.coe.int/documents/gbr/2005-01-inf-eng.pdf> (10.10.09).

²³⁰ European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (2005) *Report to the Government of the United Kingdom on the visit to the United Kingdom and the Isle of Man carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 12 to 23 May 2003*, p42.

²³¹ European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (2005) *Report to the Government of the United Kingdom on the visit to the United Kingdom and the Isle of Man carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 12 to 23 May 2003*, p43.

²³² European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (2005) *Report to the Government of the United Kingdom on the visit to the United Kingdom and the Isle of Man carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 12 to 23 May 2003*, p44.

Committee suggested that the wards of the hospital be renovated and privacy in sanitary facilities be improved.²³³

- [157]. The CPT expressed concern about the detention of persons without treatment,²³⁴ the use of handcuffs to effect the transfer between wards of one patient²³⁵ and emphasised the need to distinguish clearly between seclusion and ‘time out’ and ensure that seclusion is used for as limited a time as possible.²³⁶ Concern was also expressed that patient complaints to outside bodies such as the police had to be transmitted by hospital staff which might disincline some patients to make such complaints.
- [158]. Analysing this data, based on one hospital, and extrapolating from it to the systems of involuntary detention and treatment that apply across the UK in any meaningful way is problematic. The conditions in this hospital are better than those sometimes found elsewhere.²³⁷ The practice of seclusion in Carstairs would appear to be much more in line with the requirements of the various Codes of Practice (or, in Scotland, guidance from the Mental Welfare Commission) than in other high security hospitals in the UK.²³⁸ There is also evidence that in some hospitals staff have still not received adequate training in the use of restraint techniques.²³⁹

²³³ European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (2005) *Report to the Government of the United Kingdom on the visit to the United Kingdom and the Isle of Man carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 12 to 23 May 2003*, p44.

²³⁴ European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (2005) *Report to the Government of the United Kingdom on the visit to the United Kingdom and the Isle of Man carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 12 to 23 May 2003*, p46.

²³⁵ European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (2005) *Report to the Government of the United Kingdom on the visit to the United Kingdom and the Isle of Man carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 12 to 23 May 2003*, p47.

²³⁶ European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (2005) *Report to the Government of the United Kingdom on the visit to the United Kingdom and the Isle of Man carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 12 to 23 May 2003*, p48.

²³⁷ See for example Mental Health Act Commission (2009) *Coercion and consent: monitoring the Mental Health Act 1983 MHAC thirteenth Biennial Report 2007-2009*, paras 1.61-1.154 http://www.cqc.org.uk/db/documents/MHAC_Biennial_Report_0709_final.pdf (10.10.09).

²³⁸ See paras 265-267 below.

²³⁹ Mental Health Act Commission (2009) *Coercion and consent: monitoring the Mental Health Act 1983 MHAC thirteenth Biennial Report 2007-2009*, para 1.148.

4.1. Legal Framework

4.1.1. The general framework [35].

- [159]. Involuntary placement and treatment for mental disorder in the UK is regulated by various statutory schemes. In England and Wales, the scheme is found in the *Mental Health Act 1983*,²⁴⁰ amended in significant ways by the *Mental Health Act 2007*.²⁴¹ In Scotland, the relevant law was significantly recast by the *Mental Health (Care and Treatment) (Scotland) Act 2003*.²⁴² The involuntary placement and involuntary treatment of a person who has come to the attention of the criminal justice system is, however, provided for not by the Act of 2003 but instead by Part 6 of the *Criminal Procedure (Scotland) Act 1995*.²⁴³ In Northern Ireland the legal framework is found in the *Mental Health (Northern Ireland) Order 1986*.²⁴⁴ The Northern Ireland Assembly has recently consulted²⁴⁵ on proposed reform of both mental health and mental capacity law. New law is expected in force by April 2011. The proposals in Northern Ireland are for a framework which combines elements of the reforms that recently took place in England and Wales, and Scotland.
- [160]. *The distinction between involuntary placement and involuntary treatment* [36]. In England and Wales, a distinction is made between involuntary placement (whether for assessment or for treatment) and involuntary treatment. Involuntary placement is provided for by parts II and III of the *Mental Health Act 1983*. Once an involuntary placement has come into existence, the detained person may be treated, in accordance with the rules in Part IV of the 1983 Act. In Northern Ireland, the *Mental Health (Northern Ireland) Order 1986* follows the same pattern.
- [161]. In Scotland, section 44 *Mental Health (Care and Treatment) (Scotland) Act 2003* provides for short-term detention for medical

²⁴⁰ UK/Mental Health Act 1983 c.20.

²⁴¹ UK/Mental Health Act 2007 c.12

http://www.opsi.gov.uk/acts/acts2007/ukpga_20070012_en_1 (15.10.09).

²⁴² UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp.13.

²⁴³ UK/Criminal Procedure (Scotland) Act 1995 c.46.

²⁴⁴ UK/Mental Health (Northern Ireland) Order 1986 No. 595 (N.I. 4).

²⁴⁵ The consultation period ended on 31 March 2009. See further, Department of Health, Social Services and Public Safety (2009) 'Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland', available at <http://www.dhsspsni.gov.uk/legislative-framework-for-mental-capacity.pdf>, last accessed 8 September 2009.

assessment or treatment, up to a maximum of 28 days.²⁴⁶ Medical treatment may be given to a person subject to such an order,²⁴⁷ but if given must be in accordance with the rules found in Part 16 of the 2003 Act.

- [162]. There is no direct equivalent in Scotland to the admission for treatment order that applies elsewhere in the UK. The relevant order is, rather, a Compulsory Treatment Order.²⁴⁸ Such an order will always involve a degree of compulsion, and may but need not contain an element requiring that the person subject to the order be detained in a hospital. Rather, involuntary placement is an adjunct of involuntary treatment, which is the central purpose of a Community Treatment Order.
- [163]. *Involuntary placement without treatment* [37]. In all jurisdictions in the UK, the assumption built into the relevant legislation is that, once a person has been made subject to an involuntary placement, treatment will follow.
- [164]. In England and Wales, in order for the involuntary placement of any person for a period greater than 28 days to come into existence, it must be certified that ‘appropriate medical treatment is available for him’ in the place in which he or she is to be detained.²⁴⁹ If there is no appropriate medical treatment available in that place, the placement may not come into existence.
- [165]. However, the concept of treatment is widely defined.²⁵⁰ It ‘includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care’. The legislation further provides²⁵¹ that any reference to medical treatment ‘shall be construed as a reference to medical treatment, the purpose of which is to alleviate, or prevent the worsening of, the disorder or one or more of its symptoms or manifestations’. The concept has been widely interpreted by the courts, so that the mere fact of involuntary placement in a secure, controlled, or benign environment comes within the definition of the term.²⁵²

²⁴⁶ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp.13, s44(5)(b). This period may be renewed for up to three further working days (i.e. not including weekends) in order to allow time for a Compulsory Treatment Order to be applied for: see section 47.

²⁴⁷ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp.13, s44(5)(b).

²⁴⁸ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp.13, part 7.

²⁴⁹ UK/Mental Health Act 1983 c.20, ss 3(2)(d) and 37(2)(a)(i).

²⁵⁰ UK/Mental Health Act 1983 c.20, s145(1).

²⁵¹ UK/Mental Health Act 1983 c.20, s145(4).

²⁵² See for example Lord Hope of Craighead in *Reid v Secretary of State for Scotland* [1999] 2 AC 512 at 529, holding that ‘treatment’ may include a wide variety of interventions ‘from cure to containment’.

- [166]. In Northern Ireland, the situation is similar to that which operates in England and Wales. It differs, however, in that (i) admission for treatment must follow admission for assessment,²⁵³ which need not be the case in England and Wales; and (ii) the patient must be diagnosed as suffering from either mental illness or severe mental impairment,²⁵⁴ rather than the more generic ‘mental disorder’ in England and Wales.
- [167]. In Scotland, as already mentioned the relevant order authorises compulsory treatment, which may or may not involve involuntary placement in a hospital. Amongst the criteria to be satisfied for the making of a Community Treatment Order is the requirement that medical treatment which would be likely to prevent the mental disorder from worsening or alleviate any symptoms or effects of the disorder is available for the patient.²⁵⁵ A Community Treatment Order may include a requirement that the subject of the Order submit to involuntary placement in a hospital²⁵⁶ and may also authorise the provision of medical treatment to that person.²⁵⁷
- [168]. The presence of a treatable mental disorder is required for an order sending a person convicted by a criminal court to hospital rather than prison, or transferring such a person from prison to hospital. However, it is specifically provided in the 2003 Act that patients who have arrived in hospital from the criminal justice system may be detained ‘whether for treatment or not’ if that ‘is necessary, in order to protect any other person from serious harm’.²⁵⁸
- [169]. In all jurisdictions, in rare cases, involving patients judged to be a danger to others (typically but not necessarily ‘restricted’ patients) there will be no suitable treatment, or there is treatment available but the patient refuses to avail him- or herself of it. In such a situation, although initial placement may not occur, continued detention will nonetheless be lawful, if the patient continues to meet the *Winterwerp*²⁵⁹ criteria and continued detention is a proportionate response.²⁶⁰
- [170]. *The aims pursued by the relevant legal framework [38]*. In each jurisdiction within the UK, the legislation follows non-specific aims and provides decision-makers with a cafeteria-style choice to justify

²⁵³ UK/Mental Health (Northern Ireland) Order 1986 No. 595 (N.I. 4), art 12.

²⁵⁴ UK/Mental Health (Northern Ireland) Order 1986 No. 595 (N.I. 4), art 12(1)(a).

²⁵⁵ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp.13, ss57(2)(b), 64(5)(b).

²⁵⁶ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp.13, s66(1)(a).

²⁵⁷ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp.13, s66(1)(b).

²⁵⁸ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp.13, ss206, 212.

²⁵⁹ *Winterwerp v The Netherlands* (1979-1980) 2 EHRR 387.

²⁶⁰ See *A, D and R v Scottish Ministers* [2001] UKPC D5, upheld by the Strasbourg Court in *Hutchinson Reid v UK* (2003) 37 EHRR 211.

an involuntary placement on the basis of one or more of (i) the patient's health; (ii) the patient's welfare; (iii) public protection.

- [171]. In England and Wales, the criteria referred to above, as well as requiring that hospital treatment must be necessary and available, stipulate that involuntary placement must also be 'necessary for the health or safety of the patient or for the protection of other persons'.²⁶¹ In Northern Ireland, the phrase used is 'failure to so detain the patient would create a substantial likelihood of serious physical harm to himself or to other persons'.²⁶² In Scotland, amongst the criteria for both short-term detention and the making of a Community Treatment Order is that, without the order in question 'there would be a significant risk to the health, safety or welfare of the patient or to the safety of any other person'.²⁶³
- [172]. *Aftercare* [39]. In England and Wales local healthcare providers and social services authorities are required to provide aftercare following the ending of an involuntary placement 'until such time as the [health care provider] and the local social services authority are satisfied that the person concerned is no longer in need of such services'.²⁶⁴ This requirement applies to patients detained for treatment under section 3, or sent to hospital by a criminal court under section 37 45A, or transferred from prison under section 47 or 48.²⁶⁵ It does not apply to patients released from short-term detention under sections 2, 4 or 5.
- [173]. In Scotland there is no longer a specific duty to provide aftercare. This duty was abolished by the *Mental Health (Care and Treatment) (Scotland) Act 2003*, and has been subsumed into a general duty placed by the 2003 Act²⁶⁶ on local authorities, in co-operation with healthcare providers and voluntary organisations,²⁶⁷ to provide or secure the provision of care and support services 'for persons who are not in hospital and who have or have had a mental disorder'.²⁶⁸
- [174]. Although aftercare may be a condition of release, there is no absolute obligation on local healthcare bodies and social services departments to provide it. In *R v Camden and Islington Health Authority, ex parte*

²⁶¹ UK/Mental Health Act 1983 c.20, s3(2)(c).

²⁶² UK/Mental Health (Northern Ireland) Order 1986 No. 595 (N.I. 4), art 12(1)(b).

²⁶³ UK/ Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, ss44(4)(d), 57(2)(c), 64(5)(c).

²⁶⁴ UK/Mental Health Act 1983 c.20 s.117(2).

²⁶⁵ UK/Mental Health Act 1983 c.20 s.117(1).

²⁶⁶ UK/ Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s25.

²⁶⁷ UK/ Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, ss 30,31.

²⁶⁸ Section 26 places a further duty on local authorities to provide or secure the provision of services which are designed to promote the well-being and social development of persons who have or have had mental disorder. Section 227 places a duty on mental health officers to assess a patient's need for community care services and to organise their provision if necessary.

K [2001] 3 WLR 553 the Court of Appeal held that the duty to provide aftercare permits local providers discretion as to the nature and extent of services provided. In that case a tribunal had found that *K*, a patient detained following the making of a hospital order and a restriction order by a criminal court, could be discharged from hospital, conditional on her accepting aftercare in the shape of psychiatric supervision following her release. However it proved impossible to find a psychiatrist willing to accept *K* as a patient.

- [175]. *K* went to court and argued that the duty to provide aftercare is absolute, and also that the failure to provide it breached her rights under Article 5(1) of the Convention. The Court of Appeal held that the duty to provide aftercare is not absolute. Rather, it is to 'use reasonable endeavours to fulfil the conditions imposed by such a decision'.²⁶⁹ In a later case, in which again it had proven impossible to find a psychiatrist willing to treat a restricted patient who had been made subject to an order for conditional discharge by a MHRT, a House of Lords judge said that the duty is to use 'best endeavours'.²⁷⁰ In both cases, as the patient remained mentally disordered and, in the absence of aftercare, in need of treatment in hospital, the court held that there was no breach of Article 5(1) of the Convention in them remaining in hospital. The *ex parte K* case went to the European Court,²⁷¹ which upheld the decision of the UK courts.

4.1.2. Special provision for particular groups

- [176]. *Children and young people* [40]. In general terms, the legal regime for involuntary treatment applies to children as it does to adults in each jurisdiction in the UK. There are, however, some special measures designed specifically for some child patients.
- [177]. In England and Wales, ECT may not be given to a child if he or she has capacity and refuses to consent. Even with consent, a second opinion in favour of the treatment is required from a doctor approved for this purpose. This applies whether or not the child is detained or not, or in hospital or not. If the child lacks capacity, treatment may be given if an Approved Clinician certifies that is appropriate.
- [178]. In England and Wales, the *Mental Health Act* 1983 following reform in 2007 now²⁷² places a duty on hospital managers to give notice to all social services authorities working in the same area as the hospital that

²⁶⁹ *R v Camden and Islington Health Authority, ex parte K* [2001] 3 WLR 553 per Lord Phillips at para 20.

²⁷⁰ *R v SSHD and SSH, ex parte IH* [2003] UKHL 59 per Lord Bingham at para 29.

²⁷¹ *Kolanis v UK* 42 EHRR 12, (2006) 42 EHRR 12, [2005] ECHR 411.

²⁷² UK/Mental Health Act 1983 c.20, s140(b).

their hospital has accommodation available which is ‘specially suitable for patients who have not attained the age of 18 years’. In addition, the 2007 reforms introduced a new section, which applies to both detained and informal patients below the age of 18.²⁷³ Hospital managers ‘shall ensure that the patient’s environment in the hospital is suitable having regard to his age (subject to his needs),’²⁷⁴ and must do this in consultation with ‘a person who appears to them to have knowledge or experience of cases involving patients who have not attained the age of 18 years which makes him suitable to be consulted’,²⁷⁵ which means a specialist in children’s mental health.²⁷⁶

- [179]. There is further regulation in the form of the Codes of Practice issued under the 1983 Act. The net effect of this is that children below the age of 16 should not be detained on the same wards as adult patients.²⁷⁷ For young people of 16 or 17 years of age, it is more likely, but increasingly rare, that they will be housed on the same ward as an adult. Insofar as the ward environment has therapeutic implications, to this extent there is a degree of special regulation of treatment.
- [180]. When the involuntary detention of a child for treatment is required, this has often been achieved ‘informally’, with consent to the child’s detention and treatment authorised by a parent, or other person or body with parental responsibility. Sections 131(2) and (3) *Mental Health Act 1983* provide that a young person of 16 or 17 can give consent to hospitalisation, rather than it being sought from a person with parental responsibility, if he or she has capacity to make that decision.²⁷⁸ The autonomy of those with capacity is bolstered by section 131(4), which provides that where the young person in question has capacity and does not consent, hospitalisation may not be authorised by a person with parental responsibility. If such a young person is to be detained, therefore, it can only be under the terms of the 1983 Act.
- [181]. However, it should be noted that section 131(4) is of limited application. It only applies if the young person in question is found to have capacity, and has no application whatever to young people below the age of 16. This means for the vast majority of children and young

²⁷³ UK/Mental Health Act 1983 c.20, s131A(1).

²⁷⁴ UK/Mental Health Act 1983 c.20, s131A(2).

²⁷⁵ UK/Mental Health Act 1983 c.20, s131A(3).

²⁷⁶ See para. 104, Explanatory Note, Mental Health Act 2007

http://www.opsi.gov.uk/acts/acts2007/en/ukpgaen_20070012_en_1.htm#end (10.10.09).

²⁷⁷ Department of Health (2008) *Mental Health Act 1983 Code of Practice* paras 36.67-36.74, Welsh Assembly (2008) *Mental Health Act 1983 Code of Practice for Wales* paras 33.9-33.13.

²⁷⁸ The test for capacity to be applied is that found in UK/Mental Capacity Act 2005: s131(5)(a) UK/Mental Health Act 1983 c.20.

people, the safeguards afforded to detained patients by the *Mental Health Act 1983* will remain beyond their reach, and involuntary placement and treatment will continue to be authorised on the basis of parental permission.

- [182]. In Scotland, section 2 *Mental Health (Care and Treatment) (Scotland) Act 2003* places a duty on any person exercising duties or powers under the Act in respect of a child patient, apart from persons acting on behalf of the child, to act always in a way which best secures the welfare of the child²⁷⁹. All persons involved in the care and treatment of children must have regard to the matters mentioned in section 1 of the 2003 Act. These include the past and present wishes of the patient, any guardian, carer, welfare attorney or 'named person' (a non-professional person appointed to protect the interests of the patient),²⁸⁰ as well as the importance of the fullest possible participation of the patient in the decision in question,²⁸¹ the greatest information provision to the patient possible,²⁸² and the performance of duties in a non-discriminatory manner, and in a way which minimises the restriction of the freedom of the patient.²⁸³
- [183]. The *Children (Scotland) Act 1995*²⁸⁴ requires that services provided by a local authority under that Act shall be designed to minimise the effect on any disabled child (including a child with mental disorder) who is within the authority's area, of his disability, or the disability of another person in his or her family; and to give those children the opportunity to lead lives which are as normal as possible. Before a compulsory treatment order can be made in respect of a child, his or her needs must be assessed under that section.²⁸⁵ The Code of Practice issued alongside the 2003 Act recommends that when a child is subject to compulsory powers the doctor in charge of his or her treatment should be a child specialist.²⁸⁶ It also advises that if a child detained 'informally' on the basis of parental consent resists treatment consideration should be given to using compulsory powers.²⁸⁷
- [184]. The regime for the administration of medical treatment to patients held on an involuntary placement²⁸⁸ is modified in respect of child

²⁷⁹ UK/Mental Health (Care and Treatment)((Scotland) Act 2003 asp. 13, s1(3).

²⁸⁰ UK/Mental Health (Care and Treatment)((Scotland) Act 2003 asp. 13, ss250-253.

²⁸¹ UK/Mental Health (Care and Treatment)((Scotland) Act 2003 asp. 13, s1(3).

²⁸² UK/Mental Health (Care and Treatment)((Scotland) Act 2003,asp. 13 s1(3).

²⁸³ UK/Mental Health (Care and Treatment)((Scotland) Act 2003 asp. 13, s1(5).

²⁸⁴ UK/Children (Scotland) Act 1995 c.26, s23.

²⁸⁵ UK/Mental Health (Care and Treatment)((Scotland) Act 2003 asp. 13, s62(5)(c)(i).

²⁸⁶ Scottish Executive (2005) *Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice*, Volume 1, para 28.

²⁸⁷ Scottish Executive (2005) *Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice*, Volume 1, para 34.

²⁸⁸ Discussed at paras 240-245 below.

patients, in that any second opinion, required because the patient lacks capacity to consent to the treatment in question, must be given by a specialist in the mental health of children.²⁸⁹ For treatment which destroys brain tissue or brain functioning, a child with capacity, as with an adult, can refuse the treatment if he or she has capacity. Even where there is consent, a second opinion must be sought from an approved doctor, and if the patient is a child this doctor must also be a designated child mental health specialist.²⁹⁰

[185]. *Other groups (persons in guardianship, offenders with mental disorders, persons with addictive behaviour, etc...)* [41]. The *Mental Health Act 1983*²⁹¹ in England and Wales, and the *Mental Health (Northern Ireland) Order 1986*²⁹² in Northern Ireland, are comprehensive in their coverage. The *Mental Health (Care and Treatment) (Scotland) Act 2003*²⁹³ in Scotland applies to all groups of patients, with the exception that offenders with mental disorder are covered also by the *Criminal Procedure (Scotland) Act 1995*.²⁹⁴ There is no other statute in any jurisdiction which provides for persons in guardianship, offenders with mental disorders and so on to be detained involuntarily in a hospital.

[186]. However, the *Mental Capacity Act 2005*,²⁹⁵ as amended in 2007, does provide the legal basis for actively preventing a person lacking capacity leaving a place in which he or she is accommodated, on the basis that to do so is in that person's best interests. The new regime was introduced in 2007 in response to the decision of the European Court in the *Bournewood* case.²⁹⁶ This will be discussed in part 6 below.

4.2. Criteria and Definitions [42].

[187]. In England and Wales, the criteria for involuntary placement are found in the *Mental Health Act 1983*.²⁹⁷ In order to be admitted and detained in hospital for medical assessment, the person in question must be 'suffering from mental disorder of a nature or degree which

²⁸⁹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, ss236(6), 239(3), 241(3).

²⁹⁰ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s235(6).

²⁹¹ UK/Mental Health Act 1983 c.20.

²⁹² UK/Mental Health (Northern Ireland) Order 1986 No. 595 (N.I. 4).

²⁹³ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13.

²⁹⁴ UK/Criminal Procedure (Scotland) Act 1995 c.46.

²⁹⁵ UK/Mental Capacity Act 2005 c.9

http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1 (15.10.09).

²⁹⁶ *HL v UK* (2005) 40 EHRR 32.

²⁹⁷ UK/Mental Health Act 1983 c.20.

warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment)'.²⁹⁸ It must also be considered that 'he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons'. This second criterion elides three different justifications for detention: health, safety or the protection of others. Detention is lawful if any one or more of these requirements is met.

- [188]. Admission and detention for medical treatment is permitted if (i) the person in question 'is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital'; (ii) 'it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such and it cannot be provided unless he is detained under this section'; and (iii) 'appropriate medical treatment is available for him'.²⁹⁹
- [189]. An offender may before or on conviction be made subject to a hospital order by a criminal court. Here the criteria require that (i) 'the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment'; (ii) 'appropriate medical treatment is available for him'; and (iii) 'the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section'.³⁰⁰
- [190]. In Scotland, the criteria for involuntary placement are found in the *Mental Health (Care and Treatment) (Scotland) Act 2003*.³⁰¹ Short-term detention in a hospital is lawful (i) if 'the patient has a mental disorder'; (ii) 'because of the mental disorder, the patient's ability to make decisions about the provision of medical treatment is significantly impaired; (iii) 'it is necessary to detain the patient in hospital for the purpose of determining what medical treatment should be given to the patient or giving medical treatment to the patient'; (iv) 'the patient were not detained in hospital there would be a significant risk to the health, safety or welfare of the patient or to the safety of any other person'; and (v) 'the granting of a short-term detention certificate is necessary'.³⁰²

²⁹⁸ UK/Mental Health Act 1983 c.20, s2.

²⁹⁹ UK/Mental Health Act 1983 c.20, s2.

³⁰⁰ UK/Mental Health Act 1983 c.20, s37.

³⁰¹ UK/ Mental Health (Care and Treatment)((Scotland) Act 2003 asp. 13.

³⁰² UK/ Mental Health (Care and Treatment)((Scotland) Act 2003 asp. 13, s44.

- [191]. There is no direct equivalent in Scotland to the admission for treatment order that applies elsewhere in the UK. The relevant order is, rather, a Compulsory Treatment Order. Such an order will always involve a degree of compulsion, and may, but need not, contain an element requiring that the person subject to the order be detained in a hospital. The criteria for a Compulsory Treatment Order provide that a Compulsory Treatment Order may be made by a Tribunal if (i) the patient has a mental disorder; (ii) medical treatment which would be likely to prevent the mental disorder worsening or alleviate any of the symptoms, or effects, of the disorder is available for the patient; (iii) the patient were not provided with such medical treatment there would be a significant risk to the health, safety or welfare of the patient or to the safety of any other person; (iv) because of the mental disorder the patient's ability to make decisions about the provision of such medical treatment is significantly impaired; (v) the making of a compulsory treatment order in respect of the patient is necessary.³⁰³
- [192]. An offender may before or on conviction be made subject to an assessment order³⁰⁴ or a treatment order³⁰⁵ by a criminal court, at the request of the prosecutor³⁰⁶ or the Scottish Ministers.³⁰⁷ The criteria for these orders are essentially the same as those which apply to the making of a compulsion order in respect of a convicted offender (these are detailed immediately below).
- [193]. A convicted offender may be made subject to a compulsion order, which can authorise detention in a hospital,³⁰⁸ involuntary treatment in that hospital³⁰⁹ and or other measures such as attending as an outpatient for medical treatment for mental disorder.³¹⁰ The criteria for a compulsion order³¹¹ are: (i) that the offender has a mental disorder; (ii) that medical treatment likely to alleviate the symptoms or effects of, or prevent a worsening of, that person's mental disorder is available; (iii) that without medical treatment there would be a significant risk to the health, safety or welfare of the offender or the safety of any other person; and (iv) that the making of the order is necessary. The court must also consider the circumstances of the case, the antecedents of the offender and the possibility of dealing with the offender in any other way.³¹²

³⁰³ UK/ Mental Health (Care and Treatment)((Scotland) Act 2003 asp. 13, s64(5).

³⁰⁴ UK/Criminal Procedure (Scotland) Act 1995 c.46, s52D.

³⁰⁵ UK/Criminal Procedure (Scotland) Act 1995 c.46, s52M.

³⁰⁶ UK/Criminal Procedure (Scotland) Act 1995 c.46, ss52B, 52K.

³⁰⁷ UK/Criminal Procedure (Scotland) Act 1995 c.46, ss52C, 52L.

³⁰⁸ UK/Criminal Procedure (Scotland) Act 1995 c.46, s57A(8)(a).

³⁰⁹ UK/Criminal Procedure (Scotland) Act 1995 c.46, s57A(8)(b).

³¹⁰ UK/Criminal Procedure (Scotland) Act 1995 c.46, s57A(8)(c).

³¹¹ UK/Criminal Procedure (Scotland) Act 1995 c.46, ss57A(3), (4).

³¹² UK/Criminal Procedure (Scotland) Act 1995 c.46, s57A(4).

- [194]. *The criteria in combination* [43]. In all jurisdictions, the health, safety and protection of others criteria are alternatives and may be relied upon by those seeking to establish an involuntary placement in any combination.
- [195]. *The consideration of alternatives to involuntary placement* [44]. In no jurisdiction in the UK does the obligation to consider alternatives to the use of involuntary powers constitute an explicit statutory criterion. However, in all jurisdictions, the criteria for use by those making and granting applications for involuntary placement require consideration of alternatives before deciding on the placement.
- [196]. In England and Wales, an involuntary placement is almost always instigated by an Approved Mental Health Professional.³¹³ An Approved Mental Health Professional must not make an application for involuntary admission unless he or she is ‘satisfied that such an application ought to be made’ and that ‘it is necessary or proper for the application to be made by him’.³¹⁴ An exercise of professional judgment on these questions necessarily involves a consideration of the alternatives to involuntary placement. Similarly, the two medical recommendations upon which an involuntary placement must be founded are required to confirm that detention in hospital is ‘appropriate’, and it is ‘necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained’.³¹⁵
- [197]. The English Code of Practice provides that ‘[b]efore it is decided that admission to hospital is necessary, consideration must be given to whether there are alternative means of providing the care and treatment which the patient requires. This includes consideration of whether there might be other effective forms of care or treatment which the patient would be willing to accept, and of whether guardianship would be appropriate instead’.³¹⁶ The Welsh Code of Practice requires all those involved in the admission process to give consideration to alternatives to involuntary placement,³¹⁷ and further states that ‘Compulsory admission powers should only be exercised if there is no effective alternative way of providing support or treatment available’.³¹⁸ In Northern Ireland, the situation is essentially the same as in England and Wales.³¹⁹

³¹³ This is a specific post created by the legislation. For further details see para 264 below.

³¹⁴ UK/Mental Health Act 1983 c.20, s13(1A).

³¹⁵ UK/Mental Health Act 1983 c.20, s3(2)(a).

³¹⁶ Department of Health (2008) *Mental Health Act 1983 Code of Practice* para 4.4.

³¹⁷ Welsh Assembly (2008) *Mental Health Act 1983 Code of Practice for Wales* para 2.18.

³¹⁸ Welsh Assembly (2008) *Mental Health Act 1983 Code of Practice for Wales* para 2.27.

³¹⁹ The Department of Health, Social Services and Public Safety has published a Code of Practice for Northern Ireland. This is not currently available on line.

- [198]. In Scotland, a short-term detention may be authorised on the basis of the recommendation of an approved doctor,³²⁰ but that person must consult, and obtain the consent of, a Mental Health Officer.³²¹ All applications for a Community Treatment Order must be made by a Mental Health Officer³²² and orders can only be made by a Tribunal. All of these actors must consider that the criteria for involuntary placement are met and, as elsewhere in the UK, the proper application of them requires consideration of alternatives. A Mental Health Officer, for example, must prepare a Care Plan for consideration by the Tribunal and must state whether in his or her opinion involuntary placement is necessary. The Scottish Code of Practice requires the Mental Health Officer to provide various kinds of information to the Tribunal, including information about alternatives to involuntary placement and, if these are alternatives are not considered appropriate, why that is the case.³²³
- [199]. *The relevance of the patient's opinion to the criteria for involuntary treatment* [45]. In England and Wales, and Northern Ireland, there is no provision in the relevant legislation which requires those treating a detained patient to consider the opinion of the patient, except in those instances where treatment cannot be given without the consent of the patient.³²⁴ However, in the English case of *R(PS) v G(RMO) and W (SOAD)* [2003] EWHC 2335³²⁵ it was said that the fact that the patient has capacity and refuses to consent to the treatment in question are important factors to be taken into account by a doctor deciding whether or not to administer treatment.
- [200]. The expectation that patients should play an active role in discussions regarding their treatment is expressed in the Codes of Practice issued under the 1983 Act. In Wales, the Code of Practice is prefaced by various general principles, including the principle that '[p]atients should be involved in the planning, development and delivery of their care and treatment to the fullest extent possible'.³²⁶ The Code elaborates on this: 'patients should be enabled to be as fully involved in the process as they want and to the extent their capacity allows. Mental health professionals undertaking assessments should give due regard to patients' present and past wishes including any advance

³²⁰ UK/Mental Health (Care and Treatment)((Scotland) Act 2003 asp. 13, s44(1).

³²¹ UK/Mental Health (Care and Treatment)((Scotland) Act 2003 asp. 13, ss44(3)(c)(d).

³²² UK/Mental Health (Care and Treatment)((Scotland) Act 2003 asp. 13, 63(1). The role of the Mental Health Officer in Scotland is similar to that of the Approved Mental Health Professional in England and Wales, as described at para 271 below.

³²³ Scottish Executive (2005) Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice, Volume Two, Paras 26 and 68, available at <http://www.scotland.gov.uk/Publications/2005/08/30105347/53499> (21.09.2009).

³²⁴ See para 241 below.

³²⁵ *R(PS) v G(RMO) and W (SOAD)* [2003] EWHC 2335, para 119.

³²⁶ Welsh Assembly (2008) *Mental Health Act 1983 Code of Practice for Wales*, page 6.

decisions. Those subject to compulsion under the Act should be encouraged to participate actively in their own care'.³²⁷ The English Code is prefaced by similar principles.³²⁸

- [201]. In Scotland too, there is no specific provision to consider the opinions of the patient before giving treatment. However, Section 1 of the 2003 Act places a duty on any person discharging any function under the Act in a professional capacity to give regard to the present and past wishes of the patient, and to those of any relevant carer, guardian or welfare attorney, where applicable.³²⁹ This requirement is reiterated in the Scottish Code of Practice.³³⁰
- [202]. *The relevance of dangerousness and dangerousness thresholds* [46]. In general terms, in all jurisdictions in the UK, 'dangerousness' is not mentioned as a separate and distinct criterion in the legislation. Instead, it is subsumed under the 'safety of other persons' criterion for involuntary placement.³³¹ In England and Wales, the only instance of a specific reference to 'dangerousness' appears in section 25 *Mental Health Act 1983*. This gives the doctor in charge of an involuntary patient's treatment in hospital power to veto an application for discharge made by the nearest relative of the patient, if in the opinion of that doctor the patient, if discharged from hospital, 'would be likely to act in a manner dangerous to other persons or himself'.³³² In no jurisdiction is there specific mention in the legal framework of danger thresholds. Nor, therefore, is there any discussion in caselaw of such thresholds.

³²⁷ Welsh Assembly (2008) *Mental Health Act 1983 Code of Practice for Wales*, para 1.11.

³²⁸ Department of Health (2008) *Mental Health Act 1983 Code of Practice*, para 1.5.

³²⁹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, ss1(2),(3).

³³⁰ Scottish Executive (2005) *Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice*, Volume 1, para 03.

<http://www.scotland.gov.uk/Publications/2005/08/29100428/04289> (15.10.09).

³³¹ See para 187 above.

³³² UK/Mental Health Act 1983 c.20, s25. The equivalent provision in Northern Ireland instead uses the phrase 'a substantial likelihood of serious physical harm to himself or to other persons': UK/Mental Health (Northern Ireland) Order 1986, art 14(4)(a).

4.3. Assessment, Decision Procedures and Duration

4.3.1. The expertise of medical staff involved in the decision procedure for involuntary admission [47].

[203]. In England and Wales, except in an emergency, the decision procedure for involuntary placement involves two registered medical practitioners,³³³ both of whom must examine the patient prior to the making of an application for involuntary hospital admission. One of these must be on the list of approved psychiatrists maintained by the Secretary of State for Health, known as ‘Approved Clinicians’.³³⁴ To be approved, the doctor must have ‘special experience in the diagnosis of mental disorder’. This means that this person will be a trained psychiatrist. He or she should ideally also have prior acquaintance with the particular patient.³³⁵ The other need have no special experience of mental disorders and will often be a General Practitioner. If the expert does not, this second doctor should ‘if practicable’ have previous acquaintance with the patient.³³⁶

[204]. In urgent cases, placement for a maximum of 72 hours may be authorised on the basis of the recommendation of one medical practitioner, who should if practicable have previous acquaintance with the patient.³³⁷ It is not a requirement of this procedure that the medical practitioner have any special knowledge or experience in the diagnosis of mental disorder.

[205]. In Northern Ireland, admission for assessment or for treatment requires one medical recommendation from a doctor appointed by the Mental Health Commission for this purpose.³³⁸ This person will be a psychiatrist. There is no separate emergency procedure in Northern Ireland, although it is provided that, except in cases of urgency, the requisite medical recommendation may not be given by a doctor on the staff of the detaining hospital.³³⁹

[206]. In Scotland, the requirement for short-term detention is for examination of the patient by one ‘approved medical practitioner’,

³³³ UK/Mental Health Act 1983 c.20, ss2(3), 3(3).

³³⁴ Defined in UK/Mental Health Act 1983 c.20, s145(1).

³³⁵ UK/Mental Health Act 1983 c.20, s12(2).

³³⁶ UK/Mental Health Act 1983 c.20, s12(2).

³³⁷ UK/Mental Health Act 1983 c.20, s4(3).

³³⁸ UK/Mental Health (Northern Ireland) Order 1986, Arts 4(3), 12(1).

³³⁹ UK/Mental Health (Northern Ireland) Order 1986, Art6(c).

who may issue a short-term detention certificate with the agreement of a mental health officer.³⁴⁰ As in England, Wales and Northern Ireland, in order to be ‘approved’ a doctor must have ‘special experience in the diagnosis and treatment of mental disorder’,³⁴¹ which in practice means that this person will be a trained psychiatrist. The requirement for the making of a Compulsory Treatment Order is that the patient has been examined by two doctors, both of whom must be approved medical practitioners unless one is the patient’s General Practitioner. No other General Practitioner may be involved in the admission decision, unlike in the rest of the UK.³⁴²

[207]. Although the legislation in each UK jurisdiction refers only to the role in the admission decision procedure of doctors, in reality this will usually be a multi-disciplinary decision and this is reflected in the various Codes of Practice. In Wales, the Code requires that an Approved Mental Health Professional consult others involved with the patient’s treatment when deciding whether to make an application for involuntary admission,³⁴³ as does the English Code.³⁴⁴ The Scottish Code specifically states that ‘[i]t is essential that the decision to proceed with a Compulsory Treatment Order application is only taken after all the relevant members of the patient’s multi-disciplinary team have engaged in as much prior discussion as is practicable of the need for the application’.³⁴⁵

[208]. *The number of experts involved* [48]. This has been answered by information given immediately above. In all jurisdictions except Northern Ireland, two doctors are required to support any application for a long-term placement. In England and Wales, the same procedure applies to short-term placements for assessment. In Scotland and Northern Ireland, only one doctor is required. In all jurisdictions, the opinion of one doctor only is required in order to apply for an emergency involuntary placement, except in Northern Ireland where there is no distinct emergency placement procedure, and where the procedure for admission for assessment functions in both urgent and non-urgent situations.

³⁴⁰ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, ss44(1),(4).

³⁴¹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s22(1)(a).

³⁴² UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, ss57(2), 58.

³⁴³ Welsh Assembly (2008) *Mental Health Act 1983 Code of Practice for Wales*, para 2.50.

³⁴⁴ Department of Health (2008) *Mental Health Act 1983 Code of Practice*, para4.69.

³⁴⁵ Scottish Executive (2005) *Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice*, Volume Two, Ch 3.04.

4.3.2. The authority which decides on an involuntary placement [49].

- [209]. In England and Wales, there are technically two possibilities. In either case, the decision to initiate an involuntary placement must be founded on the requisite medical recommendations. An involuntary placement can be initiated by the Nearest Relative of the person to be detained.³⁴⁶ However in practice it is rare for a Nearest Relative to make an application for admission. The second possibility, and which applies in nearly every case, is that the decision to place is made by an ‘Approved Mental Health Professional’. This is a person who has been approved by a local social services authority, acting in accordance with centrally prescribed regulations, to perform various functions under the MHA 1983.
- [210]. Such a person must have demonstrated ‘appropriate competence in dealing with persons who are suffering from mental disorder’ to the satisfaction of the local social services authority concerned.³⁴⁷ The *Mental Health (Approval of Persons to be Approved Mental Health Professionals) (England) Regulations 2008*³⁴⁸ require that in order to be approved as an Approved Mental Health Professional, a person must be one of the following: a social worker; a nurse with practice experience in mental health; a learning disability nursing; an occupational therapist; or a chartered psychologist.³⁴⁹ That person must also have undertaken a government-approved course of training within the last five years,³⁵⁰ of at least 18 hours duration.³⁵¹ Training includes study of methods for combating discrimination and promoting the human rights and dignity of patients, as well as providing knowledge of relevant law and policy. An Approved Mental Health Professional is also required to demonstrate critical knowledge

³⁴⁶ UK/Mental Health Act 1983 c.20, s11(1). The term ‘Nearest Relative’ is defined in s26.

³⁴⁷ UK/Mental Health Act 1983 c.20, s114(3).

³⁴⁸ UK/Mental Health (Approval of Persons to be Approved Mental Health Professionals) (England) Regulations 2008 SI 1206/2008
http://www.opsi.gov.uk/si/si2008/uksi_20081206_en_1 (15.10.09). There are similar requirements in Wales. These are found in the Mental Health (Approval of Persons to be Approved Mental Health Professionals) (Wales) Regulations 2008 SI 2436/2008
http://www.opsi.gov.uk/legislation/wales/wsi2008/wsi_20082436_en_1 (15.10.09).

³⁴⁹ UK/Mental Health (Approval of Persons to be Approved Mental Health Professionals) (England) Regulations 2008 SI 1206/2008, reg 3(1) and schedule 1.

³⁵⁰ UK/Mental Health (Approval of Persons to be Approved Mental Health Professionals) (England) Regulations 2008 SI 1206/2008, reg 3(3).

³⁵¹ UK/Mental Health (Approval of Persons to be Approved Mental Health Professionals) (England) Regulations 2008 SI 1206/2008, reg 5(a).

of models of and treatments for mental disorder, as well as the social and cultural impact and context of mental disorder.³⁵²

- [211]. An Approved Mental Health Professional must locate hospital accommodation for the patient to be involuntarily placed. An application for admission is addressed to the managers of the hospital in question.³⁵³ Thus in practice, the hospital managers, and those who would be responsible for the treatment of the patient if admitted, have some sway on the decision to admit. Any application, as explained above, must also be founded on two medical recommendations.
- [212]. Essentially the same system operates in Northern Ireland in respect of admission for assessment, although at present only the patient's nearest relative or a social worker, and no other professional, may make an application.³⁵⁴ Admission for treatment can only be initiated if the patient is already detained for assessment.³⁵⁵ The process requires one psychiatrist, not being the psychiatrist who examined the patient before that person's admission to hospital for assessment,³⁵⁶ to examine the patient and report to the hospital managers that the criteria for admission for treatment are met.³⁵⁷ No other professional need be involved in the process.
- [213]. In Scotland, short-term detention, up to a maximum of 28 days,³⁵⁸ is authorised by a approved registered practitioner (a psychiatrist), with the approval of a Mental Health Officer.³⁵⁹
- [214]. All applications for a Compulsory Treatment Order must be heard by the Mental Health Tribunal for Scotland. The tribunal system was set up by Part 3 of the *Mental Health (Care and Treatment) (Scotland) Act 2003*, replacing the previous system that was operated by Sheriff's Courts. The tribunal has powers³⁶⁰ to make various compulsory orders including involuntary placement and the provision of medical treatment. A Tribunal is constituted by three persons, one of whom will be a lawyer, one a doctor and one a 'general member'.³⁶¹ The 'general member' must have relevant training, skills or experience in

³⁵² UK/Mental Health (Approval of Persons to be Approved Mental Health Professionals) (England) Regulations 2008 SI 1206/2008, schedule 2.

³⁵³ UK/Mental Health Act 1983 c.20, s11(2).

³⁵⁴ UK/Mental Health (Northern Ireland) Order 1986 SI 1986/595 (NI 4), Art 5(1)(b).

³⁵⁵ UK/Mental Health (Northern Ireland) Order 1986 SI 1986/595 (NI 4), Art 12(1).

³⁵⁶ UK/Mental Health (Northern Ireland) Order 1986 SI 1986/595 (NI 4), Art 12(2)(a).

³⁵⁷ UK/Mental Health (Northern Ireland) Order 1986 SI 1986/595 (NI 4), Art 12(1).

³⁵⁸ The period can be extended for up to three further days to allow time for an application for a Compulsory Treatment Order to be made: UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s47(4). Section 68 allows an extension period of 5 days if an application has already been made for a Compulsory Treatment Order under s63.

³⁵⁹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s44(1), (3)(d).

³⁶⁰ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s66.

³⁶¹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, Schedule 2, para 1.

dealing with mental disorder and Regulations³⁶² provide that this person must be one of the following: a registered nurse, a clinical psychologist, a social worker, an occupational therapist, or another person employed in the care sector. In any case the person concerned must have experience either as service user or as a service provider.³⁶³

4.3.3. The authority which decides on termination of an involuntary placement [50].

[215]. In England and Wales, there are various ways in which an involuntary placement may be terminated. The most common way is for the doctor in charge of the patient's treatment to decide that treatment and/or involuntary placement, is no longer required. The Nearest Relative of the patient may also apply to the managers of the detaining hospital for an order for discharge,³⁶⁴ although as detailed elsewhere in this Report³⁶⁵ the doctor in charge of the patient's hospital treatment may veto such an application by stating that the patient would be a danger to self or others if discharged.³⁶⁶ Hospital managers have their own independent powers of discharge and may discharge a patient even if the doctor in charge of that person's treatment advises against it.³⁶⁷ The Secretary of State for Health also has powers to order the discharge of a patient.³⁶⁸

[216]. The situation is essentially the same for patients whether detained under civil powers or by reason of having come into contact with the criminal justice system, although a patient who is 'restricted' because of the risk posed to other people can only be discharged by the Secretary of State or, if by any other person or body entitled to discharge the patient, with the consent of the Secretary of State.³⁶⁹

[217]. All patients may also apply, or have his or her situation referred, to a Tribunal for an order for discharge from detention.³⁷⁰ If successful, and the patient leaves hospital, it will not be possible to give that person treatment without consent unless and until a further involuntary placement has been made. A restricted patient can be

³⁶² UK/Mental Health Tribunal for Scotland (Appointment of General Members) Regulations 2004 SSI 2004 No. 375, <http://www.opsi.gov.uk/legislation/scotland/ssi2004/20040375.htm> (21.09.09).

³⁶³ UK/The Mental Health Tribunal for Scotland (Appointment of General Members) Regulations 2004 SSI 2004 No. 375, reg2(1)(a).

³⁶⁴ UK/Mental Health Act 1983 c.20, s23(2)(a).

³⁶⁵ See para 202 above.

³⁶⁶ UK/Mental Health Act 1983 c.20, s25(1).

³⁶⁷ *R v Huntercombe Maidenhead Hospital, ex parte SR* [2005] EWH 3361.

³⁶⁸ UK/Mental Health Act 1983 c.20, ss25(3) and 42(2).

³⁶⁹ UK/Mental Health Act 1983 c.20, s41(3).

³⁷⁰ UK/Mental Health Act 1983 c.20, Part IV.

discharged by a tribunal, irrespective of the views of the Secretary of State.³⁷¹ The system in Northern Ireland is in all salient respects very similar to that which operates in England and Wales.³⁷²

- [218]. In Scotland, a short-term detention order can be revoked before its automatic expiry or temporary extension³⁷³ by the doctor responsible for the patient's treatment in hospital.³⁷⁴ That doctor is under a duty to review the patient's situation and must revoke the certificate authorising short-term detention if the criteria for detention cease to be met.³⁷⁵ The patient may also apply to the Tribunal for revocation of the certificate, which must revoke it if in its opinion the criteria for detention cease to be met.³⁷⁶ The Mental Welfare Commission has independent powers to revoke a certificate if of the view that the criteria for detention cease to be met.³⁷⁷
- [219]. A patient subject to involuntary placement as a component of a Compulsory Treatment Order may be discharged in various ways. Chapter 4 of Part 7 of the 2003 Act deals with the review and revocation of Compulsory Treatment Orders. The patient's responsible medical officer must review the appropriateness of the continuation of the order at least two months before its expiration date (and subsequent expiration dates if the order is renewed),³⁷⁸ and must revoke the order if the conditions authorising initial placement cease to apply.³⁷⁹ The Mental Welfare Commission again has independent discretionary powers to revoke a Compulsory Treatment Order, again if satisfied that the conditions justifying its making cease to be met.³⁸⁰
- [220]. A patient subject to a Compulsory Treatment Order, or that person's 'named person' may apply to the Tribunal for the revocation of the order, once three months have passed since the order was made.³⁸¹ The Welfare Commission for Scotland has a discretion to refer any matter with regard to a Compulsory Treatment Order to the Tribunal

³⁷¹ UK/Mental Health Act 1983 c.20, s73.

³⁷² UK/Mental Health (Northern Ireland) Order 1986 SI 1986/595 (NI 4), arts 14(1), 48(2), Part V (which establishes the Mental Health Review Tribunal for Northern Ireland).

³⁷³ See para 213 above.

³⁷⁴ This doctor is known as the 'responsible medical officer' or RMO, and is appointed under UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s230 when a Compulsory Treatment Order is made.

³⁷⁵ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s49(2).

³⁷⁶ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s50(4).

³⁷⁷ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s51.

³⁷⁸ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, ss77,78.

³⁷⁹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s80.

³⁸⁰ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s81.

³⁸¹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s51.

for any reason, which may result in the revocation of a Compulsory Treatment Order.³⁸²

4.3.4. Converting an informal placement into an involuntary placement [51].

- [221]. Throughout the UK, there is no formal legal procedure for the initiation of a voluntary placement. A patient in need of inpatient treatment for mental disorder or intellectual disability will be admitted in the same way as any other inpatient for any other reason.
- [222]. In England and Wales, a voluntary placement can be converted into an involuntary placement for assessment or treatment.³⁸³ In Northern Ireland, it is only possible to convert a voluntary placement into an involuntary placement for assessment.³⁸⁴
- [223]. Emergency powers are also available in England and Wales. If the patient is already in hospital and the nature of the emergency is that the patient is attempting to leave the hospital in circumstances which the medical staff have concerns about, section 5 *Mental Health Act 1983* applies. The doctor in charge of the patient's treatment in hospital or another doctor approved for this purpose, or another doctor who has been delegated the powers of the doctor in charge³⁸⁵ may by written report to the hospital managers instigate the formal admission procedure. Once that report has been submitted, the patient may be detained for 72 hours.³⁸⁶ Senior nurses also have powers to detain a patient for six hours where it is necessary for his or her health or safety or the protection of other persons that he or she be 'immediately restrained' from leaving the hospital.³⁸⁷ Thereafter, the placement procedure for the involuntary placement is the same as applies to an initially involuntary placement.
- [224]. The situation is the same in Northern Ireland, which provide holding powers for any doctor on the staff of the hospital, and nurses of the prescribed class respectively.³⁸⁸
- [225]. In Scotland, there is no order providing solely for involuntary placement. The appropriate action when it is desired to convert a voluntary placement into an involuntary placement is to make a short-

³⁸² UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s98.

³⁸³ UK/Mental Health Act 1983 c.20, s5.

³⁸⁴ UK/Mental Health (Northern Ireland) Order 1986, art 7.

³⁸⁵ UK/Mental Health Act 1983 c.20, s5(3A).

³⁸⁶ UK/Mental Health Act 1983 c.20, s5(2).

³⁸⁷ UK/Mental Health Act 1983 c.20, s5(4).

³⁸⁸ UK/Mental Health (Northern Ireland) Order 1986, arts 7(2), 7(3).

term detention order or apply to a tribunal for a Compulsory Treatment Order. Again, the initial placement procedure applies as it does if the patient had not already been in hospital. As in the rest of the UK, emergency powers are also available. A person already in hospital can be detained for up to 72 hours on the authority of a doctor³⁸⁹ and 6 hours on the authority of a nurse.³⁹⁰ These powers should not however be used when it is equally possible to apply for a short-term detention order.

- [226]. In all jurisdictions, whether or not emergency powers have been used, the initial placement procedure applies in exactly the same way as it would had the patient not already been in hospital.

4.3.5. Time limits

- [227]. *The maximum period of time between the psychiatric assessment and the beginning of the compulsory placement* [52]. In England and Wales, Section 12(1) *Mental Health Act 1983* requires that the two medical recommendations must be ‘signed on or before the date of the application’ and, if the two doctors concerned have examined the patient separately, those examinations must be no more than five days apart. An application for admission, once completed, gives the legal authority to an Approved Mental Health Professional to take the patient to hospital, but the authority to admit will only subsist for 14 days after the latest medical recommendation was given.³⁹¹ This means that there is a potential maximum period of 19 days.
- [228]. In Northern Ireland, the requisite medical recommendation needed to support an admission for assessment must be made no more than two days after the doctor making the recommendation has personally examined the patient,³⁹² and the patient must be conveyed to hospital within two days of the making of the recommendation.³⁹³
- [229]. In Scotland, a short-term detention certificate must be acted on within three days.³⁹⁴ A Mental Health Officer must apply for a Compulsory Treatment Order within 14 days of the more recent of the two medical recommendations.³⁹⁵

³⁸⁹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s36.

³⁹⁰ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s299.

³⁹¹ UK/Mental Health Act 1983 c.20, s6(1)(a).

³⁹² UK/Mental Health (Northern Ireland) Order 1986, art6(a).

³⁹³ UK/Mental Health (Northern Ireland) Order 1986, art8(1)(b)(i). This can be extended to upto 14 days in exceptional circumstances on the authorisation of an approved medical practitioner: art 8(1)(b)(ii).

³⁹⁴ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s44(5)(a).

³⁹⁵ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s57(7).

- [230]. *The duration which applies in emergency situations* [53]. In England and Wales, the maximum duration in the case of an emergency application is 24 hours, beginning at the time the patient was examined by a registered medical practitioner or from the time the application for admission was made, whichever is the earlier.³⁹⁶
- [231]. In Northern Ireland, there is no separate provision for emergency situations and the procedure for admission for assessment is used. In a case of urgency, but not otherwise, a doctor on the staff of the detaining hospital may give the necessary medical recommendation.³⁹⁷
- [232]. In Scotland, a doctor may grant an emergency detention certificate which authorises the removal of the patient to hospital within 72 hours, and his or her detention there for 72 hours from admission if not previously in hospital or from the making of the emergency detention certificate if the patient was in hospital when it was made.³⁹⁸
- [233]. *The maximum duration of an initial placement* [54]. In England and Wales, a placement for assessment may last no longer than 28 days.³⁹⁹ There can not be a renewal, or new approval, of further detention for assessment: any further detention must conform to the requirements for admission for treatment.⁴⁰⁰
- [234]. A placement for treatment may last for a maximum of six months.⁴⁰¹ A new approval is required at that time, of a further six months in the first instance.⁴⁰² Thereafter renewal is required at yearly intervals.⁴⁰³
- [235]. In Northern Ireland, admission for assessment must be followed immediately by a medical examination of the patient by a doctor other than the one which made the initial recommendation for admission.⁴⁰⁴ If that doctor is the one in charge of the patient's care in hospital, or a doctor approved for these purpose by the Mental Health Commission for Northern Ireland, and is of the opinion that detention for assessment is necessary, the patient may be detained for a maximum of seven days.⁴⁰⁵ The maximum is two days if any other doctor makes the report.⁴⁰⁶ The period of detention can be extended twice for a

³⁹⁶ UK/Mental Health Act 1983 c.20,s6(1)(b).

³⁹⁷ UK/Mental Health (Northern Ireland) Order 1986, art6(c).

³⁹⁸ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s36(1),(8).

³⁹⁹ UK/Mental Health Act 1983 c.20, s2(4).

⁴⁰⁰ UK/Mental Health Act 1983 c.20, s2(4).

⁴⁰¹ UK/Mental Health Act 1983 c.20, s20(1).

⁴⁰² UK/Mental Health Act 1983 c.20, s20(2)(a).

⁴⁰³ UK/Mental Health Act 1983 c.20, s20(2)(b).

⁴⁰⁴ UK/Mental Health (Northern Ireland) Order 1986, art9(2).

⁴⁰⁵ UK/Mental Health (Northern Ireland) Order 1986, art9(4)(a).

⁴⁰⁶ UK/Mental Health (Northern Ireland) Order 1986, art9(4)(b).

further seven days on the recommendation of the doctor in charge of the patient's treatment in hospital, up to a maximum of 21 days.⁴⁰⁷

- [236]. Detention for medical treatment is for a maximum of six months in the first instance,⁴⁰⁸ renewable once for a further six months⁴⁰⁹ and thereafter annually.⁴¹⁰
- [237]. In Scotland, the grant of a short-term detention certificate authorises the detention of the patient in hospital for a maximum of 28 days, beginning when the certificate is granted if the patient is already in hospital, or when the patient is admitted to hospital if not already in hospital.⁴¹¹ A short-term detention order cannot be renewed but it can be extended for five working days.⁴¹² If an order is extended the Tribunal must determine whether to make an interim order and, if not, determine the application.⁴¹³
- [238]. A Compulsory Treatment Order can be made on an interim basis by a Tribunal. An interim Order cannot last more than 28 days⁴¹⁴ and can be renewed only once, making a maximum of 56 days.⁴¹⁵ Where either a full or an interim Compulsory Treatment Order is made authorising the removal of the patient to a hospital, the removal must occur within seven days of its making.⁴¹⁶
- [239]. The maximum duration of a full Compulsory Treatment Order is six months in the first instance.⁴¹⁷ At that point the Compulsory Treatment Order can be extended for a further six months in the first instance⁴¹⁸ and thereafter at yearly intervals.⁴¹⁹ Extension decisions are made by the patient's RMO but the RMO's decision is subject to review by the Tribunal,⁴²⁰ to which the RMO must send a report of any extension decision.⁴²¹ If the RMO determines that the Compulsory Treatment Order should continue but that its terms should be varied,

⁴⁰⁷ UK/Mental Health (Northern Ireland) Order 1986, art9(7), (8).

⁴⁰⁸ UK/Mental Health (Northern Ireland) Order 1986, art12(1).

⁴⁰⁹ UK/Mental Health (Northern Ireland) Order 1986, art13(1)(a).

⁴¹⁰ UK/Mental Health (Northern Ireland) Order 1986, art 13(1)(b), (c).

⁴¹¹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s44(5)(b).

⁴¹² UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s68(5).

⁴¹³ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s69.

⁴¹⁴ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s68(5).

⁴¹⁵ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s65(2)(a).

⁴¹⁶ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s67.

⁴¹⁷ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s64(4)(a)(i).

⁴¹⁸ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s86(2)(a).

⁴¹⁹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s86(2)(b).

⁴²⁰ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s101.

⁴²¹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s87(2).

he or she must apply to the Tribunal⁴²² for an extension and variation of the Compulsory Treatment Order.⁴²³

4.3.6. Regulating medical interventions [55].

[240]. In England and Wales, the *Mental Health Act 1983*⁴²⁴ gives to the doctor in charge of an involuntary patient's treatment a general power to provide or authorise treatment in respect of the mental disorder from which the patient is suffering.

[241]. This general power is subject to various limitations. Section 57 of the 1983 Act⁴²⁵ requires that any surgical operation designed to destroy brain tissue or the functioning of brain tissue can only be given when all of the following conditions are met: (i) the patient consents; (ii) a second opinion has been obtained from a doctor approved for this function, who has consulted two other persons professionally involved with the patient's care (not being doctors); (iii) the agreement of two other persons also appointed for this purpose. Those appointed are required to confirm in writing that the patient has given a valid, informed consent and that the treatment should be given.⁴²⁶ There is scope for further treatments to be brought within the scope of section 57,⁴²⁷ but to date this has not happened. This section applies to any patient, not only those held on an involuntary placement.⁴²⁸

[242]. The administration of medicine to a patient, beginning three months after he or she was first given medicine, is only possible either with the consent of the patient or, in cases where the patient is incapable of giving consent or has refused to give it, with the approval of the doctor and other persons appointed for the purpose.⁴²⁹ These persons must confirm in writing that it is 'appropriate for the treatment to be given'. This must be more than a rubber-stamping exercise. A doctor appointed by the state to provide second opinions has 'the responsibility of forming his own independent judgment as to whether or not the treatment should be given'.⁴³⁰ There is scope for further

⁴²² UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s92.

⁴²³ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s103.

⁴²⁴ UK/Mental Health Act 1983 c.20, s63.

⁴²⁵ UK/Mental Health Act 1983 c.20, s57.

⁴²⁶ UK/Mental Health Act 1983 c.20, s57(2)(a).

⁴²⁷ UK/Mental Health Act 1983 c.20, s57(1)(b).

⁴²⁸ UK/Mental Health Act 1983 c.20, s56(1)(b).

⁴²⁹ UK/Mental Health Act 1983 c.20, s58.

⁴³⁰ *R (Wilkinson) v Broadmoor Special Hospital Authority* [2002] 1 WLR 419 per Simon Brown LJ at para 33.

treatments to be brought within the scope of this section,⁴³¹ but to date this has not happened.

- [243]. Section 58A was added to the *Mental Health Act 1983* in 2007 to make specific provision for the regulation of ECT. ECT may only be given to a patient if (i) the patient is an adult who has consented to the treatment and the doctor in charge of that patients' treatment or an 'Approved Clinician' appointed for this purpose has certified in writing that the patient has capacity to consent and has in fact consented;⁴³² (ii) the patient is a minor, whether detained under the Act or not, and whether in hospital or not provided that he or she has consented to the treatment and an Approved Clinician (but not the doctor in charge) has certified in writing that the patient has capacity to consent and has in fact consented;⁴³³ (iii) the patient, adult or minor, has been certified in writing by a doctor appointed for this purpose by the Secretary of State as incapable of giving consent but that it would be appropriate for the treatment to be given.⁴³⁴
- [244]. Feeding by force is not subject to any particular safeguard and is covered by the general permission to treat in section 63.⁴³⁵
- [245]. The law in Northern Ireland is substantively the same as in England and Wales,⁴³⁶ except that the particular protection given to minors in respect of ECT does not yet apply.
- [246]. In Scotland, Responsible Medical Officers are also given a general power to treat, but this of more limited scope than elsewhere in the UK, because in Scotland the consent of the patient is relevant. Treatment may in any case only be administered by force if the patient is in hospital on an involuntary basis.⁴³⁷ If consent is given in writing by a patient with capacity, the treatment in question may be given.⁴³⁸ If the patient has capacity but refuses to consent, or to consent in writing, treatment may only be given if the Responsible Medical Officer, after considering the reasons for the refusal; any views expressed by the patient or the patient's named person; and the likelihood of the treatment alleviating or preventing a deterioration in the patient's condition, determines that it is in the patient's best interests for the treatment to be given.⁴³⁹

⁴³¹ UK/Mental Health Act 1983 c.20, s58(1)(a).

⁴³² UK/Mental Health Act 1983 c.20, s58A(3).

⁴³³ UK/Mental Health Act 1983 c.20, ss58A(4) and s.56(5).

⁴³⁴ UK/Mental Health Act 1983 c.20, ss58A(5).

⁴³⁵ *B v Croydon Health Authority* [1995] 1 ALL ER 683.

⁴³⁶ See UK/Mental Health (Northern Ireland) Order 1986, Part IV.

⁴³⁷ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s242(6).

⁴³⁸ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s242(3).

⁴³⁹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, ss242(4)(a),(5).

- [247]. If the patient lacks capacity, the Responsible Medical Officer must consider the factors referred to above, and also, if relevant, any advance directive made by the patient, and, as with refusing patients, only treat if he or she determines that treatment is in the best interests of the patient.⁴⁴⁰
- [248]. As elsewhere in the UK, this general power to treat is overridden by particular restrictions imposed on particular treatments. Sections 234, 235 and 236 of the 2003 Act apply to treatment the effect of which is to destroy brain tissue or any functioning of brain tissue (psychosurgery).⁴⁴¹ There is scope to add other treatments to this section⁴⁴² but to date this has not been done.
- [249]. If the patient is capable of consenting and does consent in writing, the treatment may nonetheless not be given without certification that consent has been given, and that the treatment is in the best interests of the patient having regard to likelihood of the treatment alleviating or preventing a deterioration in the patient's condition. The certification must be by a designated medical practitioner, appointed for this purpose by the Mental Welfare Commission.⁴⁴³ Two other persons appointed by the Commission for this purpose, not being doctors, must also certify in writing that the patient has capacity and has given consent.⁴⁴⁴ This means that this treatment can not be given to a patient with capacity who refuses to consent to it.
- [250]. If a patient lacks capacity to consent, treatment may only be given if the safeguards relevant to a patient with capacity have been complied with and, in addition, the Responsible Medical Officer has successfully applied to the Court of Session for an order authorising the treatment.⁴⁴⁵ The Court may only make such an order if satisfied both (i) that having regard to likelihood of the treatment alleviating or preventing a deterioration in the patient's condition the treatment is in the patient's best interests and (ii) that the patient does not object to the treatment.⁴⁴⁶ This means that an incapacitated but resisting patient can not be given this treatment.⁴⁴⁷
- [251]. ECT is also subject to specific regulation.⁴⁴⁸ ECT may only be given to a patient who has capacity to consent and who consents in writing if the Responsible Medical Officer or a designated medical practitioner

⁴⁴⁰ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, ss242(4)(a),(5).

⁴⁴¹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s234(2)(a).

⁴⁴² UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s234(2)(b).

⁴⁴³ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, ss235(3).

⁴⁴⁴ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s235(4).

⁴⁴⁵ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s236(4).

⁴⁴⁶ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s236(5).

⁴⁴⁷ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s236(1)(a), (5)(a).

⁴⁴⁸ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, ss237, 238, 239.

certifies in writing that the patient has capacity, has given consent, and that the treatment is in the best interests of the patient having regard to likelihood of the treatment alleviating or preventing a deterioration in the patient's condition.⁴⁴⁹ If the patient lacks capacity, the requirements are as for psychosurgery, provided that the patient does not resist or object to the treatment.⁴⁵⁰

[252]. If the patient, although lacking capacity, does object to or resist the administration of ECT, it may only be given if a designated medical practitioner, and not the Responsible Medical Officer, certifies that although the patient resists or objects to the treatment it is nevertheless necessary that it be given⁴⁵¹ in order to save the patient's life, prevent serious deterioration in his or her condition or alleviate serious suffering, or to prevent the patient from behaving violently or being a danger to self or others.⁴⁵² There is provision to include further treatments within this safeguards regime⁴⁵³ but to date none has been added.

[253]. Section 240 of the 2003 Act covers various treatments. These comprise medicine for the reduction of sex drive; any other medicine, and the provision of artificial nutrition without consent (forced feeding). There is provision to include further treatments within this safeguard regime⁴⁵⁴ but to date this has not been done. If the patient has capacity and consents in writing to the treatment in question it may be given provided the safeguards in section 238 (discussed above in the context of ECT) are met.⁴⁵⁵

[254]. If the patient has capacity but refuses to consent, the treatment may only be given if a designated medical practitioner, and not the Responsible Medical Officer, certifies in writing that the patient does not consent but that the treatment should be given because it is in the best interests of the patient having regard to likelihood of the treatment alleviating or preventing a deterioration in the patient's condition.⁴⁵⁶ The designated medical practitioner must also have regard to the reason for the refusal, if known.⁴⁵⁷ If the patient lacks capacity, the treatment may be given if a designated medical practitioner, and not the Responsible Medical Officer, certifies in writing that the patient lacks capacity but the treatment should be given because it is in the best interests of the patient having regard to

⁴⁴⁹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s238(1).

⁴⁵⁰ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s239(1).

⁴⁵¹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s239(2).

⁴⁵² UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, ss 239(2)(b), 243(3).

⁴⁵³ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s237(3)(b).

⁴⁵⁴ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s240(3)(d).

⁴⁵⁵ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s240(2).

⁴⁵⁶ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s241(1).

⁴⁵⁷ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s241(2).

likelihood of the treatment alleviating or preventing a deterioration in the patient's condition.⁴⁵⁸

4.3.7. Regulating other coercive measures [56].

- [255]. In England and Wales, the *Mental Health Act 1983* makes no mention of restraint and seclusion. However, both issues are discussed in the Code of Practices issued under section 118.⁴⁵⁹ The Code states that '[i]nterventions such as physical restraint, seclusion or rapid tranquillisation should be considered only if de-escalation and other strategies have failed to calm the patient'.⁴⁶⁰ However, restraint and seclusion are not only used to calm a patient. Restraint may be used, for example, to facilitate the administration of treatment in an emergency or in order to avoid an emergency situation.⁴⁶¹
- [256]. Restraint⁴⁶² should only be used as a last resort.⁴⁶³ Hospitals must have written policies on the use of restraint.⁴⁶⁴ Restraint must be used for the least amount of time and using the least amount of force necessary, by staff with appropriate training.⁴⁶⁵
- [257]. Seclusion⁴⁶⁶ similarly, should be used as a last resort,⁴⁶⁷ and hospitals must have written guidelines and procedures for the use of seclusion. The Code also lays down fairly prescriptive requirements for the review of seclusion to ensure its use ends as soon as possible. There should be a multi-disciplinary review as soon as a period of seclusion has commenced⁴⁶⁸ and four—hourly reviews should be carried out by a doctor, with two-hourly reviews being performed by a nurse.⁴⁶⁹ If a patient is secluded for more than eight hours, or for more than 12

⁴⁵⁸ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s241(1).

⁴⁵⁹ Department of Health (2008) *Mental Health Act 1983 Code of Practice* (England) Welsh Assembly (2008) *Mental Health Act 1983 Code of Practice for Wales* (Wales), Department of Health, Social Security and Public Safety *Mental Health (Northern Ireland)) Order 1986 Code of Practice* (Northern Ireland). Only those provisions found in the English Code will be discussed here. The Codes of Wales and Northern Ireland contain similar provisions.

⁴⁶⁰ Department of Health (2008) *Mental Health Act 1983 Code of Practice*, para 15.17.

⁴⁶¹ Department of Health (2008) *Mental Health Act 1983 Code of Practice* paras 15.32-33.

⁴⁶² Department of Health (2008) *Mental Health Act 1983 Code of Practice* see generally, paras. 15.21-15.39.

⁴⁶³ Department of Health (2008) *Mental Health Act 1983 Code of Practice*, para 15.23.

⁴⁶⁴ Department of Health (2008) *Mental Health Act 1983 Code of Practice*, para 15.21.

⁴⁶⁵ Department of Health (2008) *Mental Health Act 1983 Code of Practice*, para 15.22.

⁴⁶⁶ Department of Health (2008) *Mental Health Act 1983 Code of Practice* see generally, paras. 15.43-15.66.

⁴⁶⁷ Department of Health (2008) *Mental Health Act 1983 Code of Practice*, para 15.45.

⁴⁶⁸ Department of Health (2008) *Mental Health Act 1983 Code of Practice*, para 15.50.

⁴⁶⁹ Department of Health (2008) *Mental Health Act 1983 Code of Practice* Para 15.51.

hours in a 48 hour period, a multi-disciplinary review should be conducted by staff not involved in the initial decision to seclude.⁴⁷⁰

- [258]. Although the Code of Practice goes into considerable detail as to best practice, its efficacy as a mechanism to establish minimum standards or maximum acceptable usages is negated to some extent by the decision of the House of Lords in *R v Ashworth Hospital, ex parte Munjaz* [2005] UKHL 58. In this case, the hospital (which accommodates patients considered to need high security care) had introduced a policy of holding two medical reviews daily from the second day of a period of seclusion, and three reviews weekly from the eighth day. It also required daily reviews by the ward manager, two-hourly reviews by nursing staff, a weekly multi-disciplinary review and a monthly report to be made to the hospital's seclusion monitoring group. The patient in question had been secluded for 15 days. As required by the hospital's written policy, his seclusion was reviewed by doctors on three occasions in its second week, rather than the 42 reviews called for by the Code.
- [259]. The House of Lords decided that the Code of Practice did not have the force of law and so does not create binding legal duties and it was therefore lawful for a hospital to depart from the requirements of the Code as to frequency of review if there were 'cogent reasons' for it to do so.⁴⁷¹ Here, there were such reasons. Lord Hope said that 'special considerations need to be applied to the use of seclusion in a high security hospital, bearing in mind that the very reason why patients are there is because they cannot be dealt with by mental health services elsewhere in a way that will protect others from harm'.⁴⁷²
- [260]. In this case it was also held that the hospital's policy did not violate any of Articles 3, 5 or 8 of the Convention. This effectively means that hospitals are free to devise and pursue their own policies, subject to them being reasonable and defensible and based on cogent reasons.
- [261]. In Scotland, restraint and seclusion policy is within the remit of the Mental Welfare Commission for Scotland, which issued Guidance on restraint in 2006⁴⁷³ and seclusion in 2007.⁴⁷⁴ This Guidance is similar in tone to that contained in the Codes of Practice which apply

⁴⁷⁰ Department of Health (2008) *Mental Health Act 1983 Code of Practice* para 15.54.

⁴⁷¹ *R v Ashworth Hospital, ex parte Munjaz* [2005] UKHL 58 per Lord Bingham at para 21.

⁴⁷² *R v Ashworth Hospital, ex parte Munjaz* [2005] UKHL 58 per Lord Hope at para 70.

⁴⁷³ Mental Welfare Commission for Scotland (2006) *Rights, risks and limits to freedom: principles and good practice guidance for practitioners considering restraint in residential care settings* http://www.mwscot.org.uk/web/FILES/Publications/Rights_Risks_web.pdf (10.10.09).

⁴⁷⁴ Mental Welfare Commission for Scotland (2007) *The Use of Seclusion: Guidance on Good Practice* <http://www.mwscot.org.uk/web/FILES/Publications/SeclusionGuidance.pdf> (10.10.09).

elsewhere in the UK. As ‘guidance’ is clearly not legally binding, it is likely that the decision in *Munjaz* applies equally to Scotland as to the rest of the UK, so that hospitals may pursue policies contrary to the guidance. In particular, the recommendation to review a period of seclusion every 15 minutes⁴⁷⁵ does not carry the force of law.

4.3.8. Reviews and appeals concerning the lawfulness of involuntary placement and/or treatment [57].

[262]. In England, Wales and Northern Ireland there is no appeal against involuntary placement, but there is a right to seek a review of the placement by a ‘First-tier Tribunal’ (in England and Wales) or Mental Health Review Tribunal (in Northern Ireland) with powers to order the discharge of the patient from the placement if the conditions for admission are in the opinion of the Tribunal no longer made out.⁴⁷⁶

[263]. In England and Wales, a patient held for assessment may apply within 14 days of admission,⁴⁷⁷ a patient held for treatment within six months of admission.⁴⁷⁸ In Northern Ireland, a patient held for assessment or for treatment may apply within six months of admission.⁴⁷⁹ From the First-tier Tribunal there is a right of appeal, but only on a point of law, to the Upper Tribunal.⁴⁸⁰ There is also the possibility of review, at the request of the patient (or his or her representative), of a First-tier Tribunal decision by a First-tier Tribunal.⁴⁸¹ If the outcome of that review is that the initial decision is set aside, the case may be decided afresh by that Tribunal or be referred to the Upper Tribunal.⁴⁸² An Upper Tribunal may then make a fresh decision. An Upper Tribunal can also review a decision of an Upper Tribunal, at the request of the patient (or his or her representative),⁴⁸³ and may make the decision afresh if that review concludes the initial decision was at fault.⁴⁸⁴

[264]. The decisions of tribunals are subject to judicial review by the High Court and on hearing an application for judicial review the court is

⁴⁷⁵ Mental Welfare Commission for Scotland (2007) *The Use of Seclusion: Guidance on Good Practice*, page 8.

⁴⁷⁶ UK/Mental Health Act 1983 c.20, ss72, 73 (England and Wales); UK/Mental Health (Northern Ireland) Order 1986, arts 74, 75.

⁴⁷⁷ UK/Mental Health Act 1983 c.20, s66(2)(a).

⁴⁷⁸ UK/Mental Health Act 1983 c.20, s66(2)(b).

⁴⁷⁹ UK/Mental Health (Northern Ireland) Order 1986, art 71.

⁴⁸⁰ UK/Tribunals, Courts and Enforcement Act 2007 c.15, s11 (England and Wales) http://www.opsi.gov.uk/ACTS/acts2007/ukpga_20070015_en_2#pt1-ch2-pb3-l1g9 (15.10.09); UK/Mental Health Act 1983 c.20, s78A (Wales).

⁴⁸¹ UK/Tribunals, Courts and Enforcement Act 2007 c.15, s9(2)(b).

⁴⁸² UK/Tribunals, Courts and Enforcement Act 2007 c.15, s9(2)(b).

⁴⁸³ UK/Tribunals, Courts and Enforcement Act 2007 c.15, s10(2)(b).

⁴⁸⁴ UK/Tribunals, Courts and Enforcement Act 2007 c.15, s10(4).

bound by the *Human Rights Act 1998* to protect the human rights of the applicant.

- [265]. In Scotland, the Mental Health Review Tribunal for Scotland is the body which makes a Compulsory Treatment Order, which may contain a requirement that the person subject to the order be detained in a hospital.⁴⁸⁵ There is no right to review of this order by a court, although there is a series of mandatory reviews that must be undertaken by those responsible for treating the patient.⁴⁸⁶ A Compulsory Treatment Order can be extended by the Responsible Medical Officer in charge of the patient's treatment in hospital.⁴⁸⁷ If this is done, the Responsible Medical Officer must notify the Tribunal,⁴⁸⁸ and the patient or his or her named person may apply to the Tribunal for the Compulsory Treatment Order to be revoked.⁴⁸⁹
- [266]. The decisions of the Mental Health Review Tribunal for Scotland are subject to judicial review by the Court of Session and, as elsewhere in the UK, on hearing an application for judicial review the court is bound by the *Human Rights Act 1998* to protect the human rights of the applicant.
- [267]. In all jurisdictions there is no right of appeal against a decision to impose involuntary treatment, but there is a right to seek judicial review of treatment decisions. In *R (Wilkinson) v Broadmoor Special Hospital Authority* [2002] 1 WLR 419 it was established that a court hearing a judicial review application must protect the human rights of the applicant, and must, for example, order the cross-examination of witnesses where necessary to ensure that the treatment in question complies with human rights law.⁴⁹⁰ In practice, this means that a review functions in a way very similar to an appeal.
- [268]. *The availability of free legal support* [58]. In all jurisdictions, free legal support and representation before a tribunal is available. In England and Wales, this is funded by way of the *Mental Health Standard Fee Scheme* operated by the Legal Services Commission.⁴⁹¹ In Northern Ireland, free legal support is available under the *Controlled Legal Representation Scheme*, and in Scotland under the non-means tested legal aid scheme. Legal aid for any further appeal to or review by a court is subject to means and merits criteria.

⁴⁸⁵ See para 214 above.

⁴⁸⁶ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, ch 4.

⁴⁸⁷ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s86.

⁴⁸⁸ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s87.

⁴⁸⁹ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, s99.

⁴⁹⁰ See the discussion at paras 94- 97 above.

⁴⁹¹ Details of the Scheme can be found at

http://www.legalservices.gov.uk/civil/remuneration/mental_health_standard_fee_scheme.asp#defining (15.10.09).

5. Competence, Capacity and Guardianship [59].

- [269]. This Report has been made in the light of a consideration of the *Comparative Study on the Legal Systems of the Protection of Adults Lacking Legal Capacity* (2008),⁴⁹² and the *Second Disability High Level Group Report* (2009).⁴⁹³ It should be noted that the *Comparative Study* deals only with the law in England and Wales, and that although it accurately states the current legal position in that jurisdiction, it also refers to much law, both statutory and judge-made, which has been replaced by the regime now found in the *Mental Capacity Act 2005*.
- [270]. What follows in this section of the current Report should be treated as an updating of the information found in that Study. This Report also considers the situation in Scotland (Northern Ireland will legislate in this area by 2011, in order to introduce a legal framework similar to that now in operation in England and Wales, and the current law in Northern Ireland is therefore not discussed here). The information provided in the *Second Disability High Level Group Report* (2009) has been discussed above, at chapter 2.1 of the current Report.
- [271]. Mental capacity law has been the subject of review and systematic reform in all jurisdictions in the UK in recent years. In the absence of statutory provision relating to personal, including medical, decisions the common law had been developed by the judiciary, but judge-made law cannot provide all the detailed regulation of a statutory regime. Accordingly, first Scotland, in 2000, and then England and Wales, in 2005, have introduced comprehensive legislation which provides detailed regulation and guidance on the meaning of the term capacity, and for all decision-making in respect of persons lacking capacity. The Northern Ireland Assembly intends to introduce a statutory regime in the near future.
- [272]. This section of the Report describes the systems of protection which operate in the UK in respect of persons lacking capacity. However, it is important to realise that the statutory protection schemes are not intended to be used routinely and automatically whenever a person is found to lack capacity. In accordance with the principle of minimum

⁴⁹² <http://www.europarl.europa.eu/activities/committees/studies/download.do?file=23687> (15.09.09).

⁴⁹³ Available at: <http://ec.europa.eu/social/BlobServlet?docId=2790&langId=en> (5.09.09).

intervention, the use of court orders or the appointment of a guardian should be avoided if possible. Accordingly, the legislation in both jurisdictions provides, although to a more limited extent in Scotland, a general authority to act in the best interests of a person lacking capacity without the need for a court order or other formal legal intervention.

- [273]. In England and Wales, the *Mental Capacity Act 2005*⁴⁹⁴ provides such a general authority, available to treatment providers and other carers. ‘Best interests’ is to be judged by reference to a checklist of factors,⁴⁹⁵ including the past and present wishes and feelings of the person lacking capacity. Various other relevant persons - family members, professionals providing care, anyone appointed by the person to act as attorney or any guardian appointed by a court – must be consulted about the decision. If there is any disagreement, that can ultimately be resolved by the Court of Protection.⁴⁹⁶
- [274]. In Scotland, the *Adults with Incapacity (Scotland) Act 2000*⁴⁹⁷ provides for the patient’s GP, and a dentist, nurse, or optician, to certify in writing that the person in question lacks capacity. The certificate then authorises that person to treat or delegate the treatment of the patient for the period specified in the certificate, up to a maximum of one year. Such a decision is subject to appeal.⁴⁹⁸ Part IV of the 2000 Act provides for the managers of hospital, care home or other accommodation for persons lacking capacity to manage the finances and movable property of residents for the benefit of the resident concerned. The system is overseen by the Scottish Commission for the Regulation of Care,⁴⁹⁹ which may revoke the licence to manage funds held by an establishment, subject to appeal by that establishment to the Sheriff.⁵⁰⁰

⁴⁹⁴ UK/Mental Capacity Act 2005 c.9, s5.

⁴⁹⁵ UK/Mental Capacity Act 2005 c.9, s4.

⁴⁹⁶ See para 283 below.

⁴⁹⁷ UK/Adults with Incapacity (Scotland) Act 2000 asp. 4, s47.

⁴⁹⁸ UK/Adults with Incapacity (Scotland) Act 2000 asp. 4, s52.

⁴⁹⁹ UK/Adults with Incapacity (Scotland) Act 2000 asp. 4, s40.

⁵⁰⁰ UK/Adults with Incapacity (Scotland) Act 2000 asp. 4, s45(6).

5.1. The legal framework for the management of the affairs of persons lacking capacity by reason of mental disorder [60].

[275]. The *Mental Capacity Act 2005*⁵⁰¹ makes such provision for the management of affairs of persons with mental disorders and persons with intellectual disability if they are unable to do so in England and Wales. In Scotland, the *Adults with Incapacity (Scotland) Act 2000*⁵⁰² is the relevant statute. In Northern Ireland there is currently no legislation that deals in a comprehensive way with capacity-related issues. However, the Northern Ireland Assembly has recently consulted on the need for modern capacity legislation and intends to have enacted new law by April 2011.⁵⁰³ The legislative proposal in Northern Ireland is for a statutory scheme similar to that introduced in England and Wales by the *Mental Capacity Act 2005*. The current scheme for the management of the affairs of persons lacking capacity is found in the *Enduring Powers of Attorney (Northern Ireland) Order 1987*.

[276]. The legislation in England and Wales, and in Scotland, is prefaced by a set of fundamental principles, which should govern all interactions with persons lacking capacity or of doubtful capacity. In England and Wales, these are:⁵⁰⁴

- There is a presumption in favour of capacity
- A person is not to be treated as lacking capacity unless all practicable steps have been taken to help that person achieve capacity
- Irrationality must not be confused with lack of capacity
- All acts done for a person lacking capacity must be in that person's best interests
- The least restrictive option must always be taken

[277]. In Scotland, the principles are:⁵⁰⁵

⁵⁰¹ UK/Mental Capacity Act 2005 c.9.

⁵⁰² UK/Adults with Incapacity (Scotland) Act 2000 asp. 4.

⁵⁰³ Department of Health, Social Services and Public Safety (2009) *Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland*, para. 1.4 <http://www.dhsspsni.gov.uk/legislative-framework-for-mental-capacity.pdf> (15.10.09).

⁵⁰⁴ UK/Mental Capacity Act 2005 c.9, s1(1).

⁵⁰⁵ UK/Adults With Incapacity (Scotland) Act 2000, asp 4, s1(2)-(4).

- All interventions must be for the benefit of the person lacking capacity
- The least restrictive option must always be taken
- Account must always be taken of any view of the person lacking capacity and of any other relevant person, such as a carer or guardian

5.1.1. The definition of capacity [61].

[278]. Although the two terms ‘capacity’ and ‘competency’ are used interchangeably in practice, there is no statutory definition of ‘competency’ in any UK jurisdiction. Instead, in all UK jurisdictions, the term ‘capacity’ is preferred, and defined in statute.

[279]. The legislation which applies in England and Wales provides a definition of a ‘person lacking capacity’.⁵⁰⁶ This states that ‘a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in the functioning of, the mind or brain’. The 2005 Act further explains that ‘a person is unable to make a decision for himself if he is unable-(a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means)’.⁵⁰⁷

[280]. In Scotland, ‘incapable’ is defined to mean ‘incapable of- (a) acting; or (b) making decisions; or (c) communicating decisions; or (d) understanding decisions; or (e) retaining the memory of decisions... by reason of mental disorder or of inability to communicate because of physical disability...and “incapacity” shall be construed accordingly’.⁵⁰⁸

[281]. In Northern Ireland, the definition relevant to the management of property and affairs is found in the *Enduring Powers of Attorney (Northern Ireland) Order 1987*.⁵⁰⁹ This states that “mentally incapable” or “mental incapacity”... means, in relation to any person, that he is incapable by reason of mental disorder of managing and administering his property and affairs and “mentally capable” and “mental capacity” shall be construed accordingly’. In relation to

⁵⁰⁶ UK/Mental Capacity Act 2005 c.9, s2(1).

⁵⁰⁷ UK/Mental Capacity Act 2005 c.9, s3.

⁵⁰⁸ UK/Adults With Incapacity (Scotland) Act 2000 asp. 4, s1(6).

⁵⁰⁹ UK/ Enduring Powers of Attorney (Northern Ireland) Order 1987, art 1(2).

personal decisions, such as giving consent to medical treatment, the test in Northern Ireland remains that developed by the common law in England and Wales before the passing of the *Mental Capacity Act 2005*. This is found in various judicial decisions, the most authoritative statement being that of the Court of Appeal in *Re MB* [1997] 2 FLR 426. It is very similar to the statutory test now found in section 3 of the English and Welsh *Mental Capacity Act 2005*.

[282]. *The mental health related causes determining the legal incapacity of adults foreseen in the UK's legal framework* [62]. As mentioned above, in England and Wales, a finding of incapacity must be based on 'an impairment of, or disturbance in the functioning of, the mind or brain'. This is broad enough to encompass all forms of mental disorder. In Scotland, and in Northern Ireland in respect of the management of property and affairs, the gate-keeper concept is 'mental disorder', which includes mental health, intellectual disability and, in Scotland, personality disorders.⁵¹⁰ The common law test which still governs personal decisions in Northern Ireland does not explicitly rest on or require that a person's incapacity be based on mental disorder. In all jurisdictions, the law also recognises the possibility that capacity can be affected by physical disability, insofar as communication of intention may be compromised.

[283]. *Degrees of incapacity (e.g. total deprivation of capacity, limitation to perform certain acts, etc.)* [63]. In all jurisdictions in the UK, assessment of capacity in relation to personal decisions such as giving consent to medical treatment is person- and situation-specific, whether under section 2(1) of the *Mental Capacity Act 2005* in England and Wales, section 47(1) of the *Adults with Incapacity (Scotland) Act 2000* in Scotland, or under the common law in Northern Ireland. In England, Wales and Scotland, decisions relating to property and affairs are also person- and situation-specific. Section 16 *Mental Capacity Act 2005* for example allows a court to appoint a proxy decision-maker in relation to 'a matter or matters' relating to property and affairs. In Northern Ireland, as seen above, the *Enduring Powers of Attorney (Northern Ireland) Order 1987* envisages capacity in either/or terms. However, as mentioned above, the law in Northern Ireland is in the process of reform, and it is anticipated that the new law will adopt the same approach that currently applies in the rest of the UK.

⁵¹⁰ UK/Adults With Incapacity (Scotland) Act 2000 asp. 4, s87 provides that the definition of 'mental disorder' which is found in s328 of UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13 also applies for the purposes of the 2000 Act.

5.2. Systems of protection of adults lacking capacity [64].

[284]. In England and Wales there are the following mechanisms available under the *Mental Capacity Act 2005*:

- A lasting power of attorney created by the donee before he or she loses capacity.
- The Court of Protection, which may make various orders and declarations.
- A court-appointed guardian, known as a Deputy.
- Independent Mental Capacity Advocates
- There is a fifth mechanism, found in the Mental Health Act 1983:
- Guardianship, a limited set of powers.

[285]. In Scotland, the options are essentially similar, except that there is no direct equivalent to the English and Welsh version of Guardianship, because in Scotland the Compulsory Treatment Order provides for both or either inpatient and community care:

- A continuing power of attorney, either for property and affairs⁵¹¹ and/or for welfare-related decisions⁵¹²
- An Intervention Order made by a Sheriff⁵¹³
- A Sheriff-appointed Guardian.⁵¹⁴

5.2.1. The basic features of each legal protective regime [65].

[286]. The lasting power of attorney systems in England and Wales, and Scotland, are similar. A person having capacity may appoint another to make decisions relating to his or her welfare, property or affairs if and when that person should lose capacity. In England and Wales the Court, and in Scotland the Sheriff, may make decisions relating to the best interests of a person lacking capacity, or may appoint a person (a 'Deputy' in England and Wales, a 'Guardian' in Scotland) to make

⁵¹¹ UK/Adults With Incapacity (Scotland) Act 2000 asp. 4, s15.

⁵¹² UK/Adults With Incapacity (Scotland) Act 2000 asp. 4, s16.

⁵¹³ UK/Adults With Incapacity (Scotland) Act 2000 asp. 4, s53.

⁵¹⁴ UK/Adults With Incapacity (Scotland) Act 2000 asp. 4, s58.

decisions on behalf of the person lacking capacity. Deputies and Guardians may in a suitable case be given extensive powers of management over the property, affairs and welfare of the person lacking capacity.⁵¹⁵

- [287]. In England and Wales, the actions and decisions of both those holding a lasting power of attorney and court-appointed Deputies are policed by the Public Guardian, who has powers to supervise and monitor those appointed, and to investigate complaints,⁵¹⁶ including by way of visiting and inspecting those acting on behalf of persons lacking capacity.⁵¹⁷ Such visits are undertaken by Court of Protection Visitors. In Scotland, the Public Guardian has a similar function.⁵¹⁸
- [288]. The Guardianship system which operates in England, Wales and Northern Ireland under the *Mental Health Act 1983* and the *Mental Health (Northern Ireland) Order 1986* is an alternative to involuntary admission into a psychiatric facility under section 3 of the *Mental Health Act 1983*, but is also capable of acting as an alternative to the system for court-appointed Deputies in England and Wales (the 2005 Act does not apply in Northern Ireland). Typically, a social worker is appointed as Guardian.
- [289]. The *Mental Capacity Act 2005* also requires central government in England and Wales to ensure that persons are provided to act as Independent Mental Health Advocates.⁵¹⁹ An Independent Mental Health Advocate must be appointed where there is no person other than a professional acting for remuneration who is available to consult when it is proposed to provide ‘serious medical treatment’⁵²⁰ to a person lacking capacity, or to provide hospital⁵²¹ or local authority⁵²² accommodation for such a person. The Independent Mental Health Advocate must act for the patient, by consulting those responsible for the treatment and any persons who might have knowledge about the patient’s possible attitude to it, and must also seek to involve the patient in the decision-making process to the greatest possible extent.⁵²³ An Independent Mental Health Advocate may also seek

⁵¹⁵ UK/Mental Capacity Act 2005 c.9, ss 16, 17 and 18; UK/Adults With Incapacity (Scotland) Act 2000 asp. 4, s64.

⁵¹⁶ UK/Mental Capacity Act 2005 c.9, s58.

⁵¹⁷ UK/Mental Capacity Act 2005 c.9, s61.

⁵¹⁸ UK/Adults With Incapacity (Scotland) Act 2000 asp. 4, s6.

⁵¹⁹ UK/Mental Capacity Act 2005 c.9, s35.

⁵²⁰ UK/Mental Capacity Act 2005 c.9, ss35(1), 37.

⁵²¹ UK/Mental Capacity Act 2005 c.9, ss35(1), s38.

⁵²² UK/Mental Capacity Act 2005 c.9, ss35(1), 39.

⁵²³ UK/Mental Capacity Act 2005 c.9, s36(2).

second opinions on the proposed treatment, and challenge its intended administration before the Court of Protection.⁵²⁴

5.2.2. The conditions to be met for placing adults lacking capacity under the protective systems established by national law [66].

[290]. A person who suspects that he or she may lose capacity at some point in the future may establish their own protective regime through the mechanism of a lasting power of attorney.

[291]. In England and Wales, before the Court of Protection can appoint a Deputy with on-going supervisory and decision-making powers, it must be determined that to do so is in the best interests of the person lacking capacity.⁵²⁵ The court must also have regard to the fundamental principles mentioned above⁵²⁶ and must also have regard to the fact that a court order is to be preferred to the appointment of a Deputy wherever possible, as this best accords with the principle of minimum interference.⁵²⁷

[292]. In Scotland, the criteria for the appointment of a Guardian are narrower. An application for an order must be made by a local authority where it appears ‘necessary for the protection of the property, financial affairs or personal welfare’ of the person lacking capacity that a Guardian be appointed.⁵²⁸ A Sheriff hearing an application must consider that the person in question is incapable of managing his or her interests, property, financial affairs or personal welfare. The Sheriff must also be satisfied that no other means are sufficient to protect that person’s interests, property, financial affairs or personal welfare.⁵²⁹

[293]. *Time Limits* [67]. In England and Wales, there is no statutory minimum. The criteria for the appointment of a Deputy by a court specifically require the court to consider what is the shortest time that the appointment should last.⁵³⁰ There is also no statutory maximum duration of an order.

⁵²⁴ UK/The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006, SI 2006/1832, paras 6,7 <http://www.opsi.gov.uk/si/si2006/20061832.htm> (15.10.09).

⁵²⁵ UK/Mental Capacity Act 2005 c.9, s16(3).

⁵²⁶ See para 283 above.

⁵²⁷ UK/Mental Capacity Act 2005 c.9, s16(4).

⁵²⁸ UK/Adults With Incapacity (Scotland) Act 2000, s57(2)(c).

⁵²⁹ UK/Adults With Incapacity (Scotland) Act 2000, s58(1).

⁵³⁰ UK/Mental Capacity Act 2005 c.9, s16(4)(b).

- [294]. In Scotland, there is no statutory minimum duration for a Guardianship Order. Such an Order lasts typically for three years, but that can be varied to any duration, including an indefinite duration, where cause can be shown to the Sheriff making the order.⁵³¹
- [295]. *Who may request the placing of an adult lacking capacity under a protective regime* [68]. In England and Wales, all applications to the Court of Protection, including an application to place an adult lacking capacity under the protection of a court-appointed Deputy, must comply with section 50 of the *Mental Capacity Act 2005*. The following may apply as of right to the court: (i) a person who lacks, or is alleged to lack, capacity; (ii) the parent of such a person if that person is below the age of 18; (iii) the donor or donee of a Lasting Power of Attorney; (iv) a person named in an order of the court, if the application relates to that order; (v) the relevant person's representative where there has been an application to deprive that person of his or her liberty under Section 21A and Schedules A1 and 1A of the *Mental Capacity Act 2005* (see further part 6 below).⁵³²
- [296]. Any other person must seek the leave of the court to make an application. On an application for leave, the court must consider (i) the applicant's connection with the person known or suspected to lack capacity; (ii) the reasons for the application; (iii) the potential benefit to the person known or suspected to lack capacity of the court using any of its powers; and (iv) whether the proposed benefit could be achieved in any other way.⁵³³ This last factor is designed to remind the court that the creation of a formal on-going protective regime should be seen as a last resort.
- [297]. In Scotland, the *Adults with Incapacity (Scotland) Act 2000* provides that an application for the appointment by the Sheriff's Court of a Guardian may be made to the Sheriff 'by any person (including the adult himself) claiming an interest in the property, financial affairs or personal welfare of an adult'.⁵³⁴ The 2000 Act also places a duty on the relevant local social services authority to make an application in the case of a person who is and will continue to be incapable of looking after his or her own affairs, property or personal welfare, if no application has already been made nor is likely to be so.⁵³⁵

⁵³¹ UK/Adults With Incapacity (Scotland) Act 2000 asp.4, s58(4).

⁵³² UK/Mental Capacity Act 2005 c.9, s50(1).

⁵³³ UK/Mental Capacity Act 2005 c.9, s50(3).

⁵³⁴ UK/Adults With Incapacity (Scotland) Act 2000 asp.4, s57(1).

⁵³⁵ UK/Adults With Incapacity (Scotland) Act 2000, s57(2).

5.2.3. The national authorities with jurisdiction to (a) declare the legal incapacity of an adult (b) to take measures directed to the protection of the person (c) to take measures directed to the protection of the property of the person (d) to ensure and monitor the implementation and follow-up of the above-mentioned measures [69].

[298]. 5.2.3.(a) In England and Wales, although the test of capacity⁵³⁶ and the general power to act in the best interests of a person lacking capacity on the basis of an assessment which concludes that the person in question lacks capacity is designed for use by any person, only the Court of Protection has the power to declare that an adult lacks capacity.⁵³⁷

[299]. In Scotland, the situation is similar. Various actors may make a decision that a person lacks capacity. For instance, a doctor may issue a certificate that a person in a hospital or care home lacks capacity, which enables the managers of that hospital or care home to manage the finances of that person.⁵³⁸ Any person may be given medical treatment if the doctor primarily responsible for that person's care decides that that person lacks capacity and the treatment is in that person's best interests.⁵³⁹ However, any decision that a person lacks capacity may be appealed to the Sheriff.⁵⁴⁰ A decision as to lack of capacity made by a Sheriff⁵⁴¹ may be appealed to the Sheriff Principal, and from there to the Court of Session.⁵⁴² As such, only the Sheriff, subject to this appeal structure, may make a definitive decision that a person lacks capacity.

[300]. 5.2.3.(b) As described elsewhere in this Report, any person in England and Wales may take measures directed to the protection of a person lacking capacity using the general authority to act.⁵⁴³ As described above, a person may give to another lasting powers of attorney if he or she foresees losing capacity at some point in the future, and the Court of Protection may act itself or appoint a Deputy to act.

⁵³⁶ UK/Mental Capacity Act 2005 c.9, ss2, 3.

⁵³⁷ UK/Mental Capacity Act 2005 c.9, s15(1).

⁵³⁸ UK/Adults With Incapacity (Scotland) Act 2000, s37(2).

⁵³⁹ UK/Adults With Incapacity (Scotland) Act 2000, s47.

⁵⁴⁰ UK/Adults With Incapacity (Scotland) Act 2000, s14.

⁵⁴¹ UK/Adults With Incapacity (Scotland) Act 2000, s53.

⁵⁴² UK/Adults With Incapacity (Scotland) Act 2000, s14.

⁵⁴³ UK/Mental Capacity Act 2005 c.9, s5.

- [301]. In Scotland, there is no general statutory power to do acts for the protection of a person lacking capacity. Those entitled to take measures designed to protect the person of someone lacking capacity have been described elsewhere in this Report. These include a person exercising a lasting power of attorney in respect of the welfare of the person lacking capacity,⁵⁴⁴ the Sheriff,⁵⁴⁵ or a Guardian appointed by a Sheriff.⁵⁴⁶ The doctor in charge of the treatment of a person lacking capacity may provide medical treatment to that person.⁵⁴⁷
- [302]. 5.3.2.(c) In England and Wales, the situation here is the same as in respect of measures designed to protect the person, as described in the previous paragraphs, and the same powers are available to the same actors. In Scotland, the situation is essentially similar, but in addition to those actors mentioned in the previous paragraph, there is also provision for the managers of hospitals or care homes to manage the finances of residents lacking capacity.⁵⁴⁸
- [303]. 5.3.2.(d) In England and Wales, it is the responsibility of the Public Guardian, an Office established by the *Mental Capacity Act 2005* for these purposes,⁵⁴⁹ to police those who act on behalf of persons lacking capacity. The functions of the Public Guardian include the supervision of court-appointed Deputies,⁵⁵⁰ the receipt of reports from those with lasting powers of attorney or Deputies,⁵⁵¹ dealing with representations or complaints about the activities of any lasting power of attorney or Deputy,⁵⁵² and making reports for the Court of Protection.⁵⁵³ The Public Guardian is assisted by the Court of Protection Visitors, and may direct that a Visitor visit any person holding a lasting power of attorney or a court-appointed Deputy and report to the Public Guardian any findings of that visit.⁵⁵⁴
- [304]. In Scotland, similar responsibilities rest with the Public Guardian, an Office created by the *Adults With Incapacity (Scotland) Act 2000*.⁵⁵⁵ The Public Guardian is supported by the Mental Welfare Commission for Scotland, which is required to co-operate with the Public Guardian in the carrying out of his or her responsibilities.⁵⁵⁶ The main difference from the English and Welsh scheme is that in Scotland it is

⁵⁴⁴ UK/Adults With Incapacity (Scotland) Act 2000, s16.

⁵⁴⁵ UK/Adults With Incapacity (Scotland) Act 2000, s3.

⁵⁴⁶ UK/Adults With Incapacity (Scotland) Act 2000, s57.

⁵⁴⁷ UK/Adults With Incapacity (Scotland) Act 2000, s47.

⁵⁴⁸ UK/Adults With Incapacity (Scotland) Act 2000, part 4.

⁵⁴⁹ UK/Mental Capacity Act 2005 c.9, s50.

⁵⁵⁰ UK/Mental Capacity Act 2005 c.9, s51(1)(c).

⁵⁵¹ UK/Mental Capacity Act 2005 c.9, s51(1)(f).

⁵⁵² UK/Mental Capacity Act 2005 c.9, s51(1)(h).

⁵⁵³ UK/Mental Capacity Act 2005 c.9, s51(1)(g).

⁵⁵⁴ UK/Mental Capacity Act 2005 c.9, s51(1)(d).

⁵⁵⁵ UK/Adults With Incapacity (Scotland) Act 2000 asp. 4, ss6, 7.

⁵⁵⁶ UK/Adults With Incapacity (Scotland) Act 2000 asp .4, ss6, 7.

the Mental Welfare Commission which, in addition to having a general obligation to protect the personal welfare of person subject to a continuing power of attorney or in respect of whom a Sheriff has appointed a Guardian,⁵⁵⁷ is the body responsible for visiting and reporting on the conduct of those with a continuing power of attorney or a Guardian.⁵⁵⁸

- [305]. Those exercising control over the finances of hospital or care home residents in Scotland are under the jurisdiction of the Scottish Commission for the Regulation of Care.⁵⁵⁹

5.3. Appeals against a decision of incapacity [70].

- [306]. In England and Wales, a decision that a person lacks capacity made by someone acting under the general authority to act in the best interests of the person lacking capacity is not subject to any specific right of appeal. Such a decision may be challenged, however, before the Court of Protection in the form of an application for a declaration as to the capacity of the person concerned.⁵⁶⁰
- [307]. There is a right of appeal against any decision of the Court of Protection to the Court of Appeal,⁵⁶¹ although if the first instance judge is a district or circuit judge, the *Court of Protection Rules*⁵⁶² may provide instead for an appeal to a more senior judge rather than to the Court of Appeal.⁵⁶³ Any further appeal, however, can only be to the Court of Appeal.⁵⁶⁴ The Court of Appeal will not give leave unless (i) the appeal would raise an important point of principle or practice; or (ii) there is some other compelling reason for the Court of Appeal to hear the appeal.⁵⁶⁵
- [308]. In Scotland, there is provision for appeal against a decision made by a medical professional, that a person lacks capacity.⁵⁶⁶ This is to the

⁵⁵⁷ UK/Adults with Incapacity (Scotland) Act 2000 asp. 4, s9(1)(a).

⁵⁵⁸ UK/Adults with Incapacity (Scotland) Act 2000 asp. 4, s9(1)(b).

⁵⁵⁹ UK/Adults with Incapacity (Scotland) Act 2000 asp. 4, s40.

⁵⁶⁰ UK/Mental Capacity Act 2005 c.9, s9.

⁵⁶¹ UK/Mental Capacity Act 2005 c.9, s53(1).

⁵⁶² UK/Court of Protection Rules 2007 SI 2007/1744
http://www.opsi.gov.uk/si/si2007/uksi_20071744_en_1 (15.10.09).

⁵⁶³ UK/Mental Capacity Act 2005 c.9, ss53(2), (3).

⁵⁶⁴ UK/Court of Protection Rules 2007, rules 181(1), (2),

⁵⁶⁵ UK/Civil Procedure Rules 1998, rule 52.13
http://www.justice.gov.uk/civil/procrules_fin/contents/parts/part52.htm#IDAAKYCC
(15.10.09).

⁵⁶⁶ UK/Adults With Incapacity (Scotland) Act 2000, s47.

Sheriff in the first instance and then, with leave of the Sheriff, to the Court of Session.⁵⁶⁷ There is also a general right of appeal against a decision made by any person that a person lacks capacity, if that decision is made by a person other than a Sheriff, to the Sheriff.⁵⁶⁸ This right may be exercised either by the person whom it has been decided lacks capacity, or by ‘any person claiming an interest in the adult's property, financial affairs or personal welfare relating to the purpose for which the decision was taken’. Thereafter, the appeals procedure is as for that which applies to decisions made by a Sheriff.

- [309]. As to decisions as to capacity made by a Sheriff, the statute provides: ‘Unless otherwise expressly provided for, any decision of the sheriff at first instance in any application to, or in any other proceedings before, him under this Act may be appealed to the sheriff principal, and the decision upon such appeal of the sheriff principal may be appealed, with the leave of the sheriff principal, to the Court of Session’.⁵⁶⁹

5.4. Persons or bodies appointed to implement the measures placing an adult under a system of protection [71].

- [310]. There are no formal restrictions placed on which persons or bodies can be appointed as a Deputy (in England and Wales) or Guardian (in Scotland), other than they are suitable for the position.
- [311]. Any person aged 18 or older can act as a Deputy in England and Wales.⁵⁷⁰ Two or more Deputies may be jointly appointed.⁵⁷¹ A trust corporation may also act as Deputy in relation to property and affairs.⁵⁷² It is also possible to appoint a post-holder, such as the director of a social services agency.⁵⁷³ In practice this means that social workers can act as Deputies, although the Code of Practice which accompanies the 2005 Act anticipates that typically Deputies will be members of the family of the person lacking capacity.⁵⁷⁴ In any case, the person appointed should be a person who is ‘reliable and

⁵⁶⁷ UK/Adults With Incapacity (Scotland) Act 2000, s52.

⁵⁶⁸ UK/Adults With Incapacity (Scotland) Act 2000, s14.

⁵⁶⁹ UK/Adults With Incapacity (Scotland) Act 2000, s3(1).

⁵⁷⁰ UK/Mental Capacity Act 2005 c.9, s19(1)(a).

⁵⁷¹ UK/Mental Capacity Act 2005 c.9, s19(4).

⁵⁷² UK/Mental Capacity Act 2005 c.9, s19(1)(b).

⁵⁷³ UK/Mental Capacity Act 2005 c.9, s19(2).

⁵⁷⁴ UK/Mental Capacity Act 2005 Code of Practice, para 8.33

<http://www.publicguardian.gov.uk/mca/code-of-practice.htm> (27.09.09).

trustworthy and has an appropriate level of skill and competence to carry out the necessary tasks'.⁵⁷⁵

- [312]. In Scotland, a Sheriff may appoint as Guardian 'any individual whom he considers to be suitable for appointment and who has consented to being appointed'.⁵⁷⁶ Two or more people can be appointed as Guardian.⁵⁷⁷ If the guardianship order is to relate only to the personal welfare of the adult, the chief social work officer of the local authority may be appointed.⁵⁷⁸ The Sheriff is provided with a range of factors to be considered when making an appointment decision. These include the abilities of the person to be appointed, the accessibility of that person to the person lacking capacity, any likely conflict of interest between the two, any 'undue concentration of power which is likely to arise' and any possible adverse effects on the person lacking capacity of the proposed appointment.⁵⁷⁹

5.4.1. The powers of the entrusted person/body [72].

- [313]. The scope and extent of the powers of the person or body appointed to operate a protective regime for a person lacking capacity are to a large degree specified in the order appointing that person as a Deputy (in England and Wales)⁵⁸⁰ or Guardian (in Scotland).⁵⁸¹ Typically, a Deputy or Guardian will be authorised to manage the property and affairs of a person lacking capacity, and/or the welfare of that person, for example by making decisions about medical treatment, place of residence, and so on.
- [314]. The court or Sheriff can bestow wide powers on a Deputy or Guardian. In England and Wales, for example, a Deputy may be authorised to 'take possession or control of all or any specified part of P's property' and 'exercise all or any specified powers in respect of it, including such powers of investment as the court may determine'.⁵⁸² In Scotland, but not elsewhere, a Guardian may also be empowered to pursue or defend an action for nullity of marriage, divorce or judicial separation.⁵⁸³

⁵⁷⁵ UK/Mental Capacity Act 2005 Code of Practice, para 8.32.

⁵⁷⁶ UK/Adults With Incapacity (Scotland) Act 2000, s59(1)(a).

⁵⁷⁷ UK/Adults With Incapacity (Scotland) Act 2000, s62.

⁵⁷⁸ UK/Adults With Incapacity (Scotland) Act 2000, s59(1)(b).

⁵⁷⁹ UK/Adults With Incapacity (Scotland) Act 2000, s59(4).

⁵⁸⁰ UK/Mental Capacity Act 2005, s16(2).

⁵⁸¹ UK/Adults With Incapacity (Scotland) Act 2000, s64(1).

⁵⁸² UK/Mental Capacity Act 2005 c.9, s19(8).

⁵⁸³ UK/Adults With Incapacity (Scotland) Act 2000, s64(2)(c).

- [315]. There are statutory limits on the powers of a Deputy in England and Wales. A Deputy may not act on a matter if he or she knows or has reasonable grounds for believing that the person he or she is deputising for has capacity in relation to that matter.⁵⁸⁴ In particular, a Deputy may not prohibit contact between the person lacking capacity and another or ‘direct a person responsible for P’s health care to allow a different person to take over that responsibility’.⁵⁸⁵ Nor may a Deputy settle P’s property or make a will for P; exercise any power vested in P whether beneficially or as a trustee or otherwise; act in a way inconsistent with a subsisting lasting power of attorney; refuse consent to life sustaining treatment for P;⁵⁸⁶ or act to restrain P, unless authorised to do so by a court and the act of restraint is intended to prevent harm to P and is proportionate to the harm thereby sought to be avoided.⁵⁸⁷
- [316]. In addition, no person may deprive a person lacking capacity of his or her liberty, unless specifically authorised to do so by the Court of Protection or in accordance with the powers to deprive a person of his or her liberty found in Schedule A1 of the *Mental Capacity Act 2005*.⁵⁸⁸
- [317]. There are also statutory limits on the powers of a Guardian in Scotland. A Guardian may not place the person lacking capacity in hospital for treatment for mental disorder against his or her will or give consent to some other controversial medical treatments.⁵⁸⁹ Nor may a Guardian make a request that the body of the person lacking capacity be used for anatomical examination after that person’s death, consent to the donation of body parts by that person after death or authorise a post-mortem examination.⁵⁹⁰

5.4.2. Appeals against the appointment of a Deputy or Guardian

- [318]. In England and Wales, the appointment of such a person or body can only be done by a court, and any appeal against the appointment must

⁵⁸⁴ UK/Mental Capacity Act 2005 c.9, s20(1).

⁵⁸⁵ UK/Mental Capacity Act 2005 c.9, s20(2).

⁵⁸⁶ UK/Mental Capacity Act 2005 c.9, ss20(3), (4).

⁵⁸⁷ UK/Mental Capacity Act 2005 c.9, s20(7).

⁵⁸⁸ The powers in schedule A1 are discussed at paras 324-329 below.

⁵⁸⁹ UK/Adults With Incapacity (Scotland) Act 2000, s64(2). These are listed in Schedule 1 to the Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002 SSI 2002/275 <http://www.uk-legislation.hmso.gov.uk/legislation/scotland/ssi2002/20020275.htm> (15.10.09) . The list contains non-therapeutic steralisation, surgical implanation of hormones and drug treatments to reduce sexual drive, ECT, abortion and any other treatment likely to cause the steralisation of the patient.

⁵⁹⁰ UK/Adults With Incapacity (Scotland) Act 2000, ss64(2), 48(1), (2).

comply with the appeal procedures laid out in section 53 *Mental Capacity Act 2005* and the *Court of Protection Rules 2007*.⁵⁹¹ Similarly, in Scotland, a Guardian can only be appointed by a Sheriff, and the procedure for appealing against the decision of a Sheriff, found in section 3 of the *Adults with Incapacity (Scotland) Act 2000*,⁵⁹² authorises the making of an appeal against the appointment of a Guardian.

5.4.3. Periodic review of decisions of incapacity [74].

- [319]. There is no specific mechanism in the English and Welsh legislation which requires that a decision of incapacity be reviewed periodically. This is because the model of capacity which is used in the legislative scheme assumes that capacity is situation-specific and should therefore be reviewed routinely on each occasion where capacity is an issue.
- [320]. The general authority to act in the best interests of a person lacking capacity will only protect a person who ‘before doing the act... takes reasonable steps to establish whether [the patient] lacks capacity in relation to the matter in question’.⁵⁹³ According to the Code of Practice, for example, ‘[t]he person who assesses the individual’s capacity to make a decision will usually be the person who is directly concerned at the time the decision needs to be made. This means that different people will be involved in assessing someone’s capacity to make different decisions at different times’.⁵⁹⁴
- [321]. The powers given under a lasting power of attorney⁵⁹⁵ or to a court-appointed Deputy,⁵⁹⁶ or assumed by any person acting under the general authority to act in the best interests of a person lacking capacity,⁵⁹⁷ are automatically suspended if and when that person has capacity in respect of the matter in question.
- [322]. In Scotland, as in England and Wales, there is no explicit statutory requirement that a decision as to a person’s incapacity be periodically reviewed. However, as in England and Wales, this is because the statutory regime is built on the expectation that a decision as to a person’s capacity be made in each situation in which it is proposed to act on the basis that that person might lack capacity. The Code of

⁵⁹¹ See para 304 above.

⁵⁹² See para 306 above.

⁵⁹³ UK/Mental Capacity Act 2005 c.9, s5(1)(a).

⁵⁹⁴ UK/Mental Capacity Act 2005 Code of Practice, para 4.38.

⁵⁹⁵ UK/Mental Capacity Act 2005 c.9, s11(2).

⁵⁹⁶ UK/Mental Capacity Act 2005 c.9, s20(1).

⁵⁹⁷ UK/Mental Capacity Act 2005 c.9, s5(1)(a).

Practice issued alongside the legislation states: ‘It is necessary to consider whether the adult lacks capacity in relation to the relevant matter each time a decision or action needs to be taken’.⁵⁹⁸

5.4.4. Periodic review of the need for a Guardian [75].

[323]. In England and Wales there is no mechanism which provides expressly for the periodic review of the need for a Guardian. However, as explained above,⁵⁹⁹ the Office of the Public Guardian, aided by the Court of Protection Visitors, is charged with the responsibility of supervising Deputies appointed by the Court. Deputies must proffer reports to the Public Guardian and the Public Guardian must in turn report to the Court. The model of review adopted in England and Wales is therefore best characterised as ongoing rather than periodic. The Court of Protection has general powers to discharge an appointment⁶⁰⁰ and may revoke the appointment of a Deputy who has acted outside of the powers specified in the instrument of appointment, or intends to act in a way contrary to the best interests of the person lacking capacity.⁶⁰¹

[324]. In Scotland, the situation is similar, and there is provision for the Sheriff to terminate a Guardianship Order on the application of the Public Guardian, acting on his or her own initiative or at the request of any person, including the person lacking capacity. This should be done either if the guardian is no longer suitable,⁶⁰² or if ‘the interests of the adult in his property and financial affairs can be satisfactorily safeguarded or promoted otherwise than by guardianship’.⁶⁰³ This necessarily implies that the need for a guardian be reviewed periodically. The Code of Practice states that the regularity of review should be stipulated at the time the order is first made.⁶⁰⁴ Local authority social services authorities which act as Guardian are required by the Code to hold at least one review each year of the continuing need for the Order.⁶⁰⁵

⁵⁹⁸ Scottish Executive (2008) *Adults With Incapacity (Scotland) Act 2000 Code of Practice*, para 1.3. <http://www.scotland.gov.uk/Publications/2008/03/20114619/0> (27.09.09).

⁵⁹⁹ See paras 301-302 above.

⁶⁰⁰ UK/Mental Capacity Act 2005 c.9, s16(7).

⁶⁰¹ UK/Mental Capacity Act 2005 c.9, s16(8).

⁶⁰² UK/Adults With Incapacity (Scotland) Act 2000, s73(1)(a).

⁶⁰³ UK/Adults With Incapacity (Scotland) Act 2000, s73(1)(b).

⁶⁰⁴ Scottish Executive (2008) *Adults With Incapacity (Scotland) Act 2000 Code of Practice*, para 6.28.

⁶⁰⁵ Scottish Executive (2008) *Adults With Incapacity (Scotland) Act 2000 Code of Practice Code of Practice*, para 6.28.

6. Miscellaneous

6.1. Deprivation of Liberty of Persons Lacking Capacity

- [325]. Following the decision of the European Court in *HL v UK* (2005) 40 EHRR 32⁶⁰⁶ the law in England and Wales was modified by the *Mental Health Act 2007*,⁶⁰⁷ which added Schedules A1 and 1A to the *Mental Capacity Act 2005*.⁶⁰⁸
- [326]. Under these provisions, the managers of a hospital or care home in which a patient lacking capacity is accommodated may deprive that person of his or her liberty – for example by preventing that person from leaving the accommodation in question – if authorised to do. Authorisation can be given by the Court of Protection,⁶⁰⁹ but more usually will be given by the relevant ‘supervisory body’. This will be the local NHS Trust, if the patient is in a hospital, or, if in a care home, the person responsible for running that care home.⁶¹⁰
- [327]. Authorisation should be applied for by the managers of the hospital in question if it appears that a person not yet accommodated in that place is likely to be so accommodated within 28 days and the requirements for authorisation are likely to be met.⁶¹¹ It should also be applied for when it appears likely to the managers that a person already in the accommodation in question will within 28 days meet the requirements for authorisation.⁶¹²
- [328]. The following criteria must be satisfied for authorisation to be given:
- The patient must be at least 18 years of age⁶¹³
 - The patient must be suffering from mental disorder⁶¹⁴
 - The patient must lack capacity⁶¹⁵

⁶⁰⁶ Discussed at paras 103-110 above.

⁶⁰⁷ UK/Mental Health Act 2007 c.12.

⁶⁰⁸ UK/Mental Capacity Act 2005 c.9.

⁶⁰⁹ UK/Mental Capacity Act 2005 c.9, Schedule A1, para 27.

⁶¹⁰ UK/Mental Capacity Act 2005 c.9, Schedule A1, para 21.

⁶¹¹ UK/Mental Capacity Act 2005 c.9, Schedule A1, para 24(2).

⁶¹² UK/Mental Capacity Act 2005 c.9, Schedule A1, para 24(3).

⁶¹³ UK/Mental Capacity Act 2005 c.9, Schedule A1, para 13.

⁶¹⁴ UK/Mental Capacity Act 2005 c.9, Schedule A1, para 14.

⁶¹⁵ UK/Mental Capacity Act 2005 c.9, Schedule A1, para 15.

- It must be in the best interests of the patient, in order to prevent harm to him or her, that he or she be deprived of his or her liberty⁶¹⁶
- The patient must not be detained or eligible for detention under the *Mental Health Act 1983*⁶¹⁷ or, if subject to that Act but not actually in hospital, any order for deprivation of liberty under these powers must not conflict with any requirement imposed on the patient under that Act⁶¹⁸
- The patient, by means of an advance directive, or any donee of a lasting power of attorney or court-appointed deputy acting on his or her behalf, has not or does not refuse to the deprivation of liberty⁶¹⁹

- [329]. All of these factors must be the subject of an assessment,⁶²⁰ which the supervisory body must ensure is carried out.⁶²¹ The best interests assessment must amongst other things specify the maximum period for which the patient should be deprived of his or her liberty, which can be in any case no longer than one year,⁶²² and any subsequent authorisation may not specify a period longer than that specified by the best interests assessment.⁶²³
- [330]. An authorisation once made must be kept under review⁶²⁴ and must be reviewed at the request of the patient, the patient's representative (a person appointed as soon as authorisation is given)⁶²⁵ or the managers of the hospital concerned.⁶²⁶

6.2. Preventing a conflict of interests

- [331]. The *Mental Health Act 2007* introduced new provisions into the *Mental Health Act 1983* to deal with conflicts of interests.⁶²⁷ In this, the legislation in England and Wales follows that in Scotland, which introduced provision to prevent conflicts of interests in 2003.⁶²⁸ These provisions are designed to ensure that no medical or other professional making decisions about the involuntary detention or treatment of a

⁶¹⁶ UK/Mental Capacity Act 2005 c.9, Schedule A1, para 16.

⁶¹⁷ UK/Mental Capacity Act 2005 c.9, Schedule A1, para 17 and Schedule 1A.

⁶¹⁸ UK/Mental Capacity Act 2005 c.9, Schedule 1A, para 3(2).

⁶¹⁹ UK/Mental Capacity Act 2005 c.9, Schedule A1, para 18.

⁶²⁰ UK/Mental Capacity Act 2005 c.9, Schedule A1, paras 34-49.

⁶²¹ UK/Mental Capacity Act 2005 c.9, Schedule A1, para 33(1).

⁶²² UK/Mental Capacity Act 2005 c.9, Schedule A1, para 42(1), (2).

⁶²³ UK/Mental Capacity Act 2005 c.9, Schedule A1, para 51(2).

⁶²⁴ UK/Mental Capacity Act 2005 c.9, Schedule A1, part 8.

⁶²⁵ UK/Mental Capacity Act 2005 c.9, Schedule A1, para 139(2). This person could be an Independent Mental Capacity Advocate, appointed under ss 39A, 39C or 39D.

⁶²⁶ UK/Mental Capacity Act 2005 c.9, Schedule A1, para 102.

⁶²⁷ UK/Mental Health Act 1983 c.20, ss 11(1A), 12(3), 12A.

⁶²⁸ UK/Mental Health (Care and Treatment) (Scotland) Act 2003 asp. 13, ss36(3)(a), 36(9)(b), 44(3), 44(8), 47(2)(a), 58(5).

mentally disordered person is influenced by any other factor than the best interests of the person concerned.

Annexes

Annex

Case Law

Case title	Lewisham London Borough Council v Malcolm
Decision date	25 June 2008
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2008] UKHL 43, House of Lords (final court of appeal)
Key facts of the case (max. 500 chars)	M, who suffered from schizophrenia, was in breach of his tenancy agreement because he had sublet his local authority-provided apartment, contrary to its terms. This rendered M liable to be given notice to quit, which was given. M resisted the attempt to evict him, arguing that his breach of his tenancy agreement was caused by his schizophrenia, and that the local authority was consequently in breach of section 22(3)(c) of the Disability Discrimination Act 1995, which provides that it is unlawful for a person managing premises to discriminate against a disabled person occupying those premises in various ways, one of which is 'by evicting the disabled person'.

Main reasoning/argumentation (max. 500 chars)	The arguments in this case centred on two questions. <ol style="list-style-type: none"> 1. Whether there could be disability-related discrimination against a person under section 24(1)(a) of the Disability Discrimination Act 1995, which requires that the discrimination be ‘for a reason which relates to the disabled person's disability’, if the person or body accused of discrimination did not know that the person alleging discrimination was disabled. 2. What was the appropriate comparator against which to compare the treatment experienced by the person alleging discrimination.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The House of Lords decided: <ol style="list-style-type: none"> 1. That there could be no discrimination under this provision if the person or body alleged to have acted in a discriminatory way did not know of the disability of the aggrieved person. 2. That the appropriate comparator in order to assess whether discrimination had taken place was a person without disability who had also sublet his or her accommodation in breach of the tenancy agreement. As such a person would also have received notice to quit, there had been no discrimination.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The main consequence of this case is that it makes it more difficult for a person to demonstrate disability-related discrimination against them than previously. This is because the House of Lords overruled earlier caselaw, in which it had been held that the appropriate comparator for judging disability-related discrimination in this context is a person in respect of whom the disability-related reason for the treatment did not apply. In this case this would mean a person who, not having schizophrenia, had not sublet his apartment in breach of his tenancy agreement. Moreover, because this was a judgment of the final court of appeal in the UK, it was suspected, as has proven to be the case, that this approach would be followed in other contexts, not related to the management of premises (see next two cases).
Proposal of key words for data base	Disability-related discrimination, appropriate comparator

Case title	<i>Stockton on Tees BC v Arlott</i> [2009] ICR 872.
Decision date	11 March 2009
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	Appeal No. UKEAT/0401/08 Employment Appeal Tribunal
Key facts of the case (max. 500 chars)	A, who suffered from bipolar disorder, was dismissed from his employment after being absent from work for periods of several months at a time, and after having alleged harassment by colleagues and having himself behaved inappropriately. There had been an attempted return to work, involving A being appointed to a post judged to be less stressful than his previous position, but that had not been successful, in A's opinion, because of close monitoring and the imposition of deadlines on the completion of various tasks by A's line managers.
Main reasoning/argumentation (max. 500 chars)	A claimed unfair dismissal by reason of disability discrimination before an employment tribunal, which decided in his favour. On appeal the main argument before the Employment Appeal Tribunal centred on the appropriate comparator for determining if there had been discrimination against A.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The Employment Appeal followed the <i>Malcolm</i> decision, holding that the appropriate comparator for the purposes of determining whether or not there had been discrimination against A was a person who, like A, 'in addition to having a similar sickness absence record, would have been a person who had recently been moved to a different post and whose past behaviour and performance had caused concern' (para 78) but who was not disabled. Accordingly it overturned the finding in favour of A made by the employment tribunal.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case (and the next) demonstrates the extension of the <i>Malcolm</i> approach to fields beyond the management of premises. Accordingly, in the employment field too, the appropriate comparator has been drawn more narrowly than before the decision in that case. However, the Appeal Tribunal then went on to note, at para 113 that 'In our judgment this conclusion need not leave disabled

	<p>people who are disadvantaged for a reason relating to their disability but treated in the same way as non disabled people without the possibility of redress. Although they may not now be able to establish that they have been discriminated against for a reason related to their disability.... they may be able to establish discrimination by the employer's failure to make reasonable adjustments'. This might mitigate the effects of the <i>Malcolm</i> decision to an extent. The Tribunal did not find, however, that there has been such a failure in this case, because it was not clear that A was well enough to return to work, so the question of reasonable adjustments did not arise.</p>
<p>Proposal of key words for data base</p>	<p>Disability-related discrimination, appropriate comparator</p>

Case title	<i>R (on the application of N) v Independent Appeal Panel of Barking and Dagenham LBC</i>
Decision date	1 December 2008
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2009] EWCA Civ 108, Court of Appeal (penultimate court of appeal).
Key facts of the case (max. 500 chars)	N, aged 13, had been diagnosed as suffering Attention Deficit Hyperactivity Disorder at the age of seven. N had twice been suspended from school, and the school had taken various measures, including providing N with anger management training and appointing, and funding, one-to-one counselling sessions designed to help N to address her behavioural and attitudinal problems before deciding to permanently exclude N from school because of her disruptive behaviour. N, through her mother, appealed against the school's decision on the grounds of disability discrimination but an Independent Appeal Panel and subsequently the High Court found against her.
Main reasoning/argumentation (max. 500 chars)	The issue in the case was the appropriate comparator to be used in order to determine whether disability-related discrimination had taken place and, specifically, whether the decision in <i>Malcolm</i> (above) had ramifications for discrimination in the context of education. The relevant section of the <i>Disability Discrimination Act 1995</i> is section 28A, which provides in subsection (2) that 'It is unlawful for the body responsible for a school to discriminate against a disabled pupil in the education or associated services provided for, or offered to, pupils at the school by that body'. Forms of discrimination that are prohibited under s28A include exclusion from school, whether on a temporary or permanent basis. As in the context of the management of premises in the <i>Malcolm</i> case, the test for discrimination (found in s28B of the 1995 Act) provides that discrimination has taken place if a school 'for a reason which relates to his disability' treats a disabled pupil less favourably than a non-disabled pupil and cannot show that that less favourable treatment is justified.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The Court of Appeal held that the decision in <i>Malcolm</i> should also be applied in this context. It was decided that where the same formula is used in different parts of a statutory scheme there is a strong presumption that in each instance that formula should be interpreted in the same way (see para 44 of the judgement). The court also held that in policy terms the decision in <i>Malcolm</i> was sound (see para 45) as otherwise the comparative test would be too easy for complainants to satisfy. The court held, therefore, that 'proper comparator was someone who had behaved in the same way as the person concerned, but did not suffer from that person's disability' (para 44).

Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This decision in this case means that the comparator to be used in education discrimination cases involving disability-related discrimination makes it harder than it would previously have been the case for complainants to show discrimination.
Proposal of key words for data base	Disability-related discrimination, appropriate comparator

Case title	<i>R (on the application of Domb) v Fulham and Hammersmith LBC</i> [2009] EWCA Civ 941
Decision date	8 September 2009
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2009] EWCA Civ 941, Court of Appeal (penultimate court of appeal)
Key facts of the case (max. 500 chars)	The local authority wished to reduce the amount of council tax it collected from residents in its area by three per cent. In order to achieve this, it intended, amongst other things, to introduce charges (as it was lawfully entitled to do) for at home services for disabled persons. The council consulted on this proposal and carried out an equality impact assessment, and at length the policy was introduced.
Main reasoning/argumentation (max. 500 chars)	D, a disabled person in receipt of the relevant services sought judicial review of the decisions of the council arguing, amongst other things, that the council had not given due regard to its equality duty under s49A of the Disability Discrimination Act 1995 in their implementation of the new policy.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	<p>The Court made clear the nature of the duty under s49A. Lord Justice Rix emphasised that</p> <p style="padding-left: 40px;">‘the duty is to have due regard, not to achieve results or to refer in terms to the duty; that due regard does not exclude paying regard to countervailing factors, but is “the regard that is appropriate in all the circumstances”; ...the duty must be performed with vigour and with an open mind; and that it is a non-delegable duty’ (para 113).</p> <p>The Court of Appeal nevertheless upheld the decision of the first instance judge, that there was no evidence that the council had failed to have due regard to its equality duty in making the decisions that it had. The impact assessment carried out demonstrated that the council had given due regard to its equality duty and power to treat disabled persons more favourably throughout the relevant period.</p>

Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case makes clear that the duty imposed by s49A of the 1995 Act is merely to have due regard: as long as this is the case there can be no breach of it.
Proposal of key words for data base	Equality duty, obligation to have due regard

Case title	<i>R (on the application of Chavda) v Harrow LBC</i>
Decision date	20 December 2007
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2007] EWHC 3064 (Admin), High Court (senior first instance court)
Key facts of the case (max. 500 chars)	In this case a local council proposed to restrict the provision of community care services to people with critical needs. It consulted widely and carried out an equality impact assessment, although that assessment did not refer to the disability equality duty. C, who suffered from mental illness, judged to be ‘substantial’ but not ‘critical’ was one of 500 people who would be affected by the decision.
Main reasoning/argumentation (max. 500 chars)	C sought judicial review, arguing amongst other things that the council was in breach of its duty under s49A of the 1995 Act.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The court examined the nature of the consultation process and the council’s deliberations based on it, and found ‘no evidence that this legal duty and its implications were drawn to the attention of the decision-takers who should have been informed not just of the disabled as an issue but of the particular obligations which the law imposes’ (para 40).

Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The court found a breach of s49A. The case makes clear that those public authorities to which the equality duty applies must be able to demonstrate that they have taken this duty fully into account in their decision-making processes.
Proposal of key words for data base	Equality Duty – extent of obligation

Case title	<i>SCA Packaging v Boyle</i>
Decision date	1 July 2009
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2009] UKHL 37, House of Lords (final court of appeal)
Key facts of the case (max. 500 chars)	In this case B, an employee, had suffered from nodules on her vocal chords which significantly reduced her powers of speech, thus affecting her ability to attend meeting, answer telephone calls, and comply fully with other elements of her employment. Although the nodules had been successfully treated and had not returned this was because, in B's opinion, she had maintained a strict management regime, which involved minimum use of her vocal chords. Her employer eventually made her redundant on the basis that she did not comply with the duties imposed on her by her employment.

Main reasoning/argumentation (max. 500 chars)	B made various claims of discrimination, the most important of which was that she was made redundant because of her disability, but her employer claimed she was not disabled for the purposes of the <i>Disability Discrimination Act 1995</i> because her disability had been removed by the treatment. The case went to the House of Lords on the preliminary question of whether B was to be classified as disabled for the purposes of the 1995 Act.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	<p>The House of Lords held that B was disabled as defined by section 1(1) of the 1995 Act because, although her disability was absent at the time of the alleged discrimination against her, this was only because of the ongoing management regime. She thus had an ‘impairment’ for the purposes of section 1(1), determined by reference to para 6(1) of Schedule 1 to the 1995 Act. This provides that ‘an impairment which would be likely to have a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day duties, but for the fact that measures are being taken to treat or correct it, is to be treated as having that effect’.</p> <p>The court also clarified the interpretation of the words ‘would be likely’ in para 6(1). These words were to be interpreted to mean ‘may well happen’. The real importance of this case for persons with mental disorder is that the control, for instance of schizophrenia by drug treatments, such that the person in question’s disability is not apparent to those around them, does not remove that person from the scope of the protection offered by the 1995 Act.</p>
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case is important because it makes clear that persons whose disability can be controlled through on-going management or treatment are not outside the statutory definition in section 1(1) of the 1995 Act. This is especially relevant to persons whose mental disorder can be controlled through medication or other management.
Proposal of key words for data base	Definition and scope of ‘disability’, protection for latent disability

Case title	<i>Archibald v Fife Council</i>
Decision date	1 July 2004

Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2004] IRLR 651, [2004] UKHL 32 House of Lords (final court of appeal)
Key facts of the case (max. 500 chars)	A Local Authority had dismissed A from its employ as a manual labourer by reason of her disability, acquired following medical treatment, which prevented her from carrying out her duties. The council had attempted and failed to redeploy A in a non-manual labour position, despite automatically short-listing her for some posts.
Main reasoning/argumentation (max. 500 chars)	A argued that she had been discriminated against by reason of the failure of the Local Authority to make reasonable adjustments to accommodate her disability. Section 4(2) of the Disability Discrimination Act 1995 provides that it is unlawful for an employer to discriminate against a disabled employee in a variety of ways, one of which, as provided by section 4(2)(d), is by dismissing the employee. Section 6 of the 1995 Act placed an obligation on employers to take such steps as are reasonable to prevent any provision, criterion or practice which places the employee at substantial disadvantage from having that effect (NB the 1995 Act has since been amended and the relevant section of the law currently in force is section 4A). A argued that the employer had failed to take reasonable steps.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The House of Lords agreed with A. Although the employer had sought to find A another position, and had positively discriminated in her favour by automatically short-listing her for positions so identified as prima facie suitable, it had subjected her to competitive interview process in respect of those positions. The decision of an employment tribunal, that the council had acted reasonably, was overturned by the court because ‘did not explore the question whether it would have been reasonable for the council simply to have transferred [A] to a sedentary job for which she was suitable or whether the council's policy requirement for a competitive interview should have been dispensed with in her case.’ (para 18).
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case demonstrates the attitude of the courts towards the concept of ‘reasonable adjustments’ and underlines that all reasonable options to remove the substantial disadvantage caused to an employee by reason of his or her disability must be explored by the employer.

Proposal of key words for data base	The extent of the duty to make ‘reasonable accommodation’ for disabled employees.
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Case title	<i>Governing Body of X Endowed Primary School v Special Educational Needs and Disability Tribunal, Mr. and Mrs. T, The National Autistic Society</i>
Decision date	27 July 2009
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2009] EWHC 1842 (Admin) High Court (appeal court hearing appeals from tribunals)
Key facts of the case (max. 500 chars)	T, a 10 year-old boy with Attention Deficit and Hyperactivity Disorder was expelled from school by reason of his violent behaviour.
Main reasoning/argumentation (max. 500 chars)	T’s parents argued that the school had failed to make reasonable adjustments to accommodate T, in particular by failing to enlist the advice and support of an Access to Learning Specialist Team in the management of T’s admittedly disruptive behaviour. The school argued that it was not in breach of disability discrimination law because of Regulation 4 of the Disability Discrimination (Meaning of Disability) Regulations 1996, which provides that a tendency to physical abuse of other persons is not to be treated as a disability for the purposes of the 1995 Act., and T’s disability manifested partly in the form of physical abuse of others.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The court agreed with T’s parents. The school had failed to make reasonable adjustments of the type suggested by T’s parents in order to accommodate his disability. The court also said that when a person’s disability manifests inter alia in a manner which is excluded from the definition of disability this does not mean that the underlying disability is outside the protection offered to disabled persons by the 1995 Act.

Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case underlines the obligation to take reasonable steps to mitigate the effect of a policy, here concerning the exclusion of children from school, on a disabled person. The school was required to ensure that its teachers who came into contact with T were required to undertake training in disability discrimination. It also establishes that protection from discrimination is available to a person whose disability is recognised as deserving protection, notwithstanding that one manner in which it manifests is excluded from legal protection.
Proposal of key words for data base	Reasonable adjustments, relation between underlying disability and the manner of its manifestation

Case title	<i>Fareham College v Walters</i>
Decision date	14 May 2009
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2009] UKEAT 0396_08_1405 Appeal No. UKEAT/0396/08/DM Employment Appeal Tribunal
Key facts of the case (max. 500 chars)	W was a college lecturer. For reasons relating to both physical and mental disability (acute stress) she was unable to perform her duties, had been away from work for several months and would continue to be so for several further months. She was dismissed from her employment because she was unable to comply with her terms of employment, and because the employer was unable to accommodate her return to work within its existing practices.
Main reasoning/argumentation (max. 500 chars)	W claimed that she had been discriminated against by reason of failure by the employer to make reasonable adjustments to accommodate her disability to allow her to return to work.

Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The Tribunal held that although W's dismissal had not in itself been discriminatory, it became so because the employer failed to consider sufficiently the steps that should be taken to aid a disabled person to return to work following time off by reason of illness. The tribunal also held that the <i>Malcolm</i> approach to the appropriate comparator did not apply to the question of whether reasonable adjustments had been made. That is, the comparator for these purposes should not be a non-disabled person who had acted in the same way as the disabled person in question. Instead, for these purposes, 'the comparator group is other employees of the Respondent who are not disabled and who are able forthwith to attend work and to carry out the essential tasks required of them in their post' (para 59).
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This is a potentially important case because of the tribunal's ruling in relation to the appropriate comparator for the purposes of assessing of reasonable adjustments had been made by the employer. The tribunal's approach means that it is easier to show discrimination by reason of failing to make reasonable adjustments than it is to show disability-related discrimination.
Proposal of key words for data base	Reasonable adjustments – appropriate comparator

Case title	<i>Eastern and Coastal Kent PCT v Grey</i>
Decision date	23 January 2009
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	Appeal No. UKEAT/0454/08/RN Employment Appeal Tribunal
Key facts of the case (max. 500 chars)	G applied for a post with the employer E. G suffered from dyslexia. She was unsuccessful in her application because, in her view, her dyslexia put her at a disadvantage compared to other applicants in the application process, which involved a presentation which, at the last minute and because of an IT failure, had to be prepared by hand.

Main reasoning/argumentation (max. 500 chars)	G alleged that that was because E had failed to make reasonable adjustments to accommodate her disability in its application process. The employer argued that as it was unaware of her disability it could not be said to have discriminated against her, because of section 4A(3) of the <i>Disability Discrimination Act 1995</i> . This provides that an employer is not under a duty to make reasonable adjustments in relation to a person if it does not know or could not reasonably be expected to know that the person in question has a disability.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The Tribunal held that to take advantage of section 4A(3) an employer must be able to demonstrate that it: <ul style="list-style-type: none"> • does not know that the disabled person has a disability; and • does not know that the disabled person is likely to be at a substantial disadvantage compared with persons who are not disabled; and • could not reasonably be expected to know that the disabled person had a disability; and • could not reasonably be expected to know that the disabled person is likely to be placed at a substantial disadvantage in comparison with persons who are not disabled.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The importance of the case lies in the Appeal Tribunal’s elaboration of the factors to be demonstrated by an employer wishing to use the protection from liability for discrimination offered by section 4A(3).
Proposal of key words for data base	Reasonable adjustments – factors to be demonstrated in order to avoid liability for discrimination on grounds of lack of knowledge of a person’s disability.

Case title	<i>Savage v South Essex Partnership NHS Trust Foundation</i>
Decision date	10 December 2008

Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2009] 1 AC 681 House of Lords (final court of appeal)
Key facts of the case (max. 500 chars)	S, who was suffering from paranoid schizophrenia, absconded from the hospital where she was being treated as a detained patient in an open acute psychiatric ward. She walked two miles to a railway station and there committed suicide by throwing herself in front of a train.
Main reasoning/argumentation (max. 500 chars)	S's daughter claimed that the hospital was in breach of Article 2 of the European Convention for failing adequately to supervise her mother, thus allowing her to abscond.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The House of Lords agreed that there had been a breach of Article 2. Article 2 is the source of both a general positive obligation on the part of the state to have systems in place to prevent harm, including self-harm, to psychiatric hospital patients; and of an operational obligation, to do what is reasonable in the circumstances, when there is a real and immediate risk to life about which the authorities knew or ought to have known at the time.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This important decision clarifies that it is not sufficient for those institutions which detain patients for treatment for mental disorder to have a general and generic policy on prevention of harm to those in their care. It is also necessary to act in a particular case when there is a particular risk which the institution knew or should have known about.
Proposal of key words for data base	Scope of Article 2 – right to life – nature and extent of positive obligations

Case title	<i>R (Wilkinson) v Broadmoor Special Hospital Authority</i>
Decision date	22 October 2001
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2002] 1 WLR 419, Court of Appeal (penultimate court of appeal)
Key facts of the case (max. 500 chars)	W, a detained patient in poor health had been forcibly treated with anti-psychotic medication, immediately after which he had suffered an angina attack. He disputed the need for the medication and also disputed the view of the two doctors treating him and authorising his treatment that he lacked capacity to consent. He argued also that his human rights had been violated.
Main reasoning/argumentation (max. 500 chars)	The case was not about the right to refuse treatment as such, but rather whether W could challenge the decision to treat him without consent in court and whether he could require the doctors treating him to appear in court to be cross-examined.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The Court of Appeal held that, because of the passage of the <i>Human Rights Act 1998</i> , which brought the rights protected by the European Convention into UK law, W was able to challenge the decision to treat him and was also able to require his doctors to appear in court for cross-examination, if in the court's view that was necessary to protect his human rights under Articles 2, 3 and 8 of the Convention. The Court found no breach of Article 6 of the Convention, because this case established that an involuntary patient has a right to challenge treatment given without consent in court.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This important case effectively created a right to refuse treatment for patients detained under mental health legislation in the UK, based on the human rights of the patient. The human rights of the patient will often although not always be at stake when there is an intention to treat without consent. It is, however, for the court rather than the patient to determine if there is an arguable case on human rights grounds.
Proposal of key words for data base	Treatment without consent – right to refuse – right to cross-examine doctors

Case title	<i>R v Dr M and others, ex parte N</i>
Decision date	6 December 2002
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2003] 1 WLR 562, Court of Appeal (penultimate court of appeal)
Key facts of the case (max. 500 chars)	N, a detained patient who suffered from paranoid psychosis and a severe personality disorder, was treated with anti-psychotic medicine on the authority of her doctor and a second opinion doctor. N did not consent to the treatment.
Main reasoning/argumentation (max. 500 chars)	N sought to challenge the decision of both doctors by reference to her rights under the Convention and as in the previous case of <i>Wilkinson</i> the issue was whether the doctors wishing to treat N could be compelled to appear before the court in order to be cross-examined.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	<p>The Court of Appeal gave guidance to first instance courts as to when it is appropriate to require those wishing to treat a detained person who refused to consent to appear before the court in order to demonstrate that the treatment is justifiable. The factors to be considered are:</p> <ul style="list-style-type: none"> •how certain is it that the patient does suffer from a treatable mental disorder •how serious a disorder is it •how serious a risk is presented to others •how likely is it that, if the patient does suffer from such a disorder, the proposed treatment will alleviate the condition •how much alleviation is there likely to be

	<ul style="list-style-type: none"> • how likely is it that the treatment will have adverse consequences for the patient • how severe may they be
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case added further clarification to the ruling in <i>Wilkinson</i> as to when it is appropriate to require those wishing to treat a refusing patient to attend court to justify their decision.
Proposal of key words for data base	Treatment without consent – human rights – right to challenge treatment decision in court – factors to be considered when deciding whether to require doctors to appear in court to justify the decision to treat

Case title	<i>R v RMO and SOAD, ex parte JB</i> (also known as <i>R (on the application of B) v Haddock (Responsible Medical Officer)</i>)
Decision date	11 July 2006
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2006] EWCA Civ 961 Court of Appeal (penultimate court of appeal)
Key facts of the case (max. 500 chars)	B, a detained patient, had been classified as suffering from a psychopathic disorder. The doctor in charge of his treatment, H, intended to treat B with anti-psychotic medication. Such medication had already been given to B and as he did not consent force had been used to administer it. B was able to produce evidence from a psychiatrist and a psychologist, to the effect that B was not suffering from any mental illness or mental disorder, and that the treatment was not necessary. Nevertheless B was again treated by H, who had obtained a second opinion from a doctor appointed for this purpose, who agreed with H that the treatment was necessary.

Main reasoning/argumentation (max. 500 chars)	B sought to prevent any further administration of treatment on the basis that he was not mentally disordered and therefore the administration to him of anti-psychotic medication was not necessary or appropriate.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The main issue in this case, was the degree of proof needed to satisfy the court that the treatment in question could properly be administered.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The Court of Appeal declined to accept that the patient's ability to produce professional witnesses holding the opinion that the necessity of treatment had not or could not be convincingly shown did not preclude it from holding that the case for treatment had been convincingly made out. The court held that in order for the case for treatment to be convincingly shown, those wishing to treat had to persuade the court of 'the satisfaction of medical necessity on a balance of probabilities', or of the 'likelihood' of therapeutic benefit'.
Proposal of key words for data base	Treatment without consent – human rights – right to challenge treatment decision in court – level of proof required in order for the court to be satisfied that the need for treatment had been 'convincingly shown' (this form of words was adopted by the UK court because of its use by the European Court of Human Rights in the leading case of <i>Herczegfalvy v Austria</i> (1992) 15 EHRR 437).

Case title	<i>Sheffield City Council v E</i>
Decision date	2 December 2004
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2005] Fam 326, [2004] EWHC 2808 (Fam) High Court (superior first instance court)

Key facts of the case (max. 500 chars)	E was 21 years old and was physically disabled and also suffered from intellectual disability. The relevant local social services authority alleged that E functioned at the level of a 13 year old. She had made plans to marry S, a man of 37 years age of with a substantial history of sexually violent crimes. The social services sought an injunction to prevent the marriage from taking place, alleging that S lacked capacity to marry and that marriage to S was not in her best interests.
Main reasoning/argumentation (max. 500 chars)	The argumentation in this case focused on the capacity required in order to enter a valid marriage.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The issue in this case was the nature of the test for capacity to marry. The local social services authority submitted that capacity to marry had to be assessed by reference to the particular marriage proposal in question. E submitted that the test for marriage did not involve a consideration of the particular marriage.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The court decided that for a person to have capacity to marry it was not enough that he or she appreciate that she was taking part in a marriage ceremony or understand its words. What is required is that the person in question can understand the nature of the marriage contract and the duties and responsibilities that normally attached to marriage. The question of best interests was sent back to the trial court to determine.
Proposal of key words for data base	Capacity to marry – jurisdiction of the courts to protect persons with intellectual disability from a potentially exploitative marriage.

Case title	<i>M v B</i>
Decision date	25 July 2005
Reference details (reference number; type and title of court/body; in original language and English [official translation, if	[2005] EWHC 1681 In this case the parents of a woman, M, in her early 20s with severe intellectual disability, domiciled in the UK, intended to take her to Pakistan. The parents claimed that the purpose of the visit was a holiday, but the local social services authority was able to persuade the court that the real purpose of the visit was so that M could be married to a Pakistani man selected by her parents. The court further found (i) that M clearly lacked capacity to marry and (ii) marriage, and departure from the UK, would not be in her best interests. It therefore issued injunctions forbidding her parents to arrange for a marriage to take place or to take M out of the jurisdiction.

available])	
Key facts of the case (max. 500 chars)	The parents of a woman, M, in her early 20s with severe intellectual disability, domiciled in the UK, intended to take her to Pakistan. The parents claimed that the purpose of the visit was a holiday, but the local social services authority was able to persuade the court that the real purpose of the visit was so that M could be married to a Pakistani man selected by her parents.
Main reasoning/argumentation (max. 500 chars)	The main arguments centred on the capacity of M to marry and the application of the principles of best interests to her circumstances.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The court found (i) that M clearly lacked capacity to marry and (ii) marriage, and departure from the UK, would not be in her best interests. It therefore issued injunctions forbidding her parents to arrange for a marriage to take place or to take M out of the jurisdiction.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case serves as an illustration of the courts' jurisdiction to protect vulnerable adults from exploitation.
Proposal of key words for data base	Intellectual disability – protection from exploitation marriage

Case title	<i>Local Authority X v M</i>
Decision date	21 August 2007
Reference details (reference number; type and title of court/body; in original language and English [official translation, if	[2007] EWHC 2003 (Fam) [2009] 1 FLR 443 High Court (superior first instance court)

available])	
Key facts of the case (max. 500 chars)	M, aged 39 years, had moderate intellectual disabilities (IQ score 56) and also suffered from paranoid schizophrenia. She had been in a relationship with her partner, K for 15 years, who suffered from a psychopathic personality disorder and alcoholism. K announced that he intended to move to another part of the country and take M with him. The relevant local social services authority sought injunctions to the effect that M should reside in accommodation provided by it and have only limited and supervised contact with K.
Main reasoning/argumentation (max. 500 chars)	The main argument in this case concerned the application of the best interests test to a person with moderate intellectual disabilities in a situation in which measures designed to protect her also impeded significantly on her private and family life with her partner.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The court held that the requirement of proportionality meant that ‘The court should intervene only where there is a need to protect vulnerable adult from abuse or the real possibility of abuse’. The court proceeded to make various orders, concerning residence and contact between M and K.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The court referred specifically to Article 8 of the Convention and the right to respect for private and family life, expressing the view that orders which interfered with the private lives of M and K respectively must be in compliance with it. This, therefore, puts in place a higher threshold for intervention than the customary ‘best interests’ criterion, in order to respect the privacy and family rights of persons suffering from a mental disorder from unwarranted interference by the state.
Proposal of key words for data base	Right to respect for privacy and family life-proportionality-criteria for intervention in best interests of vulnerable person

Case title	<i>R v Bournewood Community and Mental Health NHS Trust, ex parte L</i> [1999] 1 AC 481/ <i>HL v UK</i> Application Number 45508/99 (2005) 40 EHRR 32,
Decision date	25 June 1998 (House of Lords), 5 October 2004 (European Court of Human Rights)

Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	House of Lords decision: [1999] AC 481 (final court of appeal) European Court ruling: (<i>Application no. 45508/99</i>) [2005] 40 EHRR 32
Key facts of the case (max. 500 chars)	L, who had significant intellectual disability such that he could not consent to or refuse an offer of hospital accommodation, was an informal patient in a hospital. However, his treatment providers felt that it was not in his best interests to leave the hospital and had he tried to do so he would have been made subject to an involuntary placement.
Main reasoning/argumentation (max. 500 chars)	The issue in this case was whether L was deprived of his liberty contrary to Article 5 of the European Convention. The hospital (and the UK Government) argued that he was not because of his informal status. L argued that he was deprived of his liberty because if he had tried to leave the hospital he would have been prevented from doing so.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The House of Lords found no breach of Article 5 and that the informal accommodation of a person like L was permitted under UK law. It also found that L did not have a case for wrongful detention as he had not actually tried to leave the hospital. The European Court of Human Rights disagreed with this. It found a breach of Article 5 because (i) it found that L was in fact detained, holding that the test for detention ‘whether the hospital exercised complete control over his care and movements’ (para 44); and (ii) there was a lack of legal and procedural safeguards to ensure that L’s detention was compatible with the Convention.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This important case required the UK to change its law to ensure that where a person with significant intellectual disability is in fact detained there is (i) a legal basis for that detention and (ii) the possibility of the patient or some interested person or body being able to challenge it.
Proposal of key words for data base	Deprivation of liberty - legal basis for detention – safeguards to prevent unlawful detention.

Case title	<i>R v Mental Health Review Tribunal, ex parte KB and seven others</i>
Decision date	23 April 2002
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2002] EWHC 639 (Admin) Case Nos: CO/2363/2001; CO/3130/2001; CO/3863/2001; CO/4052/2001; CO/4070/2001; CO/4598/2001; CO/97/2002
Key facts of the case (max. 500 chars)	Eight patients all subject to involuntary placement had waited from between four and 27 weeks for a hearing to challenge their continued detention before a Tribunal.
Main reasoning/argumentation (max. 500 chars)	All eight patients argued that the delay their application coming before a Tribunal violated their rights under Article 5(4) of the European Convention, which requires that those detained must be able to have the lawfulness of their detention decided speedily by a court.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The court found that the reason for the delay in each case was structural defects in the operation of the Tribunal system, and that in each case there was a violation of Article 5(4).
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The decision in this case obliged the UK government to increase the funding for and efficacy of the Tribunal system. All eight patients involved in this case were awarded damages by the court, to be paid by the state.
Proposal of key words for data base	Right to challenge detention – delay in the process – acceptable and unacceptable extent of delay – Article 5(4)

Case title	<i>R v Mental Health Review Tribunal London and South West Region, ex parte C</i>
Decision date	3 July 2001
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2001] MHLR 110, [2001] EWCA Civ 110 C/01/0022
Key facts of the case (max. 500 chars)	C, a detained patient, had waited eight weeks for his application for an order for discharge from hospital to be heard by a Tribunal.
Main reasoning/argumentation (max. 500 chars)	C argued that a blanket policy of an eight week delay between application and Tribunal hearing violated Article 5(4) of the European Convention.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The Court of Appeal found a violation of Article 5(4). Medical reports must be provided by the detaining hospital within three weeks according to the relevant regulations. The arbitrary setting of the standard waiting time at eight weeks therefore could not be justified. The court suggested that in a typical case the average wait should be no more than four to five weeks.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The case underscored the importance of human rights to detained patients. The decision of the Court of Appeal required those operating the Tribunal system to provide a more speedy service to persons entitled to a tribunal hearing.
Proposal of key words for data base	Right to challenge detention – delay in the process – acceptable and unacceptable extent of delay – Article 5(4)

Case title	<i>R v (M) John</i>
Decision date	14 November 2003
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2003] EWCA Crim 3452 No 20031137/B1 Court of Appeal (penultimate court of appeal)
Key facts of the case (max. 500 chars)	M, who suffered from anterograde amnesia which prevented him remembering the events in respect of which criminal charges had been pressed against him, had been found fit to plead and convicted by a criminal court for a serious sex offences.
Main reasoning/argumentation (max. 500 chars)	M appealed against his conviction on the basis that he had been unfit to plead at the time of his trial and conviction. The question for the appeal court was the capacity test to be applied in order to determine if a defendant in a criminal trial is fit for trial.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The Court of Appeal explained (para 20 of the judgment) that in order to be fit to stand trial a defendant must be capable of: <ul style="list-style-type: none"> ‘(1) understanding the charges; (2) deciding whether to plead guilty or not; (3) exercising his right to challenge jurors; (4) instructing solicitors and counsel; (5) following the course of the proceedings; (6) giving evidence in his own defence’.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case provides a modern and authoritative statement of the test for capacity to be applied in the context of a criminal trial.

Proposal of key words for data base	Fitness to stand trial – relevant factors for determining capacity
Case title	<i>R v Borkan</i>
Decision date	11 June 2004
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2004] EWCA Crim 1642 No 2003860/B3 Court of Appeal (penultimate court of appeal)
Key facts of the case (max. 500 chars)	B, who had held an ex-partner and her friend hostage for several hours and had been violent towards them, was determined as fit to stand trial by a psychiatrist. His trial proceeded but was stopped because of concerns about B's mental state. He was again seen, by a different psychiatrist, who reported that B was not mentally ill. The trial commenced again. B's lawyer requested it be adjourned for further medical reports on B's mental state as the lawyer had fresh concerns regarding B's capacity to stand trial, and that B's fitness to stand trial should be considered as a preliminary matter by a different jury. This application was refused by the trial judge and B was convicted.
Main reasoning/argumentation (max. 500 chars)	B appealed on the basis that the trial judge had been wrong not to stop his trial a second time, not to seek further medical opinion as to B's capacity to stand trial, and not to appoint a jury to determine whether B was in fact fit to stand trial.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The appeal was unsuccessful. A jury can only be asked to consider, or to find, that a defendant is unfit to stand trial if there is medical evidence suggesting the need for a jury to be appointed for that purpose. Here the trial judge had been correct not to seek further medical evidence as there was already ample evidence on which to conclude that B was fit for trial.

Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case established that once there is appropriate evidence for a court to conclude that a defendant is fit to stand trial, the defendant or his or her legal representatives may not request that further medical evidence be obtained in order to challenge that which has already been considered unless there is some specific reason caused by the defendant's behaviour at trial which calls the continued accuracy of that earlier evidence into question.
Proposal of key words for data base	Fitness to stand trial – right to seek further medical evidence - need for medical evidence before question of unfitness can be put to a jury.

Case title	<i>R v H and the Secretary of State for the Home Department</i>
Decision date	30 January 2003
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2003] UKHL 1 House of Lords (final court of appeal)
Key facts of the case (max. 500 chars)	This case concerned the compatibility of the 'trial of the facts' procedure with Article 6 of the European Convention. The 'trial of the facts' procedure applies when a defendant has been found unfit to stand trial. The procedure determines whether the defendant committed the criminal act he or she is accused of. If it is found that he or she did not, an acquittal must follow. If it is found that he or she did, the court may make one of various therapeutic orders, including detention in a hospital or involuntary supervision in the community.
Main reasoning/argumentation (max. 500 chars)	The issue was whether the 'trial of the facts' procedure is 'fair' as required by Article 6. The argument that it is not is based on the propositions (i) that if a defendant is unfit for trial he or she is equally unfit for a trial of the facts (ii) a trial of the facts is a criminal trial, in respect of which Article 6 of the Convention requires that the defendant be allowed and facilities to mount a defence, which a defendant found unfit to stand trial by definition cannot do.

Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The House of Lords held (i) that a trial of the facts is not a criminal trial because it does not seek to determine guilt, cannot result in a conviction, and permits only of acquittal or a therapeutic disposal; (ii) provided that the proceedings are conducted with ‘scrupulous regard for the interests of the accused person’ (para 20) it is fair within the meaning of Article 6.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case established that the mechanism of the trial of the facts, designed to provide access to therapeutic disposals for persons unfit to plead but also to ensure that the public is protected from the dangerous acts of those lacking capacity to be tried for them, is compatible with the European Convention, provided that the proceedings are in fact conducted fairly.
Proposal of key words for data base	Trial of the facts – compatibility with Article 6- fairness of the procedure

Case title	<i>R v Mental Health Review Tribunal, North and East London, ex parte H</i>
Decision date	28 March 1981
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2001] EWCA Civ 415 Court of Appeal (penultimate court of appeal)
Key facts of the case (max. 500 chars)	H, a detained patient with a diagnosis of schizophrenia, applied to a mental health review tribunal for an order for discharge. An order for discharge must be made if the tribunal is satisfied that the patient is no longer mentally disordered or no longer in need of involuntary hospitalisation. The law existing at that time required the patient to demonstrate that he or she no longer satisfied the above criteria for involuntary placement.

Main reasoning/argumentation (max. 500 chars)	H argued that the requirement that the patient prove that the criteria for detention were no longer applicable violated his rights under Articles 5(1) and 5(4) of the Convention.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	H's argument was accepted by the court, which made a declaration of incapacity under a procedure introduced by the <i>Human Rights Act 1998</i> . The making of such a declaration raises an expectation that the government will amend the law in question so that it is human rights law compatible.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	That is what happened in this case. By Statutory Instrument the relevant section of the <i>Mental Health Act 1983</i> was amended. The situation now is that it is for those seeking an involuntary placement to continue to convince a tribunal that the relevant criteria are satisfied. It is no longer for the patient to demonstrate that they are not.
Proposal of key words for data base	Tribunal applications -Burden of proof – state to prove the case for continued detention

Case title	<i>W v Edgell</i>
Decision date	9 December 1988
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[1989] 1 All ER 1089 High Court (superior first instance court)

Key facts of the case (max. 500 chars)	W, a patient with a diagnosis of paranoid schizophrenia, who had been detained after committing a number of homicide offences, applied after several years in hospital to mental health review tribunal for an order for discharge. W commissioned a report from Dr E which stated that W may have been wrongly diagnosed and may be more dangerous than his treatment providers thought. W then abandoned his tribunal application, which meant that Dr E's report was not made available to the tribunal or the detaining hospital. Dr E then sent his report to both tribunal and hospital.
Main reasoning/argumentation (max. 500 chars)	W sued Dr E for breach of confidence.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The court accepted that there had been a clear breach of confidence, but that it was justified on the basis that W was a potential danger to the public and although Dr E owed a duty to E he also owed a duty to the public at large to report his concerns to the appropriate authorities or bodies, as had happened in this case.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case makes clear that the duty of confidentiality is not absolute and confidential information may be disclosed to an appropriate authority if the public interest in disclosure is greater than the public interest in protecting confidences on the facts in question.
Proposal of key words for data base	Confidentiality-breach-public interest in disclosing confidential information

Case title	<i>Ashworth Hospital v Mirror Group Newspapers</i>
Decision date	27 June 2002

Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2002] UKLH 29 House of Lords (final court of appeal)
Key facts of the case (max. 500 chars)	B, a patient at Ashworth hospital diagnosed with a personality disorder, was a notorious child killer. A story appeared in a national newspaper about B which included details from his confidential medical records held by the hospital. The hospital, desiring to know the source of the information, requested the newspaper to reveal its source but the newspaper declined. The hospital then applied to a court for an order requiring the newspaper to disclose the identity of the source of its story.
Main reasoning/argumentation (max. 500 chars)	The newspaper argued that much of the information in its story had already been placed in the public domain by B, who had given various media interviews, and therefore the information in question could no longer be considered confidential.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The House of Lords upheld the ruling of lower courts, that the hospital, as owner of the data, had an independent right of confidentiality in respect of the medical records it held in respect of its previous and past patients, and it could enforce that right by seeking an order for the disclosure of identity of the person who had wrongfully leaked the story to the press thus breaching the right to confidentiality of the hospital, which continued to be enforceable irrespective of whether the patient had made the information in question public.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case established that medical establishments have an independent right of confidentiality or privacy in the records they maintain. This right can be enforced in the courts.
Proposal of key words for data base	Duty of confidence-right to privacy-rights of treatment providers in confidential patient data

Case title	<i>Dickson v UK</i>
Decision date	4 December 2007
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	(2008) 46 EHRR 41 European Court of Human Rights
Key facts of the case (max. 500 chars)	D, male, and X, female, had married whilst both were serving prison sentences. X had been released but D had several years left to serve, by which time the age for child-bearing would have passed. X and D wishes to have a child and the couple sought permission to access artificial insemination services. The policy of the UK government was that access to reproductive technology was not provided to persons in prison.
Main reasoning/argumentation (max. 500 chars)	D challenged this policy, arguing that it violated the rights to privacy and to respect for family life found in Article 8 of the European Convention
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The European Court agreed with D to the extent that a total ban on access to a health service that was generally available to the public at large through the publicly-funded national health system was disproportionate and in breach of Article 8 of the Convention.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case has required the UK government to modify its policy on the availability of reproductive services that are generally available to the general public to those detained in prison and also, by implication those detained by way of involuntary placement in a psychiatric facility.
Proposal of key words for data base	Rights of detained person to access fertility services-protection of privacy and respect for family law

Case title	<i>Hirst v UK</i>
Decision date	6 October 2005
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	(2006) EHRR 41 Application Number 740235/012 European Court of Human Rights
Key facts of the case (max. 500 chars)	UK policy was that those detained in prisons or mentally disordered offenders detained in hospitals may not vote in parliamentary or other elections.
Main reasoning/argumentation (max. 500 chars)	H challenged this policy. His challenge was based on Article 3 of Protocol 1, which requires state parties to the European Convention on Human Rights to hold free elections by secret ballot 'to ensure the free expression of the opinion of the people in the choice of legislature'.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The European Court found a violation of the Article in question. Although the Convention allowed a wide margin of appreciation on the precise extent of suffrage, which need not be universal, and although the prevention of crime is a legitimate aim of government policy, the wide and inflexible nature of the policy in the UK rendered it disproportionate.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The UK government is in the process of consulting on changes to national law so as to make it compatible with this ruling. Seperate consultations in respect of prisoners and persons detained in psychiatric facilities have taken or will soon take place.
Proposal of key words for data base	Right to vote – prisoners and detained psychiatric patients

Case title	<i>Reid v Secretary of State for Scotland</i>
Decision date	3 December 1998
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[1999] 2 AC 512 House of Lords (final court of appeal)
Key facts of the case (max. 500 chars)	R had been held in a secure psychiatric hospital for many years following his conviction for homicide. R sought release from the detaining hospital by application to a sheriff, on the grounds that his condition, a personality disorder, was not amenable to treatment.
Main reasoning/argumentation (max. 500 chars)	R argued that it was not permissible to detain him if not treatable. This was because it is a legal requirement of admission that there is treatment available to the patient which is likely to improve or prevent a deterioration in his mental state.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The House of Lords held that the continued detention of R was lawful. Although it was correct that there was no medical treatment that could improve or prevent a deterioration in R's mental state, the concept of 'treatment' in the relevant statute was broad enough to encompass other interventions such as management strategies. In this case, R was subject to a regime which managed his anger and improved his control of his own anger and this could be considered as treatment. One judge, Lord Hope, explained that 'treatment' may include a wide variety of interventions 'from cure to containment'.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case clarified the definition of 'medical treatment' in UK domestic law, showing it to be a very broad concept indeed.
Proposal of key words for data base	Definition and extent of concept of 'medical treatment'

Case title	<i>A, D and R v Scottish Ministers</i> (Privy Council) / <i>Hutchinson Reid v UK</i> (European Court)
Decision date	15 October 2001 (Privy Council), 20 February 2003 (European Court)
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2001] UKPC D5 (Privy Council), (2003) 37 EHRR 211 Application Number 50272/99 (European Court)
Key facts of the case (max. 500 chars)	Following the decision in the case immediately above, the Scottish Ministers enacted legislation which removed the requirement of treatability from Scots law. The new law stated that a person suffering from mental disorder could be detained in hospital even if not treatable if that was necessary to protect the public from serious harm. H was detained under this law by reason of his perceived dangerousness to members of the public. It was accepted that H was not treatable, even in the broad sense of that term elaborated in the <i>Reid</i> case (immediately above).
Main reasoning/argumentation (max. 500 chars)	H argued that this provision was incompatible with Article 5(1)(e) of the European Convention, which requires that those detained by reason of ‘unsound mind’ (mental disorder), because a propensity to reoffend could not justify his detention in a hospital if there was no intention to treat him during his detention there.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The Privy Council held, and the European Court agreed, that the availability of treatment was not a requirement imposed on national law by Article 5(1)(e) of the Convention. Provided that a person was mentally disordered, and his continued detention was a proportionate response to his dangerousness to others, there was no violation of any Convention right.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case established that it is lawful to detain a mentally disordered person on grounds only of public safety. The requirement that a detained patient be treatable is not found in the rights protected by the Convention.

Proposal of key words for data base	Detention of persons with untreatable mental disorder on grounds of public protection
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Case title	<i>R v Camden and Islington Health Authority, ex parte K / Kolanis v UK</i>
Decision date	21 February 2001 (Court of Appeal), 21 June 2005 (European Court)
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2001] 3 WLR 553 Court of Appeal (penultimate court of appeal) (2006) 42 EHRR 12, Application Number 517/02 (European Court)
Key facts of the case (max. 500 chars)	A mental health review tribunal had found that K, a detained patient, could be discharged from hospital, conditional on her accepting aftercare in the shape of psychiatric supervision following her release, which she did. However it proved impossible to find a psychiatrist willing to accept K as a patient and so she remained in hospital. There is a duty to provide aftercare to patients discharged from hospital in England and Wales
Main reasoning/argumentation (max. 500 chars)	K argued that the duty to provide aftercare is absolute, and also that the failure to provide it breached her rights under Article 5(1) of the Convention, as she remained because of that failure in hospital involuntarily and unnecessarily.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The Court of Appeal held that the duty to provide aftercare is not absolute. Rather it is a duty to use 'best endeavours' to enable the conditions set by a tribunal to be met and the patient discharged. But provided that the patient remained mentally disordered to the extent that in the absence of aftercare hospitalisation was appropriate, there is no breach of any aspect of Article 5 of the Convention. This decision was upheld by the European Court.

Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case established that the duty to provide aftercare is not absolute but rather an obligation to do what is reasonable to allow a patient to be released from hospital.
Proposal of key words for data base	Aftercare – inability of aftercare providers to find psychiatrists willing to be responsible for patient on release –whether

Case title	<i>R(PS) v G(RMO) and W (SOAD)</i>
Decision date	10 October 2003
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2003] EWHC 2335 High Court (superior first instance court)
Key facts of the case (max. 500 chars)	PS was detained in a psychiatric hospital suffering from schizophrenia. His doctor wished to treat PS with anti-psychotic medicine. PS, who had capacity to make his own treatment decisions, did not consent to this. However, it is possible to treat even a detained patient with capacity who refuses to consent if his doctor, supported by a required second opinion, certifies that the treatment is necessary in the best interests of the patient.
Main reasoning/argumentation (max. 500 chars)	PS challenged his treatment on the basis that the law described was incompatible with Articles 3 and 8 of the European Convention, and that it was particularly relevant that he had capacity to give or refuse consent in general terms.

Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The High Court held, applying the test laid down in <i>R v Dr M and others, ex parte N</i> (see above), that the treatment should be given. The court did state, however (para 119) that the fact that the patient had capacity was an important factor for those deciding whether to use statutory powers to treat without consent to consider.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case shows that the capacity of the patient is an important consideration when deciding whether to use legal powers to treat without consent, but also shows that if the treatment is found to be in the best interests of the patient the treatment may lawfully be given and will not violate any Convention Right.
Proposal of key words for data base	Right to refuse-relevance of capacity

Case title	<i>B v Croydon Health Authority</i>
Decision date	1 January 1995
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[1995] 1 ALL ER 683 Court of Appeal (penultimate court of appeal)
Key facts of the case (max. 500 chars)	B, a detained patient on account of her having a personality disorder, refused food. Her refusal of food was a symptom of her disorder. Her doctors wished to feed her by force in her best interests.
Main reasoning/argumentation (max. 500 chars)	The issue was whether feeding by force could constitute treatment for mental disorder, and so be given using the powers of involuntary treatment of detained patients available in the statutory scheme.

Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The Court of Appeal held that B could be fed by force, and that constituted treatment for her mental disorder. This was because the definition of treatment found in the Mental Health Act 1983 included the treatment of symptoms of the disorder in question and B's refusal of food was a symptom of her disorder.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	This case established a broad definition of the concept of treatment for mental disorder.
Proposal of key words for data base	Treatment –definition- feeding by force

Case title	<i>R v Ashworth Hospital, ex parte Munjaz</i>
Decision date	13 October 2005
Reference details (reference number; type and title of court/body; in original language and English [official translation, if available])	[2005] UKHL 58 House of Lords (final court of appeal)
Key facts of the case (max. 500 chars)	M, a patient detained in a high security hospital was secluded for periods of weeks at a time. The Code of Practice which accompanies the <i>Mental Health Act 1983</i> provides that when a patient is in seclusion the situation should be reviewed every two hours by a nurse and every four hours by a doctor. The hospital's own policy required reviews much more infrequently: two reviews a day for the first week and three reviews each week from the second week.

Main reasoning/argumentation (max. 500 chars)	M challenged the seclusion policy of the hospital. He argued that the Code of Practice has the force of law and hospitals may not depart from the requirements set out in it. He also argued that his seclusion violated Articles 3, 5 and 8 of the European Convention.
Key issues (concepts, interpretations) clarified by the case (max. 500 chars)	The House of Lords held (i) that the Code of Practice is guidance not law, and therefore hospitals may develop and pursue their own policies on seclusion, which will be lawful if there are cogent reasons which justify the policies developed; (ii) the policy at the hospital in question did not breach any Article of the Convention provided that the policy (as was the case here) was proportionate and seclusion was not used for any longer period than necessary in respect of any particular individual.
Results (sanctions) and key consequences or implications of the case (max. 500 chars)	The case gave hospitals confirmation that they have discretion to develop and implement policies most suited to their particular situation, and that such policies will not violate human rights law requirements if they are proportionate and reasonable in design and implementation.
Proposal of key words for data base	Seclusion-Convention Rights