CONNECTING
MENTAL HEALTH & HUMAN RIGHTS

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FOREWORD

The Northern Ireland Human Rights Commission engaged the authors of this report to carry out a review on its behalf of human rights issues involved in mental health law, policy and practice in Northern Ireland.

As *Connecting Mental Health & Human Rights* notes, mental health is an issue which touches the lives of many people in Northern Ireland. Government estimates that at any one time one in six people in Northern Ireland will have mental health problems. This will often affect not only the person themselves but also their family and friends. The way in which society deals with mental health issues raises many human rights points for example in relation to service provision, treatment, assessment and civil detention, protection and empowerment. The report deals with these and other complex issues.

Government has initiated a wide-ranging, independent review, lead by Professor David Bamford, of the law affecting people with mental health needs or a learning disability in Northern Ireland. The Human Rights Commission hopes that this report will provide an important contribution to the work of that review. Indeed, Lady Christine Eames is representing the Commission on the Review team's human rights sub-group.

During the course of their research, the authors presented their initial findings and recommendations at a seminar in March 2003 hosted by the Commission, involving statutory authorities, service providers, interest groups and people with experience of mental health issues. Feedback at this seminar helped to shape the final report and we would like to thank those who contributed for their support.

The Commission is grateful to Gavin, Maura and Michael for their work on the report. We have endorsed its findings and recommendations and we will follow up the work by disseminating the research widely and by pressing those in authority to adopt the recommendations. The conclusions of this research will contribute to the deliberations of the Commission when it is preparing its final advice on a Bill of Rights for Northern Ireland.

Brice Dickson
Chief Commissioner

THE AUTHORS

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EXECUTIVE SUMMARY

Introduction

The Department of Health, Social Services and Public Safety has estimated that at any point in time, one in six people will have mental health problems, which will in turn affect family and friends.[1]

All people with mental health problems have the right to live their lives without arbitrary or inappropriate interference. The enactment of the Human Rights Act 1998 (which incorporates the European Convention on Human Rights into domestic law) and the creation of the Northern Ireland Human Rights Commission have contributed to the momentum for a critical evaluation of the mental health law, policy and practices applicable in Northern Ireland.

Connecting Mental Health & Human Rights is timely given the Government's recent establishment of a Review of Mental Health and Learning Disability that will consider the reform of mental health legislation, policy and provision in Northern Ireland.[2]

It aims to stimulate further consideration and discussion of the complex issues arising in this area. It makes recommendations aimed at better protecting and promoting the human rights of people with mental health problems.

This report was funded by the Northern Ireland Human Rights Commission which has endorsed its findings and recommendations.

The Structure of the Report

The recommendations are contained in each Chapter and are presented in their entirety in Chapter 8 for ease of reference. The focus is on mental health so the related areas of learning disability, brain injury and dementia and the issues arising in these areas are not examined in depth. The report concentrates on the areas where concerns have been identified which are:

- The assessment and civil detention of people with mental health problems;
- The Mental Health Review Tribunal;
- The Mental Health Commission for Northern Ireland;
- Treatment;
- Mental health and the criminal justice system; and
- Protection and empowerment.

[1] *Promoting Mental Health. Strategy and Action Plan 2003-2008.* Department of Health Social Services and Public Safety, 2003.
[2] The review, which was initiated by the DHSSPS in October 2002, is chaired by Professor David Bamford and is expected to last approximately two years.

Each section of the report is structured in the same way. The issues are examined by looking at:

- The relevant international standards;
- Law, policy and practice in Northern Ireland;
- The potential human rights violations or concerns arising; and
- The experience of other jurisdictions: in particular the proposals for mental health law reform in England and Wales and the new Mental Health (Care and Treatment) (Scotland) Act 2003.

Finally, recommendations are made in relation to addressing the human rights issues identified in Northern Ireland.

Equality issues are identified in relation to specific issues throughout the report and some of the general issues are discussed in the introduction.

During the research and consultation for this report the importance of the use of language in this area was emphasised. This debate is acknowledged and the term 'people with mental health problems' has been adopted as this was considered to be the least problematic at present.

Main Findings and Recommendations

General issues

- Some of the main recommendations are highlighted here but it is important for all of the recommendations (collated in Chapter 8) to be considered in detail.

- Aspects of mental health law, policy and practice in Northern Ireland must be amended to ensure compliance with human rights law and standards.

- Three particular types of situation give rise to human rights issues in mental health law, policy and practice:

    1. Where a person is not mentally competent to make a relevant decision;
    2. Where a mentally competent person is unwilling to consent to proposed care and/or treatment; and/or
    3. Where a person with mental health problems presents a risk of harm to self and/or others.

- Inequalities in mental health arise through social factors such as poverty, discrimination, isolation and poor housing and also in relation to discrimination on the basis of age, ethnic minority, gender and sexual orientation.

- The impact of 'the Troubles' and sectarianism on mental health needs to be taken into consideration in the provision of services.

- There are particular concerns about inadequacies in services for children and young people with mental health problems.

The assessment and civil detention of people with mental health problems

- Involuntary intervention raises particular concerns, for example in Northern Ireland persons involuntarily detained may be treated against their will, even if mentally capable.

- The procedures for detention under mental health legislation in Northern Ireland do not appear to meet the standards of swiftness, independence and impartiality required by Articles 5 and 6 of the Human Rights Act.

- All compulsory admissions should be independently reviewed within the assessment period.

- A narrow and clear definition of mental health should be used in legislation to prevent arbitrary detention.

- Proposals for the better protection of voluntary and incapable patients should be adopted.

- The role of the nearest relative as applicant should end but people should be able to nominate a person they would like to be consulted.

- Better information and advocacy should be available.

- Further compulsory powers could be counter-therapeutic and violate human rights.

The Mental Health Tribunal

- There are serious concerns about the tribunal review process relating to detention decisions including potential delay, fairness and adequate representation in hearings.

- The report suggests the introduction of an automatic review of detention decisions by an independent tribunal.

- There should be increased resourcing of the tribunal system together with a time limit within which a hearing can be expected in order to tackle delay.

- Funding should be provided for specialist independent and accessible mental health legal advice and representation.

- There needs to be greater transparency in the role of the medical member by requiring the disclosure to the parties of the basis upon which the opinion is given.

- The current burden of proof at tribunal hearings should be reversed as required by the European Convention on Human Rights.

The Mental Health Commission for Northern Ireland

- In order to promote and protect the rights of people with mental health problems it is necessary to have a body that has clear responsibility for monitoring the implementation of mental health legislation and ensuring law, policy and practice is compatible with the agreed human rights standards.

- Despite having a broad remit, it seems that resource limitations have constrained the work of the Mental Health Commission and more resources are needed if this body is to fulfil its comprehensive remit.

Treatment

- Particular human rights concerns are the forced treatment of capable patients, the types of treatment authorised, the inadequate testing of capacity to consent to treatment and the under-funding of community services.

- Legislation should ensure that people with capacity to refuse treatment are no longer treated against their will, except in very limited circumstances.

- Detailed research should be carried out on the use of ECT and other potentially irreversible treatments, involving the psychiatric profession and users.

- Additional funding should be provided for mental health promotion, prevention, early intervention services and community mental health and learning disability services with a view to reducing the need for compulsory treatment.

- Legislation should require the provision of accessible treatment for people diagnosed as having a personality disorder.

Mental health and the criminal justice system

- It appears that not all people with mental health problems are receiving the care and treatment they need in appropriate settings in Northern Ireland.

- There are particular concerns when people with mental health problems are inappropriately detained in prison.

- An inter-agency group is needed to co-ordinate policy, guidance, training and service provision.

- People with mental health problems should be diverted from the criminal justice system to health and social services at the earliest possible point.

- Health and social services should provide in-reach to the prison service to support the prison health care service and facilitate transfer, continuity and resettlement.

Protection and empowerment

- People who have the capacity to make decisions about their everyday life should be encouraged to make these decisions.

- Those who do not have capacity also have the right to respect for their private life but may require assistance in exercising their rights and in order to prevent abuse, there is an obligation on public authorities to provide appropriate protection.

- More comprehensive legislation governing people with incapacity should be introduced as a matter of priority.

- The incapacity legislation should ensure an appeal procedure for any decision on incapacity. The appeal should be to a court or tribunal which is accessible in terms of cost and time.

- The new legislation should allow for a tribunal appeal where there is a welfare dispute.

- A specific audit of legislative provision prohibiting sexual relationships with women with a severe mental handicap should be carried out to ensure compliance with Articles 8 and 14 of the European Convention on Human Rights.

1: INTRODUCTION

Mental health issues touch the lives of many people in Northern Ireland. The Department of Health[3] has estimated that as many as one in four of us will experience a mental health problem at some time in our lives, and the Department of Health, Social Services and Public Safety[4] has estimated that, at any point in time, one in six people will have mental health problems, which will in turn affect family and friends. All people with mental health problems have the right to live their lives without arbitrary or inappropriate interference.

The health and social services authorities have responsibility for providing assistance, care and treatment for people with mental health problems in accordance with their statutory duties and prevailing mental health law. Traditionally the provision of care and treatment has been broadly premised upon a principle of individual autonomy: the principle's underlying concept being the preservation of a person's right to decide whether to accept proposed care and/or treatment, assuming that person is deemed to have sufficient mental health and capacity to do so.

Most difficulties and complexities in mental health law, policy and practice, generally arise in three types of situation:

(1) Where a person is not mentally competent to make a relevant decision;
(2) Where a mentally competent person is unwilling to consent to proposed care and/or treatment; and/or
(3) Where a person with mental health problems presents a risk of harm to self and/or others.

Where health and social services professionals conclude that a person requires care and/or treatment, but that person is unable or unwilling to give consent, the law should facilitate the adoption of an appropriate course in the circumstances.

Involuntary intervention in whatever form causes considerable controversy in the field of mental health, and raises a plethora of human rights concerns. For example, pursuant to the prevailing mental health legislation in Northern Ireland, persons involuntarily detained may be treated against their will, even if mentally capable. The legislation permits the use of electro-convulsive therapy (ECT), a potentially irreversible treatment, in the treatment of competent persons. Such non-consensual intervention arguably constitutes one of the most invasive provisions in Northern Ireland law.

The law should provide a framework for the care and treatment of people with mental health problems that is specifically designed to facilitate only that degree of intervention which is appropriate in the given circumstances, whilst seeking to protect the rights and interests of the particular person. Consequently, it is imperative that Northern Ireland mental health law, policy and practice complies with applicable

[3] *The Journey to Recovery – The Government's vision for mental healthcare.* Department of Health, 2001.
[4] *Promoting Mental Health. Strategy and Action Plan 2003-2008.* Department of Health, Social Services and Public Safety, 2003.

human rights law, and takes appropriate account of relevant human rights standards, to ensure that due regard is afforded to the rights, interests and dignity of persons with mental health problems.

The enactment of the Human Rights Act 1998 (which incorporates the European Convention into domestic law) and the establishment of the Northern Ireland Human Rights Commission have contributed to momentum for a critical evaluation of the mental health law, policy and practices applicable in this jurisdiction. The Commission has funded this research project specifically for the purpose of analysing Northern Ireland mental health law, policy and practice from a human rights perspective. The paper is timely given the Government's recent establishment of a Review of Mental Health and Learning Disability that will consider the reform of mental health legislation, policy and provision in Northern Ireland.

The paper focuses on key parts of the mental health care framework, which are:

- The assessment and civil detention of people with mental health problems (Chapter 2);
- The Mental Health Review Tribunal (Chapter 3);
- The Mental Health Commission for Northern Ireland (Chapter 4);
- Treatment (Chapter 5);
- Mental health and the criminal justice system (Chapter 6); and
- Protection and empowerment (Chapter 7).

It draws upon international law and standards governing the care and treatment of people with mental health problems. It also takes account of practice in other jurisdictions as well as the recent reports and recommendations concerning the reform of mental health law in England, Wales and Scotland.

1.1 Underpinning Principles

An initial consideration is the principles upon which mental health legislation should be based and whether these should be included in legislation and/or the Code of Practice.

The principles on which the Mental Health (NI) Order 1986 should be currently interpreted are contained in the Code of Practice.[5] These are that people with mental health problems should:

- "be treated and cared for in such a way as to maintain their dignity;
- receive respect for and consideration of their individual qualities and background – social, cultural, and religious;
- have their needs taken fully into account notwithstanding the fact that within available resources it may not always be practical to meet them;
- receive any necessary treatment or care with the least degree of control and segregation consistent with their safety and the safety of others;

[5] Department of Health and Social Services. *Mental Health (Northern Ireland) Order 1986: Code of Practice.* HMSO, 1992, p.3, para. 1.8.

- be discharged from any form of constraint or control to which they are subject under the Order immediately this is no longer necessary;
- be treated or cared for in such a way as to promote their self-determination and encourage personal responsibility to the greatest possible degree consistent with their needs, wishes and abilities".

The European Convention on Human Rights, its case law and the Council of Europe's[6] White Paper on mental health and human rights have focused more on the protection of negative rights than establishing general principles relating to people with a mental disorder, but as discussed later some more positive rights to services may be argued.

The United Nations' 25 Mental Illness (MI) Principles were "the first step in providing a global set of minimum standards for protecting persons with mental illness and improving mental health care",[7] and so are very useful but necessarily general. The principles include that "all persons have the right to the best available mental health care, which shall be part of the health and social care system" (1.1); that "every person with a mental illness shall have the right to live and work, as far as possible, in the community" (3); and that "every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others" (9.1).

The Richardson Committee which reviewed the mental health law for England and Wales recommended that the new legislation should include statements of principle covering "informal care, the provision of the least restrictive alternative compatible with the delivery of safe and effective care, consensual care, reciprocity, respect of diversity and the recognition of the role of carers".[8] It also defined reciprocity as meaning "if society is to impose a duty to comply with care and treatment on some of those who suffer from mental disorder it must impose a parallel duty on health and social care authorities to provide an appropriate standard of care and treatment for those subject to compulsion". Part One of the Draft Bill does refer to some of these principles but states they should be detailed in the Code of Practice rather than the Bill itself which perhaps lessens their impact.

The Law Society[9] has suggested that the principle of reciprocity should be included in the Mental Health Bill.

In Scotland, the Millan Committee[10] proposed a very comprehensive list of principles to be included in the Act and Code of Practice: non discrimination, equality, respect for diversity, reciprocity, informal care, participation, respect for carers, least

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[6] Steering Committee on Bioethics of the Council of Europe. *White Paper on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment.* Council of Europe, 2000.
[7] Maingay *et al.* 'Mental Health and human rights: the MI Principles - turning rhetoric into action'. *Journal of Mental Health,* 2002, vol. 14, p.19.
[8] *Review of the Mental Health Act 1983: Report of the Expert Committee.* Department of Health, 1999, pp.1-2 (Richardson Committee).
[9] Law Society of England and Wales. *Response to the government's consultation process on the draft Mental Health Bill 2002*. 2002.
[10] *Renewing Mental Health Law*. Scottish Executive, 2001.

restrictive alternative, benefit and child welfare. Some of these principles have been included in the Mental Health (Care and Treatment) (Scotland) Act 2003.

Establishing the underpinning principles and deciding which should be explicitly included in legislation would appear to be an important foundation for mental health law. The list devised by the Millan Committee provides a useful basis for discussion.

1.2 Terminology

There is on-going debate[11] about the terminology to use in this area. The main possibilities appear to be patient, client, service user, customer, consumer, survivor, people with mental disorder, people with mental health problems, people with mental health needs and people with learning disabilities. 'Patient' has been criticised for implying a passive, dependent role with the professional as expert and 'client' has sometimes been used as an alternative to move away from the medical model.[12] A recent survey,[13] however, found most people preferred 'patient' to 'client'. 'Service user', 'consumer' and 'customer' all suggest choice but perhaps do not acknowledge that sometimes people do not have a range of options and are sometimes not using services voluntarily. During the consultation for this report it was agreed that we should acknowledge the debate and the importance of language and use the terms 'people with mental health problems' and 'people with learning disabilities'. These were agreed to be the least problematic. We have therefore tried to use these terms throughout except when quoting or using specific terms from legislation.

1.3 Equality Issues

Equality issues are identified in relation to specific issues throughout the report but it is also useful to identify some of the general issues.[14] The Acheson Report[15] on inequalities in health found that:

- Mental health varies markedly by social class.
- The use of psychiatric, especially in-patient hospital services is positively correlated with high levels of deprivation and unemployment.
- Suicide is more common in men than in women, and in lower socio-economic groups.
- Caring for young children in disadvantaged circumstances, particularly as a lone mother, carries with it an increased risk of poor mental health.
- Race was identified as a significant factor, a finding reinforced in the National Service Framework for Mental Health[16] which stated that, at present, services

[11] Neuberger, J. 'Let's do away with "patients"'. *British Medical Journal*, vol. 318, 1999, pp.1756-1757.
[12] Burns, T. and Firn, M. *Assertive Outreach in Mental Health.* Oxford University Press, 2002, p.11.
[13] Ritchie, C.W. 'Patient or client? The opinions of people attending a psychiatric clinic'. *Psychiatric Bulletin*, 2000, vol. 24, pp.447-450.
[14] Where there is no data available for Northern Ireland we have referred to the most appropriate existing data – usually for other parts of the UK. This highlights the need for more local research.
[15] Acheson, D. *Inequalities in Health.* The Stationery Office, 1998.
[16] *National Framework for Mental Health.* Department of Health, 1999.

are not meeting the needs of black and ethnic minority communities. There is particular concern about the over-representation of young, black men sectioned under the Mental Health Act 1983 in England. These concerns have also recently been expressed locally by the Northern Ireland Council for Ethnic Minorities.[17]

Other equality issues have also been identified as important:

- Age has been highlighted as older people are less likely to be referred for counselling, are more likely to experience certain forms of mental health problems and suicide rates increase with age.[18] The mental health needs of children and young people have also been dramatically under-estimated and there remain substantial gaps in service provision.[19] This has lead to the unacceptable situation where young people are detained and treated on adult psychiatric wards.
- The impact of 'the Troubles' and sectarianism on mental health is a further local consideration.[20]
- Research[21] has also identified the discrimination and prejudice that lesbians, gay men and bisexual men and women face within mental health services, and the impact of oppression from wider society. Particularly alarming is the finding that lesbian and gay young people are up to six times more likely to attempt suicide than heterosexual young people.[22]
- Finally, the combined impact of the many different forms of discrimination should be considered as it appears rare for one form of oppression to be experienced in isolation.

Inequalities in mental health arise, not only through broad social factors such as poverty, discrimination, isolation and poor housing, but also through the delivery of mental health services which may incorporate the discrimination of wider society and create, either actively or passively, inequalities of access to care. Access goes beyond the basics of physical and geographical access to how people find out about and perceive the services and how they are enabled to use them effectively. Although it goes beyond the scope of this report to address all of the equality issues in depth it is nonetheless important to highlight them from the start and to recommend consideration of further positive public health campaigns such as the 'See Me'

[17] O'Rawe, Dr.A. *Response from NICEM to the DHSS&PS on the review of mental health legislation, policy and provision.* Northern Ireland Council for Ethnic Minorities (NICEM), 2002.
[18] Dunn, S. *Creating Accepting Communities: Report of the Mind Inquiry into Social Exclusion.* Mind, 1999.
[19] O'Rawe, Dr.A. *Children and Adolescent Mental Health Services in Northern Ireland 2003.* Children's Law Centre, 2003.
[20] See for example: Bloomfield, Sir Kenneth. *We will Remember them. Report of the Northern Ireland Victims Commissioner.* The Stationery Office, 1998 and Park, J. *Living with the Trauma of the Troubles.* The Stationery Office, 1998. There are many on-going initiatives which aim to directly address some of the impact of trauma and sectarianism through, for example, the Family Trauma Centre, Wave (a victims organisation), Parents and Children Together (PACT) and the Probation Board's work with young people; but the issue remains an important local factor.
[21] Golding, J. *Without Prejudice.* Mind, 1997.
[22] *Ibid.* The Parents Advice Centre and Carafriend offer support and advice to young people and parents around sexual identity issues but the wider societal issues of discrimination and exclusion also need to be addressed.

campaign by the Scottish Executive, launched in 2002, to attempt to address some of the stigma and social exclusion associated with mental health problems.

1.4 Conclusion

Ultimately, this paper seeks to stimulate further consideration and discussion of the many complex issues arising in this area; and, to that end, makes a number of recommendations designed to strike a more appropriate balance between the rights of persons with mental health problems and the responsibilities of the state.

2: THE ASSESSMENT AND CIVIL DETENTION OF PEOPLE WITH MENTAL HEALTH PROBLEMS

2.1 Introduction

This Chapter examines the area of the assessment and civil detention of people with mental health problems. The following issues arise in relation to this area and potentially cause interference with human rights:

- The definition of mental disorder;
- The process of assessment and civil detention;
- The rights of voluntary patients;
- The role of the nearest relative;
- Access to information and representation; and
- The potential extension of compulsory powers to the community.

The Chapter looks at each of these issues separately and examines:

- The relevant international standards;
- Law, policy and practice in Northern Ireland;
- The potential human rights violations or concerns arising;
- The experience of other jurisdictions: in particular England, Wales and Scotland including the proposals for mental health law reform in those jurisdictions; and
- Makes recommendations in relation to addressing the human rights issues identified in Northern Ireland.

The following Chapters will cover: the Mental Health Review Tribunal system; the Mental Health Commission; treatment; mental health and the criminal justice system; and vulnerable adults. So while all of these areas are relevant to assessment and detention, they will not be dealt with in detail here.

2.2 The Definition of 'Mental Disorder'

It is important to acknowledge this section is focusing on the definition of mental health problems rather than the broader definition of mental health that is also a debated area.[23]

[23]"Mental Health has been defined variously by scholars from different cultures. Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualisation of one's intellectual and emotional potential, among others. From a cross-cultural perspective, it is nearly impossible to define mental health comprehensively. It is, however, generally agreed that mental health is broader than a lack of mental disorders." *The World Health Report 2001 - Mental Health: New Understanding, New Hope.* World Health Organisation, 2001, p.5.

2.2.1 International Standards

European Convention on Human Rights

Article 5.1 of the European Convention on Human Rights (ECHR) states: "Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law…" part (E) then allows "the lawful detention of persons for the prevention of the spread of infectious disease, of persons of unsound mind, alcoholics or drug addicts, or vagrants". The Convention therefore requires a finding of unsoundness of mind to justify detention but does not define the term.[24] This was explained in *Winterwerp v the Netherlands*[25] - "the Convention does not state what is to be understood by the words 'persons of unsound mind'. This term is not one that can be given a definite interpretation...it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitude to mental illness changes, in particular so that a greater understanding of the problems of mental patients is becoming more widespread".

Council of Europe

The Council of Europe[26] has suggested "an alternative proposal to the use of mental disorder is to use the concept of mental incapacity whereby decisions are based on the ability of the individual, as determined by medical and other professional staff, to understand the nature of treatment or admissions, weigh up the benefits of such, make a choice and communicate that choice".

UN Principles

The United Nations'[27] "Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care" (the MI Principles) do not specifically define 'mental disorder' but Principle 4 states that "a determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards". It is debatable whether this Principle entails that this determination should be made by a specialist, a psychiatrist, or whether any medical practitioner is qualified to do so. However, given the potential implications of this determination, a specialist assessment would appear more appropriate.

World Health Organisation

More recently the World Health Organisation has discussed the concept of mental health: "mental health has been defined variously by scholars from different cultures. Concepts of mental health include subjective well-being, perceived self-efficacy,

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[24] Gostin, L.O. 'Human Rights of Persons with Mental Disabilities: the European Convention of Human Rights'. *International Journal of Law and Psychiatry*, vol. 23, No 2, 2000, p.141.
[25] *Winterwerp v The Netherlands* (1979) 2 EHRR at para. 37.
[26] Steering Committee on Bioethics of the Council of Europe. *White paper on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment.* Council of Europe, 2000, p.5.5.
[27] United Nations. *Principles for the protection of persons with mental illness and the improvement of mental health care.* Adopted by UN General Assembly resolution 46/119 of 17 December 1991.

autonomy, competence, intergenerational dependence and self-actualisation of one's intellectual and emotional potential, among others. From a cross-cultural perspective, it is nearly impossible to define mental health comprehensively. It is however, generally agreed that mental health is broader than a lack of mental disorder".

2.2.2 Law, Policy and Practice in Northern Ireland

'Mental disorder' is defined in Article 3.1 of the Mental Health (Northern Ireland) Order 1986 as "mental illness, mental handicap and any other disorder or disability of mind". Article 3.2 specifically excludes detention "by reason only of personality disorder, promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs".

There has been general debate about the grey areas involved in the exclusions[28] and, more specifically, in the Fenton Report[29] following the Brian Doherty Inquiry. The Report stated that "the specific exclusion of personality disorder unless accompanied by other forms of mental disorder means that it is difficult to obtain assessment and treatment for people with severe personality disorder accompanied by potentially violent and irresponsible behaviour" and recommended that "severe personality disorder should be introduced as "an additional category of mental disorder".[30] The difficulties in accessing appropriate services experienced by people with a diagnosis of personality disorder and their carers were highlighted during the consultation for this report. This report acknowledges the on-going difficulties people with a diagnosis of personality disorder face in accessing appropriate services. To address this issue it may be appropriate to issue specific guidance on personality disorder to require health authorities to assess comprehensively the person and their carers' needs, devise a written care plan, formally identify any areas of unmet need and provide access to appropriate care and treatment.

2.2.3 Potential Human Rights Violations

The main human rights concern associated with the definition of 'mental disorder' is that if the definition is too broad and does not have specific exclusions it could allow the detention of people on the basis of moral, social, political or cultural judgements rather than mental health and safety necessity. As has been mentioned, because understanding of mental health is still developing it is difficult to define 'mental disorder' very precisely, however, it does not seem to be an adequate safeguard to defer entirely to medical opinion at the time of assessment. There is currently no lower age limit which means that children can be detained using the Order and are sometimes placed in adult psychiatric wards which are inappropriate environments.

Concerns have been raised that, at present, the diagnosis of personality disorder may be used to inappropriately restrict people's access to services.

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[28] Daly, E.D. 'Detention - the grey area. Problems in the use of the Mental Health (Northern Ireland) Order 1986'. *Psychiatric Bulletin*, vol. 13, 1989, pp.12-13.
[29] Fenton, G. (Chair) *The Brian Doherty Inquiry*. Western Health and Social Services Board, 1995, p.182.
[30] *Ibid.* p.7.

The definition of learning disability contained in the Order is beyond the scope of this report, however, it does appear to employ archaic and inappropriate language (*e.g.* mental handicap) and perhaps does not distinguish between categories in a way that easily translates into practice. There is also an argument, which again cannot be dealt with in detail here, that learning disability and other areas such as brain injury and dementia would be more appropriately considered under incapacity legislation unless mental illness is also an issue.

2.2.4 Other Jurisdictions

The Richardson Committee[31] in the Report of the Review of the Mental Health Act, 1983, recommended keeping the term 'mental disorder' and including a very broad definition within the new act with more specific definition in the Code of Practice. It also suggested, however, that learning disability should be removed when not co-existing with another 'mental disorder' as it is better viewed from a welfare, rather than a treatment, perspective. A broad definition was indeed included in the Draft Mental Health Bill for England and Wales.[32] It defined 'mental disorder' as "any disability of mind or brain which results in an impairment or disturbance of mental functioning" leaving further definition to the Code and not specifying any exclusions. The earlier controversial proposals involving the preventative detention of people diagnosed as having dangerous severe personality disorder have not been explicitly included in the Draft Bill but the lack of definition of 'mental disorder' and the extraordinarily wide meaning of 'treatment' do still allow for this form of detention. A central issue of concern is that a system of indeterminate detention is premised on a concept that is ill-defined and controversial .[33]

The Joint Committee on Human Rights[34] has responded that "the proposed definition of 'mental disorder' appears to us to be over-inclusive, potentially covering a number of conditions which would not normally be characterised as mental disorders and allowing health professionals to act as guardians of morality as well as health". The Law Society[35] has suggested that further ways of qualifying these criteria would be to include: "(i) a capacity criterion and (ii) a 'health benefit' to replace the 'treatability' test".

Under the new Scottish Act 'mental disorder' is defined as 'any mental illness; personality disorder; or learning disability, however caused or manifested; and cognate expressions shall be construed accordingly'. The new Act also states that "a person is not mentally disordered by reason only of any of the following – sexual orientation; sexual deviancy; transexualism; transvestism; dependence on, or use of, alcohol or drugs; behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person; acting as no prudent person would act".[36]

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[31] *Review of the Mental Health Act 1983: Report of the Expert Committee.* Department of Health, pp.1-2 (Richardson Committee).
[32] *Draft Mental Health Bill.* Department of Health, 2002 (Cm 5538-1).
[33] Gledhill. In Davidson, L. 'Human rights vs public protection. English mental health law in crisis?', *International Journal of Law and Psychiatry,* vol. 25, 2002, p.503.
[34] Joint Committee on Human Rights. *Draft Mental Health Bill,* 25th Report of Session 2001-02. The Stationery Office, 2002 (HL Paper 181, HC 1294) p.91.
[35] *Response to the government's consultation process on the draft Mental Health Bill 2002.* The Law Society, 2002, p.14.
[36] *Mental Health (Care and Treatment) (Scotland) Act 2003*, Part 23, para. 328.

In the Republic of Ireland the Mental Health Act, 2001, defines 'mental disorder' as "mental illness, severe dementia or significant intellectual disability".

2.2.5 Recommendations

1. The concept of 'mental disorder' should be clearly defined in legislation, not just in a code of practice.
2. The concept of mental disorder must be defined sufficiently narrowly to be compliant with Article 5 of the ECHR.
3. Careful consideration should be given to whether the current statutory exclusions, including the concept of personality disorder, should be retained.
4. In light of the on-going difficulties people with a diagnosis of personality disorder face in accessing appropriate services, there should be detailed guidance to require:

   (1) The comprehensive assessment of the needs of both the person concerned and their carer;
   (2) The compilation of a care plan; and
   (3) The provision of care and treatment, as appropriate.

5. A determination of 'mental illness' should be made by a medical practitioner with specialist training in this area, namely, a psychiatrist. Ideally two medical opinions would be required, one from a GP who knows the person and one from a psychiatrist before detention can be considered.
6. The Government Review of Mental Health and Learning Disability should commission a more detailed examination of the human rights issues involved in the areas of mental health, learning disability, brain injury and dementia.

2.3 The Process of Assessment and Civil Detention

2.3.1 International Standards

European Convention on Human Rights

In addition to Article 5.1(e) the minimum criteria for detention to be lawful under the European Convention on Human Rights (ECHR) were specified in *Winterwerp v The Netherlands*: "except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind'. The very nature of what has to be established before the competent national authority - that is, a true mental disorder – calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder".[37] So, what is needed is a 'true mental disorder', established by medical expertise, of a kind or degree warranting compulsory confinement which is dependent on the persistence of the 'disorder'. As discussed, "true mental disorder" is not defined further. Despite the persistence criterion patients do not have to be

[37] In Boland, F. and Laing, J.M. 'Human Rights and Mental Health Law - Challenging Compulsory Detention under Article 5 of the ECHR - A Comparative Study of the Law in Ireland and England'. *Contemporary Issues in Law*, vol. 5, issue 3, 2000/2001, p.168.

unconditionally released as soon as the 'disorder' desists as their interests and those of the community should be considered, however, although discharge can be conditional it should not be unreasonably delayed as was established in *Johnson v UK*.[38]

Article 5.4 states: "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful". Article 6.1 states: "In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law". Although the Mental Health Review Tribunal system will be dealt with in more detail in a later Chapter these articles suggest a hearing should be speedy and perhaps automatic rather than dependent on a request. It seems obvious that a person with mental disorder may not be sufficiently able to make such a request, by reason of their mental disorder. A request dependent safeguard, where the person who has been detained has to apply for a hearing, in many circumstances amounts to no safeguard at all.

The need for thorough risk assessment and management in the assessment process has been reinforced through the European Court in relation to Article 2 (the right to life). "The *Association X* Case (1978) and, more recently, the *Osman* Case (2000), have established that public authorities must not only refrain from ending life, they also have a positive obligation to protect it".[39]

UN Principles

Principle 16.1 of the MI Principles[40] covers the process of admission and states: "a person may (a) be admitted involuntarily to a mental health facility as a patient; or (b) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorised by law to that purpose determines… that that person has a mental illness and considers:

(a) that, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or
(b) that, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative".

[38] Gostin, L.O. 'Human Rights of Persons with Mental Disabilities: The European Convention on Human Rights'. *International Journal of Law and Psychiatry*, vol. 23, No. 2, 2000, pp.125-159.
[39] Persaud, A. and Hewitt, D. 'European Convention on Human Rights: effects on psychiatric care'. *Nursing Standard*, vol 15, (44), 2001, p.35.
[40] United Nations. *Principles for the protection of persons with mental illness and the improvement of mental health care.* Adopted by UN General Assembly resolution 46/119 of 17 December 1991.

UN Convention on the Rights of the Child

For those under the age of 18, the UN Convention on the Rights of the Child sets international standards for the protection of children's rights. Article 23 states that a child with a mental disability should enjoy a full and decent life in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community. Article 24 provides for the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States are under a positive obligation to ensure that no child is deprived of the right to access such health care services. If a child is deprived of his or her liberty then it is necessary to treat the child in a manner which takes into account his or her age. Article 37 states in particular that children should be separated from adults in detention unless it is considered in the child's best interests not to do so. The UK has entered a reservation to this aspect of the Convention.

2.3.2 Law, Policy and Practice in Northern Ireland

The Mental Health (NI) Order 1986 sets out the conditions under which a person not involved in criminal proceedings may be compulsorily detained in hospital. Article 4(2) states:

"An application for assessment may be made in respect of a patient on the grounds that

(a) He is suffering from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or for assessment followed by medical treatment); and
(b) Failure to so detain him would create a substantial likelihood of serious physical harm to himself or to other persons".

The application for assessment can be made by either an Approved Social Worker (ASW) or the person's nearest relative and has to be accompanied by a medical recommendation completed by a doctor, usually a GP, preferably but not necessarily who knows the person. The person is then further assessed in hospital to ascertain whether continued detention is justified. This initial period of assessment can be extended to 14 days after which, if continued detention is required the person must be detained, under Article 12, for treatment. Article 12 states that to be detained for treatment a doctor, who has been appointed by the Mental Health Commission for this purpose, usually the person's consultant psychiatrist, must state:

"(a) that, in his opinion, the patient is suffering from mental illness or severe mental impairment of a nature or degree which warrants his detention in hospital for medical treatment; and
(b) that, in his opinion, failure to so detain the patient would create a substantial likelihood of serious physical harm to himself or to other persons".

Detention for treatment can be for up to six months, then can be extended for a further six months and then by a year at a time. If the person disagrees with their detention then they have to apply to a Mental Health Review Tribunal for their case to be considered.

Under Article 10 if a person is only admitted for the assessment period and not further detained under Article 12 then, presumably to protect the person from discrimination, this period can be disregarded for certain purposes, although not in judicial proceedings. It is not clear, however, how far this protection extends. If, for example, an occupational health questionnaire asked the person if they had ever had any contact with mental health services, rather than had they ever been detained, could the person still legally deny this contact?

Children are detained within adult psychiatric units in Northern Ireland usually as a result of there being insufficient age-appropriate facilities available. This raises particular concerns as an adult ward is an inappropriate environment to care for children.[41]

2.3.3 Potential Human Rights Violations

Although the procedure for detention is prescribed by law, in accordance with Article 5.1 of the ECHR, it does not appear to offer the automatic, speedy involvement of a court or independent and impartial tribunal to determine the lawfulness of detention as required by Articles 5.4 and 6.1. Although the role of the ASW is designed to bring an element of independence to the assessment it certainly does not constitute a court or tribunal.

As already mentioned, Article 5.4 requires speedy access for detainees to a court and Article 6.1 states that everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law, so perhaps a hearing should be speedy and automatic rather than dependent on a request.

It is debatable how many compulsory admissions could be prevented if community services were better developed but there appears to be great potential in Northern Ireland to establish more appropriate community alternatives so that people's liberty is not unnecessarily restricted.

The need to develop specialist community and residential alternatives for young people, particularly to prevent the need for potentially damaging admission to adult acute wards, was highlighted during consultation for this report. The persistence in detention alongside adults is contrary to Article 37 of the Convention on the Rights of the Child and was highlighted by the Committee on the Rights of the Child in its 2002 report[42]. The current gaps in services for young people[43] are creating huge difficulties for young people and mental health services as well as for parents, teachers and society in general.[44] Current provision impacts detrimentally on younger people and may also breach section 75 of the Northern Ireland Act 1998. It has been

[41] O'Rawe, Dr. A. *Children and Adolescent Mental Health Services in Northern Ireland.* Children's Law Centre, 2003.
[42] UN Committee on the Rights of the Child. 31st Session. Concluding Observations on the UK. CRC/C/15/Add.188, 9 October 2002.
[43] Including services to meet the educational needs of children and young people with mental health problems as well as specialist mental health promotion, prevention and early intervention services.
[44] Catherine McCurry at the BELB is currently doing research in this area.

noted that lack of access to mental health services was unequal among children of poorer socio-economic status and ethnicity throughout the UK.[45]

2.3.4 Other Jurisdictions

The draft Mental Health Bill for England and Wales proposes to introduce a three stage process of examination, assessment and Tribunal, and similar proposals have been included in Scotland. The main proposed changes are that, except for offenders, a Mental Health Tribunal will consider all detention beyond 28 days and community based compulsory orders may be used.[46]

2.3.5 Recommendations

1. All compulsory admissions for assessment should be considered by a Mental Health Review Tribunal, within the assessment period, to independently determine the lawfulness of detention.
2. The assessment period should be extended, possibly to a period of 28 days, to ensure independent judicial scrutiny of the assessment before a person is detained for treatment.
3. Community services, especially for young people,[47] should be further developed to reduce the need for hospital admission.
4. Where admission is necessary, children should be detained separately from adults and in an environment which recognises and accommodates their needs as children.
5. The protection of Article 10 of the Mental Health (Northern Ireland) Order 1986 should be extended to maximise the protection for persons who have been admitted for assessment but not detained for treatment from stigmatisation, prejudice and discrimination.

2.4 Voluntary Patients

There are patients who are being treated in hospital or who are resident in care homes who are not there as a result of compulsion. This would often be people with learning disability and dementia. There are human rights concerns in relation to those who lack sufficient mental capacity to understand why they are in hospital or care or that they may leave the institution. In some cases if the person tried to leave the assessment and detention process under the Order would be initiated. In other situations, the trust may seek to rely on the common law doctrine of necessity as regards the need to detain the person in their best interests.

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[45] UN Committee on the Rights of the Child. 31st Session. Concluding Observations on the UK. CRC/C/15/Add.188, 9 October 2002.
[46] Department of Health, *Draft Mental Health Bill.* HMSO, 2002, (Cm 5538-I).
[47] Australia has been particularly progressive in developing and researching services in this area. See: *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000, A Joint Commonwealth, State and Territory Initiative under the Second Mental Health Plan.* Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, 2000.

2.4.1 International Standards

European Convention on Human Rights

Article 5 of the ECHR, as noted above, protects people from arbitrary deprivation of liberty. Any deprivation must be in accordance with a procedure prescribed by law and the person detained must be able to challenge the decision to detain before a court or tribunal. The court procedure must be one which complies with Article 6 of the ECHR standards on a 'fair hearing'.

UN Principles

The UN Mental Illness (MI) Principles require that voluntary patients must have the right to leave at any time and be informed of this right.[48] Otherwise the criteria for involuntary admission need to be complied with and an automatic review carried out by a review body within a short period of time, as set out in Principle 16.

2.4.2 Law, Policy and Practice in Northern Ireland

Article 127 of the Mental Health Order appears to preserve the common law power of a trust to detain other than by using the Order although the title does refer to 'voluntary' admission. The common law is not contained in legislation but is derived from legal tradition and judicial decisions in the courts. In an English House of Lords case, it was held that there is a common law power which can be exercised by a local authority which would allow them to detain a person where it was necessary to do so for that person's best interests.[49] A similar common law power would be likely to be upheld in Northern Ireland. This could be relied on, for example, where guardianship or detention under the Order was inappropriate. The common law power on current interpretation would allow for forcible detention of an adult with mental incapacity in either hospital or residential care.[50]

In cases where there is a dispute between family and health or social care professionals, or among family members themselves as to the best interests of an incapacitated person, the local authority may seek a declaration as to whether the power to act under the doctrine of necessity applies and also as to what the best interests of the person are. In the majority of cases, even where there is a dispute, the trust will proceed to place the person in residential care or come to an agreement with the family. Those who are not actively opposing a hospital placement similarly are detained without any court intervention.

The Mental Health Review Tribunal has no jurisdiction to consider the lawfulness of detention under the doctrine of necessity or the more casual detention of those who do not actively object. To challenge such a decision would involve application to the High Court, *e.g.* by way of a habeas corpus application or judicial review.

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[48] Principle 15(3).
[49] *R v Bournewood Community and Mental Health NHS Trust, ex parte L* (1999) AC 458.
[50] In *Re F* (Adult Patient) 3 CCLR September 2000, 210.

2.4.3 Potential Human Rights Violations

The lack of accessible independent review of a decision to detain a person under common law or to treat those who are passive and mentally incapable as voluntary patients may contravene Article 5(4).[51] Similarly the lack of certainty in the common law power may contravene the Convention's requirements. Moreover, the fact that a decision can be made by one professional with no obligation to present objective evidence to any authority does not appear to provide for sufficient protection against arbitrary detention[52]. The *Bournewood* case referred to above will now be heard by the European Court of Human Rights on the compatibility of common law detention in English law with Article 5.

As it is a particularly vulnerable group of people, *i.e.* those deemed incapable of making decisions, who are affected by this type of detention, there would be a need for an independent advocate to assist in the instruction of a lawyer to bring proceedings. In such situations it would be necessary to appoint an advocate to ensure protection.

Furthermore, for those with even moderate assets or income, *e.g.* older people with dementia who have an occupational pension or savings, there would be no financial entitlement to legal aid, making High Court litigation usually too expensive.

The lack of a review procedure leaves incapacitated adults vulnerable to decisions being made about their best interests which may be heavily influenced by the interests of the professionals who operate under budget pressure, or those of family or carers who may have conflicting interests. The right to respect for private life of the individual protected by Article 8 of the ECHR would suggest that time should be taken to identify his or her wishes to the extent that this is possible.

2.4.4 Other Jurisdictions

The draft mental health legislation for England and Wales seeks to provide some safeguards for compliant incapable patients. Clause 121 prevents a person being treated as a voluntary patient if it seems that the person is incapable of consenting to treatment, and either would resist the treatment or is at substantial risk of committing suicide or causing serious harm to others. This will result in more people being detained but they will benefit from the automatic tribunal review.

For those who can still be treated as voluntary but incapable hospital patients, there are a number of safeguards such as the appointment of a nominated person to act as advocate, a decision-making structure with an element of independent review and an opportunity to apply to the review tribunal for discharge.

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[51] Children and young people who are subject to care orders would be subject to a review process under 'Looked after Children' procedures and some may be visited by 'independent representatives' or Guardian ad Litem but access to an independent review of a decision to detain should be available to all.

[52] See further, Fennell, P. 'The Third Way in Mental Health Policy: Negative Rights, Positive Rights, and the Convention'. *Journal of Law and Society*, vol. 26, No. 1, March 1999, p.103.

These safeguards have not been extended to children or to those in residential care and this has been criticised on human rights grounds.[53]

2.4.5 Recommendations

1. That adoption of the draft proposals for protection of incapable adult patients contained within the Draft Mental Health Bill for England and Wales be considered for Northern Ireland.
2. Consideration should be given to the extension of such proposals to include children and those in residential care.
3. Guidance and training should be provided for all relevant staff on the test to be applied before a person is deemed incapable of consenting to a placement and/or treatment.

2.5 The Role of the Nearest Relative

2.5.1 International Standards

European Convention on Human Rights

The legislation on the nearest relative has been influenced by Convention rights. In *JT v UK* (2000) a patient claimed a breach of Article 8 (right to respect for private and family life) as she was unable to apply to a court to change her nearest relative, her mother. "Her stepfather had allegedly sexually abused her and so she objected to her mother receiving confidential information and discussing it with him".[54] A friendly settlement was found in which the Government agreed to amend the law to allow detained patients to apply to a court to have the nearest relative replaced where "he or she reasonably objected to the person concerned acting in that capacity".[55]

2.5.2 Law, Policy and Practice in Northern Ireland

The application for admission is founded on and accompanied by a medical (GP) recommendation and can be completed by the person's nearest relative, as determined by legislation, or by an approved social worker.

2.5.3 Potential Human Rights Violations

Prior[56] has argued that "the social work application is now seen as containing a professional opinion and recommendation requiring a certain level of training and expertise in mental health work…the problem lies in the fact that the legislation gives similar powers in applying for hospital admission to the nearest relative, who has no

[53] Joint Committee on Human Rights. *Report on Draft Mental Health Bill.* The Stationery Office, 2002 (HL Paper 181, HC 1294), para. 79-81.
[54] MacGregor-Morris *et al.* 'Potential impact of the Human Rights Act on psychiatric practice: the best of British values?'. *British Medical Journal,* vol. 322, 2001, p.849.
[55] Cooke, S. and Baring, S. 'A hard act to follow: the Human Rights Act?'. *Criminal Behaviour and Mental Health,* vol. 10, 2000, p.211.
[56] Prior, P. 'The Approved Social Worker - Reflections on Origins'. *British Journal of Social Work,* (22), 1992, p.107.

expertise, no training and who is not expected to be objective about what is best for the patient".

The nearest relative is unlikely to know the detail of the law so will be unable to assess if they are acting legally and if any guidance from others is correct. This means that more objective consideration of the rights and needs of the patient may be very difficult. The impact on the future relationship between patient and nearest relative will also be difficult to predict at the time of application.[57] The nearest relative, however, may know the person and the situation extremely well and so should be able to request an assessment and be consulted during this process.

The set order by which the nearest relative is determined under the Order is problematic. At present people who are married or cohabiting as husband or wife are regarded as taking priority but it is not clear if this extends to same sex partners. This has been challenged recently[58] and same sex partners should not be discriminated against but this should be clarified in the legislation. A further issue relates to the guidance that the nearest caring relative should take priority but again clarity is needed about what constitutes 'caring'.

2.5.4 Other Jurisdictions

The Richardson Committee[59] had recommended that "future legislation make no reference to the nearest relative, instead the new act should make provision for the identification, by the patient if possible, of a nominated person, and should accord that figure certain rights and responsibilities", though not to act as applicant. In Scotland this role will be fulfilled by a person nominated by the patient or if a person hasn't been nominated then the primary carer or if there is no primary carer then the nearest relative.[60] It does appear important to retain the right to have a nominated person involved in the process, so that the person has contact with someone they have chosen, who can also appeal against the detention on the person's behalf and so that the professionals involved are required to consult and inform the nominated person.

2.5.5 Recommendations

1. The nearest relative should no longer be able to act as applicant but relatives should continue to be able to request an assessment.
2. People should be permitted to nominate a person who can look out for their interests, rather than have this role determined according to a prescribed nearest relative definition.
3. If there is no nominated person, and the person is unable to nominate, a set order should be followed which does not discriminate against same sex relationships and clarifies what constitutes a 'caring' relative.
4. The duty to consult should be retained.

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[57] Sheppard, M. *Mental Health: The Role of the Approved Social Worker*. University of Sheffield, 1991.
[58] *R (on the application of SSG) v Liverpool City Council (1) Secretary of State for Health (2) and LS (Interested Party)* 22 October 2002.
[59] Churchill, R. *et al. A systematic review of research relating to the Mental Health Act (1983).* Department of Health, 1999, p.8.
[60] *Mental Health (Care and Treatment) (Scotland) Act 2003*, Part 12, Chapter 1.

2.6 Access to Information and Representation

2.6.1 International Standards

European Convention on Human Rights

Article 5(2) of the ECHR states: "everyone who is arrested shall be informed properly, in a language which he understands, of the reasons for his arrest and of any charges against him". This entails detained patients should be informed of their rights under mental health and human rights law, of the reasons for detention and of their rights to challenge this.[61] In *Van der Leer v the Netherlands* (1990) the person was not informed of the reasons for her confinement so 5(2) was violated.[62]

UN Principles

Principle 12.1 of the UN MI principles states that "a patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with these Principles and under domestic law, which information shall include an explanation of these rights and how to exercise them".

UN Convention on the Rights of the Child

Article 12 of the UN Convention on the Rights of the Child gives children the right to participate in decisions affecting them. This necessitates information being made available to children in language and a form which they can understand.

2.6.2 Law, Policy and Practice in Northern Ireland

Article 27 of the Order imposes a duty to "take such steps as are practicable to ensure that the patient understands" by which powers the patient has been detained; his/her right to apply to the Review Tribunal; that their correspondence may be withheld; under what conditions they may be discharged and that they may contact the Mental Health Commission. This Article also requires that nearest relative be given the same information.

There is no right to representation or advocacy under the Order and people are not automatically offered or allocated a lawyer or advocate.

2.6.3 Potential Human Rights Violations

Despite the Article 27 duty to inform a recent local study[63] found that: "generally, the process of admission to hospital was viewed negatively by service users. They complained about a lack of information and understanding about civil rights".

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[61] MacGregor-Morris *et al.* 'Potential impact of the Human Rights Act on psychiatric practice: the best of British values?'. *British Medical Journal,* vol. 322, 2001, pp.848-850.
[62] Prior, P.M. 'Protective Europe: does it exist for people with mental disorders?'. *Journal of European Social Policy,* vol. 11(1), 2001, pp.25-38.
[63] Britton *et al. A Study of Approved Social Work in Northern Ireland.* Department of Health and Social Services, 1999, p.ix.

McGouran[64] reported that in the process of assessment for admission "there are a high number of relatives who are either not being informed of their rights under the legislation or are not being given this information in a simple and easily understandable format. Their ability to make informed decisions is therefore impaired".

2.6.4 Other Jurisdictions

In England, Marriott *et al*[65] found that information routinely available to users and carers is inadequate and their awareness and understanding of the Act limited. Goldbeck *et al*[66] wrote that results of existing studies suggest patients are often poorly informed. In their own study at Carstairs in Scotland they found "more than half of all patients felt they had not received enough information on their detention and legal rights during their hospital admission" and so they recommended that "information, emphasising verbal communication, should be given on several occasions and this should take into account patients' current mental state as well as their intellectual disabilities. Patients should be given the opportunity to discuss matters with reference to their own situation".

Rights to independent advocacy and adequate information have been included in both the Draft Bill for England and Wales and the Mental Health (Care and Treatment) (Scotland) Act 2003.

2.6.5 Recommendations

1. The means by which the duty to inform is fulfilled should be examined and standardised. A standard procedure could be outlined in the Code of Practice.
2. Independent, specialist advocacy should be available to all detained patients.
3. Information on relevant statutory provisions and a patient's rights should be provided to all people who are admitted to mental health in-patient care.
4. The above information should be made available for children admitted to mental health in-patient care in an accessible form. Information should also be available in other languages in use in Northern Ireland as appropriate.

2.7 Compulsory Powers in the Community

This issue is included as the extension of compulsory powers to people living in the community may amount to detention. Community Treatment Orders (CTOs) are used in some countries to require people to comply with their treatment and care plan. These orders do not usually allow treatment to be forced in non-clinical settings but can allow a person to be forcibly taken to a clinical setting for this purpose. Their introduction is being debated in all parts of the UK and there are concerns about the implications for human rights.

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[64] McGouran, M. *Detained Admissions: the Relative's Viewpoint.* University of Ulster, 1999, p.v.
[65] Marriott *et al.* 'Research into the Mental Health Act: a qualitative study of the views of those using or affected by it'. *Journal of Mental Health,* vol. 10(1), 2001.
[66] Goldbeck *et al.* ''Detained patients' knowledge of their legal status and rights'. *The Journal of Forensic Psychiatry,* vol. 3(3), 1997, p.580-581.

2.7.1 International Standards

European Convention on Human Rights

The protection of liberty under Article 5 depends on the person being detained, and it appears that this may not necessarily extend to compulsory powers in the community. As Gostin[67] identifies, "the Commission, for example, has found that provisional discharge on condition that the patient accept medical treatment on an out-patient basis was not a 'deprivation of liberty' (*L v Sweden*, 1988)". Community powers may engage Article 8 (private and family life) as private life was defined, in *Botta v Italy*, as including physical and psychological integrity; and Article 11 (freedom of association) as the CTO may specify who the person must see and when.
CTOs may also engage Article 3 (inhuman and degrading treatment) although as this is an absolute right the threshold has been set very high, for instance, in *Grare v France*[68] the imposition of medicine (depot injection) with unpleasant side effects was unsuccessfully challenged under Article 3 but the judgement noted that the "degree of seriousness of side effects would have to be considered in further challenges". Thorold[69] concludes that "community controls where applied to patients assessed as needing follow-up…appear to be treated as insufficiently invasive or serious to engage any of the relevant Articles of the Convention". Fennell[70] goes on to suggest, however, that it will be how the jurisprudence under Article 8 develops that will be the key to considering compulsion in the community.

2.7.2 Law, Policy and Practice in Northern Ireland

The main powers under the Order that apply to people in the community are under Guardianship, this is perhaps an unhelpful term as it is usually associated with children. Guardianship can be used when "it is necessary in the interests of the welfare of the patient" (Article 18b).

Guardianship, under Article 22, allows:

> "(a) the power to require a patient to reside at a place specified by the Board or person named as guardian;
> (b) the power to require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training;
> (c) the power to require access to the patient to be given at any place where the patient is residing to any medical practitioner, approved social worker or other person so specified".

A form of compulsion in the community also exists as people who are detained in hospital can be granted 'trial leave' and returned to hospital during this period of leave without being formally reassessed. The purpose of this, however, appears to be to facilitate discharge rather than force treatment.

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[67] Gostin, L.O. 'Human Rights of Persons with Mental Disabilities: The European Convention on Human Rights'. *International Journal of Law and Psychiatry*, 2000, p139.
[68] *Grare v France* (1992) 15 EHRR CD100.
[69] In Fennell, P. 'The Third Way in Mental Health Policy: Negative Rights, Positive Rights and the Convention', *Journal of Law and Society*, vol. 26(1), 1999, p.125.
[70] *Ibid.*

2.7.3 Potential Human Rights Violations

In a review of the international literature to inform the Scottish review, Warner *et al* found that "community treatment orders (CTOs) have been challenged as an infringement of a person's civil liberty and as problematic under Article 5.1 of the ECHR. Other arguments put forward against CTOs are that they turn staff into 'parole agents', that they may put staff at more risk, that people may be kept on CTOs for unacceptably long periods of time and that problems with enforcement and sanctions make them unworkable. …Even where CTOs exist (such as in most of the USA and Australia) what sanctions can be imposed on patients on a CTO who still refuse treatment, beyond readmitting them to hospital, is unclear. Where there is data there is some suggestion that CTOs were not enforced or there were problems with enforcement when a patient refused treatment" .[71]

There is also little or no evidence to show that a compulsory community based order produces better outcomes than well-resourced community services alone. Moreover, the use of CTOs may prevent or damage therapeutic relationships and undermine efforts to ensure voluntary compliance.[72]

2.7.4 Other Jurisdictions

Although there are already some forms of compulsory powers in the community in England and Wales, and Scotland, namely supervised discharge, leave of absence and community care orders these are following detention for treatment and are designed to facilitate rehabilitation. The new compulsory powers proposed in England and Wales and just recently introduced in Scotland involve imposing compulsion without the need for hospital admission. This is presented as enabling avoidance of the potential disruption and disempowerment of admission but it also significantly broadens the scope of compulsion in the community. Neither jurisdiction proposes the forcible administration of medication in the community and the alternative sanctions for non-compliance are not clear. If it is simply assessment for admission this could be achieved through the ordinary assessment process, if it involves readmission (detention) without assessment then Article 5 may well be engaged.

It may be the case that currently, under ECHR jurisprudence, enforcing compulsory treatment in the community is an insufficient curtailment of liberty to amount to 'detention' and so would not breach Article 5. The proposals for England and Wales, and the Act in Scotland, have been drafted to attempt to comply with current standards however, the Law Society[73] made a crucial point: "The Society is particularly concerned at the potential human rights consequences of the draft Bill proposals. It is not adequate to draft legislation which merely reflects past thinking in this rapidly evolving field of law. The Law Society suggests that the Government considers what further human rights challenges will arise, and then looks at proposals that reflect the highest standard of protection for this most vulnerable group".

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[71] Warner *et al. Review of Literature Relating to Mental Health Legislation.* Scottish Executive Central Research Unit, 2000, p.2.
[72] McDougall, S. 'Compulsion and Mental Health – where do we draw the line?'. *SCOLAG Journal,* September 2002, p.161-162.
[73] *Response to the government's consultation process on the draft Mental Health Bill 2002.* Law Society, 2002, p.1.

2.7.5 Recommendation

1. In the event that CTOs are considered by the Review careful consideration should be given to their potential to both violate human rights and have a counter-therapeutic impact.

3: THE MENTAL HEALTH REVIEW TRIBUNAL

3.1 Introduction

This Chapter considers the operation of the Mental Health Review Tribunal for Northern Ireland against human rights standards.

There are a number of concerns in relation to the barriers to access to a tribunal review of the detention decision including:

(1) The delay in the arranging of a hearing;
(2) The fairness of the hearing itself in terms of the lack of specialist advice and representation;
(3) The role of the medical member;
(4) The burden of proof;
(5) The withholding of documentation; and
(6) A failure to ensure equality of treatment in relation to specific groups including children and young people and those from minority ethnic backgrounds.

3.2 International Standards

European Convention on Human Rights

Article 5 protects the right to liberty but allows for the detention of those of 'unsound' mind. However those who are detained under mental health legislation are entitled to have the lawfulness of the detention reviewed. This protection in Article 5(4) confers a 'right to take proceedings by which the lawfulness of a person's detention shall be decided speedily by a court and release ordered if the detention is not lawful'.

This has been interpreted by judges to include a right to a periodic review.[74] European Convention case law requires that the initial review should take place quickly due to the importance of an independent check on the legality of the detention but that the same need for speed should not necessarily be applied to a further review. No specific time limit has been provided as each case has particular factors and the judge will take account of any contribution to the delay by the person detained.[75]

The European Court of Human Rights has also considered a UK case[76] on the issue of deferred discharge by the tribunal until appropriate ongoing care and accommodation arrangements were in place. The indefinite deferral of the applicant's discharge pending a hostel place becoming available was inconsistent with Article 5. While the

[74] *Megyeri v Germany* (1993) 15 EHRR 584.
[75] A period of just under eight weeks for the first review of a mental health detention was considered to be too long in the circumstances of the case in *E v Norway* (1994) 17 EHRR 30. The court in *Koendjbiharie v Netherlands* (1990) 13 EHRR 820, considering a periodic review, found a delay of four months between application and decision too long. However, the Commission has also ruled that a ten month delay contributed to by the applicant was not contrary to the ECHR (*Cottenham v UK* [1999] EHRLR 530-1).
[76] *Johnson v UK* (1999) 27 EHRR 296.

court held that there was no obligation to secure an immediate release when a person is held not to suffer from a mental disorder, any delay should be reasonable and there must be appropriate safeguards in place to ensure that the deferral "is consonant with the purpose of Article 5(1) and with the aim of the restriction in sub-paragraph (e)".[77] In this particular case the fact that the tribunal could not order the provision of a hostel place meant that there were insufficient safeguards.

Article 6 of the ECHR enshrines the right to a fair hearing. The European Court of Human Rights in *Megyeri v Germany*[78] explored the process for challenging mental health detention in Germany in light of Article 6. It held that not all the normal requirements of Article 6 need be complied with in relation to mental health tribunals. A key aspect of Article 6 which was held to apply however is the right of access to a court or tribunal.

Any limitations on the Article 6 right of access to a court also need to be justified as proportionate to the legitimate aim pursued and not so restrictive as to damage the very essence of the right.[79] Therefore any controls on the number of tribunal applications would need to meet this test.

Article 6 jurisprudence details a number of features of a fair hearing. These include a hearing by an impartial and independent tribunal.

Two Strasbourg cases have considered the standard of a fair hearing where advice is given to the judge in private after submissions have been completed. The later case, *Borgers v Belgium*,[80] found a breach of Article 6 where the advice given was detrimental to the accused. This taken with the link between the adviser and the prosecution amounted to a breach of Article 6. There was no breach found in the earlier case[81] but there was a recognition of the development of the jurisprudence as regards the appearance of impartiality.

Article 6 standards require 'equality of arms' at a hearing if it is to be considered fair. This means that one party should not be operating under conditions which places them at a substantial disadvantage as regards the other party.[82]

Disclosure of all documents considered by a court is generally considered to be an essential element of a fair hearing as envisaged by Articles 5(4) and 6.[83] However, not all the Article 6(1) safeguards need necessarily be in place for a mental health hearing to comply with Article 5(4) given the nature of such cases.[84]

Which party bears the burden of proof is a fundamental aspect of the overall fairness of a hearing. The *Winterwerp*[85] case appears to place the burden of proof of a lawful

[77] *Johnson v UK* (1999) at para. 61-63.
[78] *Megyeri v Germany* (1993) 15 EHRR 584.
[79] *Osman v UK* (1998) 29 EHRR 245 at para. 147.
[80] *Borgers v Belgium* (1993) 15 EHRR 92.
[81] *Delcourt v Belgium* (1970) 1 EHRR 355.
[82] *Dombo Beheer BV v Netherlands* (1994) 18 EHRR 213, at para. 22.
[83] *McMichael v UK* (1995) 20 EHRR 205; *Feldbrugge v Netherlands* (1986) 8 EHRR 425.
[84] *Megyeri v Germany* (1993) 15 EHRR 584.
[85] *Winterwerp v The Netherlands* (1979) 2 EHRR 387.

mental health detention on the detaining authority. If this is not the case then it may be argued that the overall fairness of the hearing is materially damaged.

Article 14 requires that no-one should be discriminated against in the protection of the rights set out in the Convention by reason of, for example, their "race". Case law has extended the grounds to include age.

Council of Europe

Recommendation R(83)2 of the Committee of Ministers to the member states concerning 'the legal protection of people suffering from mental disorder placed as involuntary patients' sets out a number of rules with which member states are invited to comply. Article 4.2 states that where a placement decision is taken by a non-judicial body or person then that body or person should be different from that which originally requested or recommended placement. There should be a right of appeal to a court by a simple and speedy procedure and a person should be designated to assist the patient in deciding whether or not to appeal. It is notable that the UK made a specific reservation to Article 4.2 reserving the right not to comply with the designated advocate aspect.

The Council of Europe working party on psychiatry and human rights produced a consultation paper in 2000. The group of experts making up the working party state that consideration should be given to providing legal counsel automatically in all procedures before a tribunal with regard to involuntary placement and treatment

UN Principles

Respect for the inherent dignity of people with mental illness is recognised in MI Principle 1.

Principles 17 and 18 outline standards for a detention review body and procedural safeguards for those detained. Principle 17 provides for an initial review by an independent and impartial body as soon as possible after the detention decision has been made and thereafter automatic periodic review, a right for patients to apply for review at reasonable intervals as specified by domestic law and provides for a right of appeal to a higher court.

Principle 17 specifically states that the review body 'shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account'. This may be read so as to ensure that the tribunal includes a medical member rather than dictating their particular role.

The procedural safeguards set out in Principle 18 include the provision of a legal representative for those who cannot afford a lawyer. This Principle also states that full disclosure of documentation is to be made 'except in special cases where it is determined that a specific disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others'. It is suggested that disclosure can be made to the personal representative and counsel. The fact that disclosure has been withheld must be advised to the patient or their lawyer and reasons given.

UN Convention on the Rights of the Child

Articles 25 and 37(b) provide rights for children not to be arbitrarily deprived of their liberty and to have a periodic review of detention. They are also afforded the right to participate in matters affecting them.[86]

3.3 Law, Policy and Practice in Northern Ireland

A person seeking to challenge his or her detention has a right to apply to a tribunal for a hearing. The Mental Health Review Tribunal for Northern Ireland was first established in 1961.[87] Its current statutory authority is derived from the Mental Health (NI) Order 1986[88] and the Mental Health Review Tribunal Rules 1986. The tribunal is designed to be an independent judicial mechanism for adjudication upon the lawfulness of decisions made under the 1986 Order in relation to involuntary detention or control under guardianship.

If satisfied that a detention is unlawful then a tribunal can discharge the person from detention. This power is restricted for those who are detained under Part III of the 1986 Order (criminal detention) when discharge must be authorised by the Secretary of State.

For those who are detained other than as a result of criminal proceedings, the tribunal is under a duty to discharge the patient if it is satisfied that the person is not suffering from a mental illness or severe mental impairment at all or not to the extent that warrants detention in hospital for treatment, or that discharge would not create a substantial likelihood of serious physical harm to themselves or another person.[89]

Tribunal applications can be made by the person detained or by his or her nearest relative,[90] in certain circumstances. There is a 28 day time limit on an application by the nearest relative. The other time limits for applications depend on the category of the patient but there is a general restriction which limits applicants to one application within the specified time frame. In effect, the most generous provision is that there can be no more than one application within a 6 month period and in some situations the restriction is one application per year.[91]

There is also a mandatory referral system for those subject to long term detention[92] and certain governmental and judicial authorities have the power to refer a case to the tribunal for consideration.[93]

There is a provision within the Order aimed at preventing discrimination against a person who has been detained for assessment but not then detained for treatment[94].

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[86] Articles 12 and 17 CRC.
[87] *Mental Health (Northern Ireland) Act 1961*. The Stationery Office, 1961.
[88] Part V and Schedule 3.
[89] *Mental Health (Northern Ireland) Order 1986.* HMSO, 1986, Article 77.
[90] 'Nearest relative' is defined in Article 32 of the 1986 Order.
[91] *Mental Health (Northern Ireland) Order 1986.* HMSO, 1986, Article 82.
[92] A person detained or controlled must have their case reviewed by the tribunal at least once every two years (one year for those under 16), *Mental Health (NI) Order 1986*, Article 73.
[93] See Articles 72 and 86(3)(a) of the 1986 Order.

Such a person is not required to disclose the assessment period and can answer questions about their health without regard to the assessment period. As discussed above, this may not be as effective a safeguard in practice as was envisaged by the legislators.

The patient or nearest relative has a right to legal representation at the hearing and a form of legal aid is available for those who have limited means.

The burden of proof that the detention is unlawful under the 1986 Order lies with the applicant.

The tribunal includes a medically qualified member. The medical member carries out an examination and may consider medical records in order to form an opinion on the person's mental condition. The opinion is given to the other members of the tribunal only and there is no opportunity for examination of it. He or she then goes on to take part in the hearing of the case and the eventual decision. The role could be described as a mixture of the investigatory and adjudicatory.

Rule 12 of its rules, allows the tribunal to withhold documents from a patient which would 'adversely affect the health or welfare of the patient or others'. This is a wider test than that envisaged by the UN principles. These documents are disclosed to the representative. Where there is no representative then there is no disclosure.

Rule 12 has been used to prevent the disclosure of the trust psychiatrist's report so as to avoid damage to the therapeutic relationship between doctor and patient.

Tribunal hearings are heard in the board room of the hospital where the applicant is detained.

Government guidance advises that hospitals should only discharge a patient to the community when suitable community care arrangements are in place, if such care is needed.

There is evidence within the UK as a whole that there is significant discrimination within the mental health system.[95] It is conceivable that similar practices pertain within Northern Ireland. A problem of institutional racism and racial stereotyping within psychiatry, along with other professions, has been identified in the UK.[96] Research suggests that persons from a non-white background may be detrimentally affected by the application of differential health care practices to differing racial groups.

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[94] *Mental Health (Northern Ireland) Order 1986*, Article 10.
[95] See detailed reference in O'Rawe, Dr. A. *Response from NICEM to the DHSSPS on the review of mental health legislation, policy and provision. Position Paper.* Northern Ireland Council for Ethnic Minorities, 2002.
[96] Minnis *et al.* 'Racial stereotyping: a survey of psychiatrists in the United Kingdom'. *British Medical Journal*, (323) 2001, pp.905-906.

Children and young people are sometimes detained under the Mental Health Order[97] but their detention is often arranged under the Children (NI) Order 1995. The safeguards provided in the Mental Health Order are not guaranteed under detention using the Children Order. The Mental Health Order, however, does not take account of children as a unique grouping and its use may engender considerable stigma.

3.4 Potential Human Rights Violations

Since October 2000, the tribunal has had to look to the provisions of the European Convention on Human Rights (ECHR) in carrying out its functions. The Human Rights Act 1998 obliges the tribunal to take into account ECHR jurisprudence and to interpret legislation in a way which is compatible with Convention rights, to the extent that it is possible to do so. Further, as a public authority, the tribunal itself must act compatibly with Convention rights. It is unlawful for it to do otherwise unless it is prevented from doing so by primary legislation.

The only automatic tribunal review of detention for patients in Northern Ireland is for those detained long term who have not availed of the tribunal procedure. For those who do initiate review the tribunal hearing is not immediate. This means that people are unable to access a speedy check on the lawfulness of their detention. For those patients who request a tribunal hearing, the delay may amount to a breach of Article 5 of the ECHR depending on the circumstances of the case. For those who move from detention for assessment to detention for treatment before accessing a hearing there is the added loss of the protection from the need to disclose the detention. This can impact on, for example, mortgage and insurance applications. Given the unfortunate stigma which can be experienced by those who have been detained, the delay in access to a tribunal is particularly damaging.

The UN Principles set a standard of automatic and immediate independent review. It is also thought that Strasbourg jurisprudence may develop, in light of the judicial acknowledgement in *Megyeri v Germany* of the particular problems faced by those detained under mental health legislation, so as to impose an obligation on states to arrange legal advice or even an automatic hearing for detained patients. This is particularly important for patients with a low level of mental capacity and for those without access to an advocate.

The restrictions on applications set out above may not comply with Articles 5 and 6 of the ECHR and Principle 17 of the UN MI Principles. These require that people are able to access a hearing on the lawfulness of their detention. The rationale behind restrictions may be that they prevent vexatious applications and damage to the patient's well-being. Overall however the restrictions on access to a court need to be reasonable in order to meet UN standards and must be proportionate if tested against ECHR standards. It may be that a more flexible approach is necessary to meet this test, *e.g.* an exception to the rule if a change of circumstances can be shown. Moreover, the 28 day time limit on an application by the nearest relative for a review

[97] The Mental Health Order is the only route to compulsory detention used in the Eastern Health and Social Services Board. See: O'Rawe, Dr. A. *Children and Adolescent Mental Health Services in Northern Ireland 2003.* Children's Law Centre, 2003.

of the decision to prevent may be too rigid given the emotional circumstances and the need for the relative to seek advice before lodging an application.

Mental health law is complex and impacts substantially on an individual's human rights. It often requires skilled and experienced lawyers to effectively advocate on a person's behalf**.** There is however a lack of this specialist representation in Northern Ireland which may be considered to impede effective access to the tribunal and sits uneasily with both Article 6 of the ECHR and UN standards.

The requirement[98] on the applicant to prove that the statutory tests for detention or guardianship are not met is in contradiction to Article 5 which places the burden of proof on the public body to show that it has acted lawfully in detaining.[99]

It has been argued that the dual role allocated to the medical member results in a breach of Article 6 of the ECHR.[100] Potentially, the medical member is in a position to influence the views of the other tribunal members without either party to the case being able to challenge the medical member's opinion or any view adopted by the tribunal.

The involvement of the medical member may benefit the patient by providing an alternative perspective to that of the trust psychiatrist, particularly where the patient has not obtained an independent expert report. In some cases then the medical member helps to ensure a fair hearing by providing an alternative expert view to inform the tribunal as to the reliability of the medical evidence submitted.

The dual role and the lack of transparency could potentially be reconciled if the tribunal treats the medical member's opinion not as evidence but as 'judicial insight and knowledge' with which to assess the submitted evidence.

Rule 12 of the tribunal rules which deals with disclosure of documents is not sufficiently tightly drafted to comply with the UN standard as it is not limited to serious harm to health. A failure to disclose may breach Articles 5(4) and 6 of the ECHR in individual cases depending on the extent to which it impacted upon the overall fairness of the case. A failure to provide relevant information could prevent effective participation in the hearing.

A general disclosure rule may have a harmful effect in mental health cases and there would be concern therefore about a lack of respect for the dignity of the person or even degrading treatment.[101] Conversely, a routine failure to disclose could also be seen as a potential breach.

The holding of the tribunal on the premises of one of the parties to the hearing may create an appearance of bias and/or disadvantage the patient. It may be that in some cases due to the health of the patient it is necessary to hold the hearing in the hospital. However, it may be that the majority of tribunal hearings could be heard at an

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[98] *Mental Health (Northern Ireland) Order 1986*. HMSO, 1986, Articles 77 and 78.
[99] *Winterwerp v The Netherlands* (1979) 2 EHRR 387.
[100] Chahal and Robinson. 'Mental Health Law and the Human Rights Act'. *Legal Action*, December 2000, p.10.
[101] Articles 3 and 8 of the ECHR; Principle 1 of the UN MI Principles.

independent location which would help to ensure that Articles 5 and 6 of the ECHR standards are respected.

Community care and the question of charges also raises concerns for human rights. Many health trusts have waiting lists for essential community care services. The discharge guidance is in place for the protection of the patient but can lead to extended stays in hospital accommodation beyond the need for medical treatment due to a difficulty in setting up a care package.

Once a patient is discharged there may be a charge for the ongoing care services. If the service is considered as personal or domiciliary care or involves respite for a carer then there is a possibility of a charge. Those who receive medical or nursing care receive it free of charge. The distinction between the provision of free nursing and medical care in the community as opposed to free personal or social care may discriminate against those with mental illness as opposed to physical ill-health. This might contravene the Disability Discrimination Act 1995.

The failure to carry out monitoring of the position for minority ethnic users of the tribunal system may perpetuate the discrimination which they are at risk of suffering. The diagnosis and detention patterns which occur in the UK as a whole need to be taken into account. It is vital that all involved in the detention and review process, including trust officers, tribunal members, independent psychiatrists and representatives, are aware of the potential for discrimination and are trained to address it.

For those children and young people detained under the Children (NI) Order there is a potential for a breach of Article 5 of the ECHR in the lack of periodic review. It fails to meet UN Convention on the Rights of the Child standards on review of detention. Moreover, there is also an equality issue given that this human rights violation is linked to the age of the person detained and therefore the non-discrimination provision in Article 14 of the ECHR is engaged[102] as well as section 75 of the Northern Ireland Act 1998.

3.5 Other Jurisdictions

The impact of Article 6 of the ECHR on tribunal access in England and Wales has been tested. The Court of Appeal held that a routine practice of listing cases for eight weeks time from the date of application with no regard to the individual circumstances of the case was contrary to Article 5(4) and therefore unlawful.[103] There has been no ruling on how long a delay would be justified. Consideration has to be given to the balance of ensuring justice and achieving a speedy hearing. Delay caused by, for example, a lack of availability of a medical member of the tribunal has been held to be a breach of Article 6 of the ECHR.[104]

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[102] See positive admissibility decision in *HL v UK* 45508/99.
[103] *R (on the application of C) v Mental Health Review Tribunal, London S & SW Region* (Court of Appeal, 3 July 2001).
[104] *R(on the application of C) v Mental Health Review Tribunal, London S & SW Region* (2001) EWCA civ 1110; *R (on the application of KB and others) v Mental Health Review Tribunal (2) Secretary of State for Health* (2002) EWHC 639 (Admin).

The concept of an automatic independent review for all detainees after the initial assessment period has been included in the draft reforming mental health legislation for England and Wales.

The draft England and Wales legislation also includes a requirement for the government to ensure the availability of mental health advocates to provide information on the law and to assist people in exercising their rights under the legislation.[105]

The burden of proof has been reversed in England and Wales following a declaration of incompatibility with the ECHR.[106] Amending legislation was introduced to place the onus on the detaining authority to prove its actions are lawful.

The issue of advice being given to a court outside the presence of the parties has arisen in Scotland.[107] It was held that it was not a breach of Article 6 for the legal assessor, not a member of the court, to give private legal advice to a lay judge. It was suggested by the High Court, and approved as good practice by the Judicial Committee of the Privy Council, that the lay judge should 'raise in open court any matter upon which the defence, or indeed the prosecution, might reasonably wish to make material comment', including, for example, an opinion that case law has been wrongly interpreted.

The proposed legislation for England and Wales includes the setting up of a panel of clinical experts to take over the examination function of the medical member. The tribunal would receive its medical opinion from an independent expert drawn from this panel. The issue of whether the panel expert opinion will be available for discussion at the tribunal remains. Concerns about the availability of people willing to serve as experts have been raised.[108]

An English judicial review case considered a Human Rights Act challenge to the role of the medical member and found that there was no breach.[109] Significantly, the judge did issue general guidance stating that fairness and natural justice required that the applicant should be informed of evidence which is to be taken into account and the expert views of the medical member in sufficient detail and at a sufficiently early stage to allow them to be dealt with in the hearing.

The position regarding community care services in England and Wales is different. Section 117 of the Mental Health Act 1983 has no direct equivalent in Northern Ireland. It contains an obligation on the state to provide free aftercare to those who have been detained. The government is aiming to remove the free aftercare duty in the proposed legislation.

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[105] *Ibid.* Clause 159.
[106] *R(on the application of H) v Mental Health Review Tribunal, N & E London Region and another* (Court of Appeal, 28 March 2001).
[107] *Hellen Clark (Procurator Fiscal, Kirkcaldy) v Christopher John Kelly*, 11 February 2003. Privy Council DRA No.2 of 2002.
[108] Joint Committee on Human Rights, 25th Report of Session 2001-2, *Draft Mental Health Bill, The Stationery Office*, 2002 (HL Paper 181, HC 1294).
[109] *R (on the application of H) v Mental Health Review Tribunal, N & E London Region* (QBD, 15 Sept 1999).

3.6 Recommendations

1. An automatic review of detention decisions by an independent tribunal should be introduced. This review must take place at the earliest practical opportunity and within 28 days.
2. Rigid restrictions should be lifted on applications to the tribunal to allow further applications if a change of circumstances can be shown on the face of the application.
3. There should be increased resourcing of the tribunal system together with a time limit within which a hearing can be expected in order to tackle delay.
4. There should be funding for specialist independent and accessible mental health legal advice and representation. This should include children and should take account of their particular needs. Advice and representation funding needs to take account of the need for translation and interpreting services for those from minority ethnic backgrounds.
5. Greater transparency should be introduced to the role of the medical member by requiring the disclosure to the parties of the basis upon which the opinion is given.
6. The current burden of proof at tribunal hearings should be reversed as required by the European Convention on Human Rights.
7. The tribunal rules should be amended to meet UN standards on the withholding of documentation from patients.
8. Consideration should be given to the provision of independent premises for the mental health review tribunal.
9. A free, statutory aftercare duty should be introduced as in England and Wales, together with funding, in order to allow discharge by the tribunal without delay on the grounds of inadequate care arrangements
10. Monitoring should be carried out of the experience of tribunal users from a minority ethnic background and all other section 75 groups to assess whether there is evidence of unequal treatment and to ensure any access and communication issues are being adequately addressed, for example the provision of sign language interpreters.
11. Equality training should be provided for all those involved in the tribunal system.
12. Specific provision should be made for children and young people within mental health legislation.
13. Children and young people should be afforded a right to an automatic review of detention.

4. THE MENTAL HEALTH COMMISSION

4.1 Introduction

In order to promote and protect the rights of people with mental health problems it is necessary to have a body that has clear responsibility for monitoring the implementation of mental health legislation and ensuring law, policy and practice is compatible with the agreed human rights standards. "Whatever the rights, 'the language of rights does not guarantee their realisation', risking accusations of them being a mere 'hollow mantra'. Rights can only protect if society legally endorses *and* enforces them".[110] In Northern Ireland the body charged with reviewing the care and treatment of people with mental health problems and monitoring the implementation of the Order is the Mental Health Commission (the Commission).

This Chapter examines the role of the Mental Health Commission in protecting and promoting the human rights of people with mental health problems. Despite having a broad remit, it seems that resource limitations have constrained the work of the Mental Health Commission. Concerns therefore arise about how closely mental health law, policy and practice is being scrutinised by the statutory watchdog.

4.2 International Standards

Council of Europe

Whilst case-law under the European Convention has focused on the protection of individual negative rights, the Council of Europe's 'White Paper on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment'[111] goes into detail about the practicalities of how standards for the implementation of mental health legislation should be set-up, monitored and reviewed. Its recommendations include that systems should:

a) "be provided with sufficient financial and human resources to perform their tasks;
b) be organisationally independent from the management of the Mental Health Services or premises which are being monitored;
c) be co-ordinated between themselves and with other audits and quality assurance services;

In addition, professionals, both psychiatrists and non-psychiatrists, as well as lay-persons and users should be involved in the system for the setting up and monitoring of quality standards for the implementation of mental health legislation".

[110] Kazmierow, M. 'The New Zealand Health and Disability Commissioner: A Comparative Assessment of the Commissioner's Contribution to Protecting the Rights of Mental Health Consumers'. *Journal of Law and Medicine*, vol. 9(3), 2002, p.280.
[111] Council of Europe, 2000, p.19.

It goes on to state that arrangements should include:

a) "ensuring that persons with mental disorder are not detained in premises which are not registered by the appropriate authority;
b) notifying to the appropriate authority the death of persons subject to involuntary placement or treatment; ensuring that powers exist to order an investigation into the death of a patient and that an independent investigation of the local mental health services into the death of the person concerned has occurred;
c) visiting and inspecting such premises to establish their suitability for the care of patients with mental disorder, at any time and, where deemed necessary, without prior notice;
d) users of services should be involved in visiting and inspecting local Mental Health Services to establish that suitable alternatives to detention in hospital are provided for the care of patients with mental disorder;
e) the managers of the mental health services or premises and staff who treat, nurse or care for those persons subject to mental health legislation provide any information required in so far as this may reasonably be deemed necessary for the purposes of setting-up and monitoring quality standards;
f) meeting privately with patients subject to provisions of Mental Health legislation and accessing their medical and clinical file at any time;
g) receiving complaints confidentially from any such patients and ensuring that local complaints procedures are in place and that complaints are appropriately replied to;
h) reviewing situations in which restrictions to communication have been applied;
i) ensuring that relevant professional obligations and standards are met…;
j) ensuring that statistical information on the use of Mental Health legislation and complaints is collected reliably and systematically;
k) providing a report (usually annually) to those, up to and including Minister, responsible for the care of patients with mental disorder, who should consider publishing the report; in case the report itself is not published, information should nevertheless be given to the general public by the chief official of the State on such matters as the mental health of the society, activities for improving the life quality of people suffering from mental disorder and the conditions of their treatment;
l) advising those, up to and including the Minister, responsible for the care of patients with mental disorder, on the conditions and facilities appropriate for such care;
m) ensuring that those, up to and including the Minister, responsible for the care of patients with mental disorder, respond to questions raised during the visits and, at a later stage, to advise and reports arising from the arrangements for the setting-up and monitoring of quality standards. The arrangements for the setting-up of quality standards should ensure that follow-up action is taken".[112]

[112] *Ibid.* pp.20-21.

This final point is crucial as monitoring, identifying and highlighting rights abuses and bad practice is of little use if the subsequent recommendations to redress the difficulties are not implemented.

UN Principles

The MI Principles[113] specifically refer to the need for this monitoring and enforcement role. Principle 22 declares that "States shall ensure that appropriate mechanisms are in force to promote compliance with these Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient".

4.3 Law, Policy and Practice in Northern Ireland

The Mental Health Commission for Northern Ireland was established under Part VI of the Mental Health (Northern Ireland) Order 1986 "to keep under review the care and treatment of patients, including (without prejudice to the generality of the foregoing) the exercise of the powers and the discharge of the duties conferred or imposed by this Order" (Article 86(1)). The Guide to the Order describes it as "an independent, multi-disciplinary body with investigative, inspectorial and advisory functions whose role is to protect the rights and welfare of mentally disordered people and to safeguard staff involved in their care and treatment. The Commission's role is not confined to patients detained in hospital, on the contrary, its jurisdiction extends to voluntary patients, people subject to guardianship, patients in nursing homes or residential accommodation and anyone suffering, or even appearing to suffer, from mental disorder".[114]

Article 86(2) of the Order sets out the specific duties of the Commission. These include:

a) to make inquiry into any case where it appears to the Commission that there may be ill-treatment, deficiency in care or treatment, or improper detention in hospital or reception into guardianship of any patient, or where the property of any patient may, by reason of his mental disorder, be exposed to loss or damage;
b) as often as the Commission thinks appropriate to visit and interview in private patients who are liable to be detained in hospital under this Order; bring to the attention of the relevant authority cases where they action may be desirable to secure the welfare of any patient;
c) bring to the attention of the relevant authority cases where the action may be desirable to secure the welfare of any patient;
d) advise the relevant authority of any relevant matters;
e) alert the relevant authority to any matter concerning the welfare of patients.

Article 86(3) enables the Commission to:

[113] United Nations. *Principles for the protection of persons with mental illness and for the improvement of mental health care.* Adopted by the UN General Assembly resolution 46/119 of 17 December 1991.
[114] *The Mental Health (Northern Ireland) Order 1986: A Guide.* Department of Health and Social Services, 1986, para 218.

a) refer cases to the Mental Health Review Tribunal;
b) visit, interview and medically examine any patient in private;
c) require the production and inspection of records relating to the detention, guardianship and treatment of people.

The Commission consists of a Chief Executive, approximately eight full-time equivalent staff, a chairperson and 15 Commissioners who are all part-time.

The main tasks completed by the Commission in 2001/02 were training the Commission members in the various relevant areas; monitoring forms and treatment plans; and appointing Part II and Part IV doctors. The Commission also reviewed all complaints and untoward incidents referred to it and Commissioners completed 25 visits, of which five were unannounced and unusually only one was to a community facility. HMP Maghaberry was included in these visits. The year 2002/03 was perhaps more representative of the usual level of visiting as there were 61 visits completed of which 19 were announced hospitals visits and 42 unannounced community visits.

4.4 Potential Human Rights Violations

The central issue is that if the Commission does not have sufficient resources to fully and thoroughly review the care and treatment of people with mental health problems in Northern Ireland then human rights violations may not be identified, investigated and addressed. The Commission, by necessity, has essentially confined its work to the monitoring of compliance with legal documentation, providing advice to persons and visiting hospital and community facilities. Many aspects of mental health care and treatment have not been addressed by the Commission. For example there does not appear to be any monitoring of police powers. A related issue is that all of the Commissioners are part-time. Moreover, some members are also involved in service provision, which raises issues of independence and conflict of interest which are managed by a 'conflict of interests' policy that ensures members only review areas where they have no perceived bias.

Service providers try to comply with the Commission's recommendations but it is not clear what happens if there are insufficient resources to do so. It would be a useful indicator of the effectiveness of the Commission if a summary of its reports, recommendations and an account of the subsequent action were included in its annual report.

One matter inhibiting the Commission from fulfilling its remit is that Article 87(2) restricts the power to require the production of records relating to detention and treatment to medical practitioners. This would appear to greatly restrict the investigatory potential of non-medical Commissioners, making the protection of human rights much more difficult.

The Commission does seem to have taken on an informal role in providing advice to practitioners on issues relating to the Order. This raises some concerns about advice being provided by staff who may not have been suitably trained to do so, and about

how accountable the Commission is for the advice it provides. As was highlighted in the consultation for this report, the Commission's central role is to protect the rights of service users but if it is also advising service providers, this may create some confusion and potential conflicts of interest. There is a clear need for practitioners to be able to easily access advice but this should perhaps be met by suitably trained individuals independent of the Commission.

It is also unclear if the Commission effectively communicates to patients its role and how the roles of service providers' complaints procedures, the police and the Ombudsman relate to its work.

A further concern raised in the consultation was that there are not enough users and carers working as Commissioners. The appointment of more users and carers to the Commission could provide a more balanced composition, make the Commission more accessible and help stimulate new ideas about how it can more effectively perform its important statutory function. It should also be acknowledged that the Commission has already attempted to appoint at least two members who are users or ex-users and at least one who is a carer.

4.5 Other Jurisdictions

The Draft Mental Health Bill for England and Wales does not propose that the current Mental Health Act Commission (whose remit is narrower than the Northern Ireland Commission as it only extends to detained patients) continues. Instead it suggests this role may be taken on by a specialised division of a new health service inspectorate (the Commission for Healthcare Audit and Inspection – CHAI) and also by the advocacy services included in the Draft. The Mental Health Act Commission[115] has responded that "we are concerned that, without significant additional provisions, the combination of the healthcare inspectorate and advocacy services will still not enable all of the necessary safeguarding functions to be carried out".

In Scotland, the Mental Welfare Commission, whose remit is similar to the Northern Ireland Commission, is proposed to continue in the Mental Health (Care and Treatment) (Scotland) Act 2003. Its duties include monitoring the Act, providing advice, visiting, investigating, and promoting good practice. The Millan Committee also recommended "the membership of the Commission should include increased representation of service users and carers. At least two members should have personal experience of mental disorder, and two members should have personal experience as carers"[116]. The new Act does not specify the level of service user and carer representation but does leave it open for this to be done.

An international example of these arrangements suggests an important factor is the powers available to the Commission to require compliance with its recommendations. "The New Zealand experience indicates that effective enforcement of rights must be

[115] *The Mental Health Act Commission Response to the Draft Mental Health Bill Consultation.* Mental Health Act Commission, 2002, p.6.
[116] Millan Committee. *New Directions: Report on the Review of the Mental Health (Scotland) Act 1984.* Scottish Executive, 2001, p.22.

other than ‘name [and] shame’ and ‘democratic accountability’, or consumers can pay a high price”.[117]

4.6 Recommendations

1. The remit of the Mental Health Commission should be reviewed against international standards which clearly require an independent, specialist body to monitor mental health services.
2. The Commission should receive adequate funding to ensure that it can effectively exercise its functions.
3. As highlighted in the Commission’s strategic plan, it should be considered whether the Commission might be more effective and independent if a number of full-time Commissioners were appointed on a one or two yearly basis; perhaps seconded from their normal employment.
4. There should be more service users and/or carers appointed as Commissioners and involved in the running of the Commission.
5. Non-medical Commissioners should have access to whatever records they need to investigate any concerns.
6. The Commission should take the lead in providing information on the roles of service providers including the Commission itself, the police and the Ombudsman in relation to concerns and complaints.
7. The Commission should review evaluate the current practice of providing advice to service providers.
8. Due to the particular concerns about the admission of young people to adult psychiatric wards any admission of a young person under 18 should be automatically referred to the Commission and an urgent visit completed.[118]

[117] Kazmierow, M. ‘The New Zealand Health and Disability Commissioner: A Comparative Assessment of the Commissioner's Contribution to Protecting the Rights of Mental Health Consumers’. *Journal of Law and Medicine*, vol. 9(3), 2002, p.301.

[118] It is likely that this situation would also be of interest to the Children’s Commissioner and there may also be a role for the planned Health and Social Services Regional Inspection Authority.

5: TREATMENT

5.1 Introduction

This Chapter looks at the human rights implications of treatment for mental health. Particular human rights concerns are the forced treatment of capable patients, the types of treatment authorised, the inadequate testing of capacity to consent to treatment and the under-funding of community services which may have prevented the need for forced treatment. There is particular concern over the inadequacy of services for children and young people with mental health problems.

5.1 International Standards

European Convention on Human Rights

The principle of bodily integrity is captured in both Article 3 and Article 8. No one can be treated in an inhuman or degrading manner and everyone has a right to respect for his or her private life, including their physical and psychological integrity.[119] There can be no justification for inhuman or degrading treatment. Interference with physical or psychological integrity may be justified in certain circumstance, for example, for the protection of health or to protect the rights of others. The steps taken to protect those rights must be proportionate to the impact on the individual.

The European Court of Human Rights has considered complaints about treatment such as forced administration of sedatives, handcuffing, forced feeding but found that there was no inhuman or degrading treatment because, in that particular case, the action could be medically justified.[120] The court took the approach that whilst it would consider ultimately whether Article 3 had been breached, the medical authorities were well placed to decide on the therapeutic methods to be used to preserve the physical and mental health of the patient. There would be no breach of Article 3 where therapeutic necessity has convincingly been shown to exist. This approach has been described as highly deferential to mental health professionals.[121]

In relation to state actions or omissions leading to degrading treatment, there have been some developments in the Strasbourg court which mean that health and social services can no longer consider themselves exempt from negligence claims.[122] These cases have involved children who claimed that the local authority did not adequately protect them from abuse, however the failure of a state to protect a child or an adult from the effect of mental ill-health by providing inadequate services could also be held to be in contravention of the ECHR.

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[119] *Botta v Italy* (1998) 26 EHRR 241.
[120] *Herczegfalvy v Austria* (1993)15 EHRR 437.
[121] Gostin, L.O. 'Human Rights of Persons with Mental Disabilities: The European Convention on Human Rights'. *International Journal of Law and Psychiatry*, vol.23, No. 2, 2000, pp.125-129.
[122] *Z and others v UK* (App. 29392/95) ECtHR 10 May 2001. See also: *ER and others v UK*, ECtHR 26 November 2001.

A case has been referred to the Strasbourg court from the UK on the issue of compulsory treatment and Article 8. The question concerns the justification of forced treatment under Article 8 (2) and may, in due course, provide some guidance.[123]

Council of Europe

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) also gives some guidance on human rights standards in Europe. It has stated that "every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances".[124]

The Council of Europe's Steering Committee on Bioethics has produced a white paper on the protection of the human rights and dignity of people suffering from mental disorder. It states that psychosurgery has not yet been shown to be effective and therefore the consent of the patient is fundamental together with a second opinion from a committee which is not exclusively made up of psychiatric experts.[125]

The 1997 Convention on Human Rights and Biomedicine provides that a person who has a mental disorder of a serious nature may be subjected, without his or her consent, to treatment only where a failure to treat would result in serious harm to the person's health.[126] This Convention has not been signed by the United Kingdom.

UN Principles

The MI Principles also cover consent to treatment and treatment itself. Principle 9 sets out the right of patients to the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others and establishes that treatment must be directed towards preserving and enhancing personal autonomy. Principle 10.1 states that medication must only be given for therapeutic or diagnostic purposes and never for the convenience of others.

Principle 11 sets a standard of no treatment without informed consent except in certain defined circumstances. Informed consent can only be obtained once the patient has been made aware of the diagnostic assessment, the purpose, method, likely duration and expected benefit of the proposed treatment, alternative modes of treatment, including those less intrusive, any possible pain or discomfort, risks and side effects of the treatment.

The defined circumstances when treatment can be given without informed consent are when a person is detained as an involuntary patient and there has been an independent review which holds that the treatment is in the best interests of the patient's health needs and either the patient lacks capacity to give consent or is unreasonably withholding it, with regard to his or her own safety or the safety of others. There is also a provision for emergency treatment without informed consent.

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[123] *Wilkinson v UK*, 2003.
[124] The CPT Standards, Council of Europe CPT/Inf/E (2003) at p.57, para 41.
[125] CM, 2000, 23 Addendum at para. 7.
[126] *Ibid.* Article 7.

Principle 11 also establishes human rights standards as regards the type of treatment which can be given. Sterilisation can never be carried out as a treatment for mental illness. Major medical or surgical procedures may only be carried out with informed consent, or where this is not possible, after an independent review. This prevents capable patients from being forced to undergo this type of treatment against their will. Involuntary patients, whether capable of consenting or not, should never be subjected to psychosurgery or other intrusive or irreversible treatments for mental illness.

UN International Covenants

As regards discrimination against people with a mental illness in relation to treatment, Article 14 taken with either Article 3 or 8 of the ECHR and Article 26 of the International Covenant on Civil and Political Rights (ICCPR) prohibit detrimental differential treatment which has no objective justification.

The International Covenant on Economic, Social and Cultural Rights secures the right of everyone to the highest attainable standard of mental health.[127] This is replicated in the UN Convention on the Rights of the Child. This has been interpreted to include the placing of a positive obligation on governments to provide accessible mental health services.[128] An aspect of accessibility is that there is a right to receive information about health issues, such as why certain medication is beneficial and how it works.

5.2 Law, Policy and Practice in Northern Ireland

It is a principle of common law that a person has the capacity to give informed consent to treatment unless it is shown otherwise. A person's capacity to understand can be reduced by their mental illness and this may be to the extent that they are unable to make an informed decision about treatment. A patient is held to be unable to make a decision when he or she is:

a) …unable to comprehend and retain the information which is material to the decision especially as to the likely consequences of having or not having the treatment in question

and/or

b) …is unable to use the information and weigh it in the balance as part of the process of arriving at the decision.[129]

A person who does not have capacity (an incompetent person) can be treated under the common law if the treatment is in his or her best interests and is necessary to preserve the person's life, health or wellbeing.[130] An exception to this is where a

[127] Article 12.
[128] CESCR General Comment No.14 (E/C.12/2000/4).
[129] *Re C (Refusal of Medical Treatment)* [1994] 1 FLR 31.
[130] *Re F (Mental Patient: Sterilisation)* [1989] 2 FLR 376.

valid advance directive refusing the treatment is in existence.[131] (There is a recent health board policy statement in relation to anticipatory refusals.)

The Mental Health (NI) Order overrides the common law position in defined circumstances. Article 69 of the Order provides that the consent of most involuntary detained patients is not necessary for treatment for his or her mental disorder.

There are some specified exceptions to this general dispensation. Some types of treatment require consent and a second opinion, such as any surgical operation for destroying brain tissue or for destroying the functioning of brain tissue and the surgical implantation of hormones for the purpose of reducing male sexual drive.[132] There is a procedure for validating the consent. The second opinion must be from a psychiatrist appointed by the Mental Health Commission for Northern Ireland. This 'second opinion appointed doctor' (SOAD) must certify that the treatment is appropriate 'having regard to the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition'.[133]

It is possible to give some other forms of treatment without consent if a second opinion is obtained. These include the administration of medicines after a patient has been receiving medication for three months and prior to any electro-convulsive therapy.

Article 64 of the Order provides that where the person consents to ECT or to continued medication, there is still a need for a psychiatrist to certify that the person has the capacity to consent and has actually consented.

Where the person is incapable of consenting, a SOAD must certify that the person is incapable of consenting and that the treatment is appropriate, as above.

If the person could consent but refuses to do so then a SOAD must certify that the treatment should be given due to it alleviating or preventing a deterioration of his or her condition.

Consent and a second opinion are not required where the treatment is immediately necessary to save the person's life. Any treatment which is not irreversible can also be given in an emergency to prevent a serious deterioration of the person's health without the need for consent or a second opinion. Treatment which is not irreversible or hazardous may be given without the safeguards of consent and a second opinion if it is immediately necessary to alleviate serious suffering by the patient or to prevent violent behaviour or danger to the person or others, as long as the treatment represents the minimum interference necessary. These emergency provisions are contained within Article 68 of the Order.

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[131] *Re T* [1992] 4 AER 649.
[132] *The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986.* HMSO, 1986.
[133] *Mental Health (Northern Ireland) Order 1986,* Article 63(2)(b).

New government guidance has been issued on consent for examination, treatment or care.[134] The useful guidance on obtaining informed consent applies to those situations where the consent of detained patients is required.

5.3 Potential Human Rights Violations

The general provision for non-consensual treatment of capable detained patients raises a major human rights concern. For the first three months of detention there is no need for either consent or review for the forcible administration of medication. The legislation now needs to be read in the light of the Human Rights Act 1998. It is arguable the blanket permission for medication without consent for three months is at odds with the requirement in Article 8 of the ECHR that any interference with respect for private life needs to be justified and proportionate in the circumstances of each case.

The current Article 69 of the Mental Health (Northern Ireland) Order 1986 position of no consent being necessary except in defined circumstances is at odds with the CPT standard of informed consent with only strictly defined exceptions.

The position in Northern Ireland falls short of the UN MI Principles as regards compulsory treatment in the first three months of detention as the proposed treatment is not subject to independent review which would consider both whether consent was possible or withheld and the patient's best interests.

The possibility of psychosurgery being carried out on detained patients in Northern Ireland, even with consent and a second opinion, is contrary to Principle 11 of the MI Principles.

In Northern Ireland there has been concern over the use of electro- convulsive therapy (ECT). This can be given without consent to detained patients but requires the agreement of an appointed psychiatrist. The appointed doctor must not just simply review the opinion of the registered medical officer but come to his or her own independent view as to whether the statutory test is met.[135]

There is some concern about a lack of awareness among patients and relatives of the procedures which the medical authorities need to follow and whether these procedures are being followed. The medical authorities need to be aware of their obligation to protect the human rights of the person concerned whether or not consent is given. The lawfulness of the application of electro-convulsive therapy in individual cases may be questionable, particularly since the enactment of the Human Rights Act 1998. The statutory test must be applied in light of Articles 3 and 8 of the ECHR so that the application of ECT must not be degrading or disproportionately impact upon the person's psychological integrity, even if it would alleviate or prevent a deterioration

[134] *Reference Guide to Consent for Examination, Treatment or Care.* Department of Health, Social Services and Public Safety, 2003.
[135] A tendency towards deference by SOADs in England to the original doctor's view was criticised by the Court of Appeal in *R (on the Application of Wilkinson) v The Responsible Medical Officer Broadmoor Hospital [2001] EWCA Civ 1545.*

in the person's condition. Some groups in Northern Ireland are of the view that ECT should not be used.

It appears that the current law discriminates between persons who require treatment by reason of a mental condition compared to those who require treatment for a physical condition. Even where both people are capable of making a treatment decision and the decision not to proceed only impacts on the individual and not others, the mentally ill person can be forcibly treated but the decision of the person with the physical illness is respected.

It is questionable whether the legal test for capacity takes sufficient account of the different levels of understanding needed for different decisions and adequately acknowledges the fluctuating nature of capacity as a result of some conditions. A decision that someone lacks capacity has significant implications for their autonomy. There is no element of independent review of this major decision for the majority of deemed incapable people receiving treatment in Northern Ireland. It is possible that there is a lack of consistency across Northern Ireland as to the decisions being made about capacity to consent to treatment as there is no monitoring or accountability mechanism other than judicial review in the High Court.

For children and young people there is a particular need to ensure that the information given in relation to proposed treatment is accessible and that sufficient time is taken to assess whether the young person in question has the capacity to decide.[136] This applies equally to those with a low level of capacity.

It seems obvious that tests of capacity need to take account of cultural differences.[137]

If a person lacks capacity to manage their financial affairs then there is often a referral to the Office of Care and Protection[138] and a controller is appointed who is subject to monitoring on the financial decisions made. There is no equivalent independent monitoring of treatment decisions made about a person deemed incapable.[139]

Human rights concerns have also been raised about treatment of compliant voluntary hospital patients or residential care residents who do not have capacity to consent. As the treatment is carried out under the common law doctrine of necessity by the doctor or nurse there are no safeguards for these people's rights about the type of medication or treatment which they are given. There is no automatic second opinion required for their protection and they are reliant on relatives to raise any issues such as excessive sedation. An inspection of a residential care home may also act as a safeguard but is insufficient in itself. The new departmental guidance on consent to examination, treatment and care is useful in its setting out of the best interests test and may go some

[136] Also referred to as Gillick Competent see *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.
[137] O'Rawe, Dr. A. *Response from NICEM to the DHSSPS on the review of mental health legislation, policy and provision.* Northern Ireland Council for Ethnic Minorities, 2002.
[138] The Office of Care and Protection is a part of the High Court and deals with the administrative work of handling financial affairs of patients.
[139] The DHSSPS has highlighted that the Mental Health Commission does review all treatment plans of detained people after three months.

way to helping to change attitudes to ensure that the dignity of the person with incapacity is protected.

Although advance directives are legal at common law, there is a lack of awareness of this. There is a therefore a vulnerability to inconsistent practice.

Research has shown that time taken to work in the community with people about the benefits of taking medication and developing a positive approach to managing their mental disorder results in less need for compulsory detention and treatment.[140] A failure to work with people in this way could be viewed as inconsistent with the positive obligation to provide information on health as identified by the UN Committee on Economic, Social and Cultural Rights. There is a relative under-funding of community mental health and learning disability services and this has an impact on the human rights of those with mental disorder who are more likely to be detained and treated against their will.

Failure to provide treatment to those with a diagnosis of personality disorder may also mean that the authorities are failing to take the required steps to ensure that people are afforded the highest attainable standard of mental health, as required by the International Covenant on Economic, Social and Cultural Rights.

Despite the recent increase in beds there is a relative under funding of children and adolescent mental health services. The lack of overall strategy also impacts heavily on this vulnerable group.[141] Waiting lists for treatment can be lengthy.[142] Early intervention could prevent further psychological harm (Article 8 ECHR). Prioritisation of other services could be in breach of Article 14 of the ECHR, taken with Article 3 or 8. There is also an equality concern under section 75 of the Northern Ireland Act 1998 and a failure to meet the concerns of the UN Committee on the Rights of the Child.

There is concern that people with a diagnosis of personality disorder are often unable to access appropriate treatment in Northern Ireland.[143]

5.4 Other Jurisdictions

The proposed mental health legislation for England and Wales requires the mental health authority to apply to a tribunal for authorisation for treatment for detained patients. Patients may also apply to have a treatment order discharged.

New protection is also proposed for patients who are not detained but who are not capable of making treatment decisions. Some of these people, ie those who would be

[140] *National Service Framework for Mental Health.* Department of Health, 1999.
[141] See: O'Rawe, Dr. A. *Children and Adolescent Mental Health Services in Northern Ireland 2003.* Children's Law Centre, 2003.
[142] For example, 36 months for a routine out-patient referral in one trust area in March 2001, and two years with no new referrals for clinic appointments for children with Attention Deficit Hyperactivity Disorder. See above.
[143] This was highlighted at the Northern Ireland Human Rights Commission consultation session held during the course of this research in March 2003.

likely to resist treatment or are at substantial risk of suicide or causing serious harm to others, will need to be detained and cannot be treated as voluntary patients. This will increase the number of those detained but will mean that they are afforded better safeguards.

For those remaining compliant voluntary incompetent patients who require hospital based medical treatment for their mental disorder, there will be an element of independent review of treatment decisions by a medical adviser and a tribunal, if necessary. The proposed reforms have been criticised for not including children and those receiving treatment in places other than hospital, *e.g.* in residential care homes.[144]

In Scotland, under the relatively new Adults with Incapacity (Scotland) Act 2000, it is possible for a person, while capable, to appoint a welfare attorney to consent to some forms of treatment in the event that she or he becomes incapable of consenting. A decision to consent to treatment would need to benefit the incapable adult, take account of his or her current and past wishes and the views of certain others, such as the primary carer. The proposed treatment must be the least restrictive option. The Law Commission for England and Wales has made a similar recommendation for its jurisdiction.[145]

Neuro-surgery for mental disorder has been prohibited in Scotland for those who are unable to consent to the procedure.

In the Republic of Ireland, the new Mental Health Act 2001 provides that a patient must consent in writing to psycho-surgery and it must be approved by a tribunal as in the best interests of the patient's health.[146]

In Canada, the right of a capable person to refuse treatment for mental illness despite it being considered by psychiatrists to be in his best interests has been upheld by the Court of Appeal for Ontario.[147] The judgement held that forced treatment in this case would be contrary to the right to security of the person, which is similar to the right to respect for private life. This decision has been further appealed to the Supreme Court of Canada.

Advance directives are included in the proposed Mental Incapacity Bill for England and Wales.

5.5 Recommendations

1. Legislation should ensure that people with capacity to refuse treatment are no longer treated against their will, except in very limited circumstances.

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[144] Joint Committee on Human Rights. *Report on the Draft Mental Health Bill.* 25th Report of Session 2001-2. The Stationery Office, 2002, p.29 (HL Paper 181, HC 1294).
[145] See: *Who Decides? – Making Decisions on Behalf of Mentally Incapacitated Adults, a consultation paper issued by the Lord Chancellor's Department.* The Stationery Office, 1997 (CM 3808).
[146] *Mental Health Act 2001*, s.58 – not yet in force.
[147] *Professor Scott Starson v Dr Ian Swayze & Dr Paul Pozner*, Court of Appeal for Ontario, June 2001.

2. Legislation governing non-consensual treatment should be premised on the presumption that intervention must be consensual. Legislation should set out the circumstances where intervention is permissible, including appropriate safeguards to protect both competent and non-competent patients, as people without capacity retain their right to physical and psychological integrity.
3. Legislation should require that all compulsory treatment accord with a treatment plan, and that the plan be subject to authorisation and review by an independent person or organisation. Treatment considered necessary which is not contained within the plan would require independent review before being carried out, other than in an emergency. Users should be involved in the planning process and be informed of this right.
4. Legislation should require a decision to be made about capacity before a treatment decision is made, either in the community or in hospital. The guidance should emphasise the need to take appropriate steps to ensure that the diagnosis, particularly in relation to children and older people and where cultural issues are felt to be important, accurately assesses the patient's capacity.
5. Every determination of incapacity should be recorded in writing with reasons. Such determination should be subject to monitoring and regular review. There should be a right of appeal to a court or tribunal in relation to an incapacity determination.
6. Consideration should be given to whether legislation should prohibit, or at least restrict the use of, psychosurgery for mental disorder, in line with the UN MI Principles.
7. Detailed research should be carried out on the use of ECT and other potentially irreversible treatments, involving the psychiatric profession and users.
8. Legislation should introduce an enduring welfare power of attorney instrument to allow treatment decisions to be made by an appointed person in accordance with the wishes of the donor and/or his or her benefit. The Office of Care and Protection should have a role in monitoring the use of the enduring welfare power of attorney.
9. Legislation should regulate the use of advance directives.
10. Additional funding should be provided for mental health promotion, prevention, early intervention services and community mental health and learning disability services with a view to reducing the need for compulsory treatment.
11. Legislation should require the provision of accessible treatment for people diagnosed as having a personality disorder.
12. Legislation should ensure that the particular needs of children and young people in relation to treatment are encompassed, including a framework which takes account of their best interests and their health requirements as well as recognising and as far as possible safeguarding their autonomy in matters of consent to treatment.
13. A priority should be given to improving services for children and adolescents, in particular, commitment to a regional Child and Adolescent Mental Health Service Programme.
14. Additional funding should be provided for community mental health and learning disability services for training in relation to cultural differences.

6: MENTAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM

6.1 Introduction

This Chapter examines the law, policy and practice relevant to the human rights of people with mental health problems in contact with the criminal justice system. This group is usually referred to as 'mentally disordered offenders' however this was identified as potentially offensive and inaccurate in the consultation for this report and so 'people with mental health problems' in this Chapter is used to refer to those in contact or at risk of contact with the criminal justice system. A number of issues will be considered including:

- The definition of this group;
- The concepts of responsibility and diversion;
- The relevant international standards;
- The current law, policy and services in Northern Ireland; and
- The human rights implications of inappropriate and inadequate services.

There is no generally agreed operational definition of this group[148] however in this Chapter a broad definition will be used to include people who have not been convicted of an offence but may have committed an offence or are at a high risk of offending. A concise definition was used by the Social Services Inspectorate[149] who used 'mentally disordered offenders' to refer to "the full range of people with a mental disorder…who come into contact with the criminal justice system or are at risk of offending". The four main groups in this area are:

- The people who have committed offences, some of which may not have been detected, or formally recorded, or reported, for example, non-reported assaults on staff in residential settings, as well as those referred for police investigation, or the subject of prosecution;
- People with mental health problems who are in custody, under probation or have been diverted away from the criminal justice system;
- People in the mental health services whose offences are ignored; and
- Those in special hospitals, regional secure units[150] and under probation orders with a condition of psychiatric treatment.[151]

The concept of responsibility is central to consideration of the human rights of people with mental health problems. It is a general principle of law "that the person liable to be punished should at the time of his crime have had the capacity to understand what he is required by law to do, and to control his conduct in the light of such decisions. Normal adults are generally assumed to have these capacities, but they may be lacking

[148] Cohen, A. and Eastman, N. 'Needs assessment for mentally disordered offenders and others requiring similar services. Theoretical issues and a methodological framework'. *British Journal of Psychiatry*, vol. 171, 1997, p.412.
[149] Robbins, D. *Mentally Disordered Offenders: Improving Services.* Department of Health, 1996, p.i.
[150] As discussed later, these levels of care (high and medium security) are not yet available in Northern Ireland.
[151] Vaughan, P.J. and Badger, D. *Working with the Mentally Disordered Offender in the Community*. Chapman and Hall, 1995.

where there is mental disorder or immaturity, and the possession of these normal capacities is very often signified by the expression 'responsible for his action'".[152] If someone is not responsible for his/her actions then it is argued they should not be punished for them and instead diverted to the appropriate services.

The courts, therefore, have to consider a number of factors when deciding on the appropriate 'disposal'. These include "the safety of the public, retribution for the offence, the general deterrent effect of the sentence on the offender and on others, and…the interests of the offender…In general…there is a presumption against prosecuting a person who was mentally disordered at the time of the offence unless over-ridden by public interest as in serious cases".[153]

It has also been suggested, however, that "excusing offending may not always be in the patients' interests [this quote refers specifically to in-patients]. The formal legal process can be a valuable exercise in reality testing. The patient can measure his or her own perceptions of his or her own behaviour against those of society. This can be useful preparation for life outside hospital. The knowledge that prosecution is routine rather than exceptional may deter further assaults and help aggressive patients to accept responsibility for their behaviour. Sometimes encouraging such patients to accept responsibility can be clinically beneficial".[154]

It has also been highlighted that "diversion is an inherently offender-orientated process, its primary focus being his or her needs, and that there is therefore a danger that other principles within the criminal justice system, such as respect for public safety and the rights of victims may be jeopardised".[155] The potential tension between the human rights of the person with mental health problems and the rights of others is a recurring theme in this area.[156]

6.2 International Standards

European Convention on Human Rights

A number of cases under the European Convention of Human Rights have implications for the law, policy and practice affecting the human rights of this group.

In *Aerts v Belgium* the European Court of Human Rights found "there should be some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention".[157] In this case the Court ruled Lantin Prison's psychiatric wing could not be regarded as appropriate for someone with mental health problems because it did not provide sufficient medical care or a therapeutic

[152] Hart. In Laing, J.M. *Care or Custody? Mentally Disordered Offenders in the Criminal Justice System.* Oxford University Press, 1999, p.36.
[153] Faulk, M. B*asic Forensic Psychiatry.* (2nd Ed.) Blackwell Science, 1995, p.11.
[154] Smith and Donovan. In Prins, H. *Offenders, deviants or patients?.* (2nd Ed.) Routledge, 1995, p54.
[155] Laing, J.M. *Care or Custody? Mentally Disordered Offenders in the Criminal Justice System.* Oxford University Press, 1999.
[156] Restorative approaches may be helpful. See: Dignan, J. and Lowey, K. 'Restorative Justice Options for Northern Ireland: A Comparative Review'. *Review of the Criminal Justice System in Northern Ireland Research Report 10.* The Stationery Office, 2000.
[157] *Aerts v Belgium* (1998), judgment of ECtHR at para.46.

environment and so Article 5(e) had been breached.[158] This could also be the basis of a positive right to therapeutic conditions under Article 5[159] and "it seems likely that patients waiting for a bed in a unit of a different level of security could bring similar cases".[160]

In the case of *Keenan v UK*[161] the European Court of Human Rights held that Mark Keenan, who hanged himself following placement in a segregation unit, had been subjected to inhuman and degrading treatment by English prison authorities in violation of Article 3. As well as the direct implications for policy and practice in prisons, this case may have "a have a substantial impact on hospitals' suicide prevention policies, as well as on the resultant inquiries that now automatically follow suicides of psychiatric patients".[162]

In *Keenan v UK* it was found Article 2 had not been breached but in the case of *Paul and Audrey Edwards v UK*[163] the European Court concluded the UK had failed to protect the life of Christopher Edwards and so violated Article 2. He was killed by another man with mental health problems who had been placed in the same cell. The Court reinforced the policy of diversion by concluding neither man should have been in prison and certainly should not have been sharing a cell. It also highlighted poor record keeping, inadequate communication and limited inter-agency communication.

Council of Europe

The Council of Europe's Steering Committee on Bioethics' White Paper recommended that: "member States should ensure that sufficient provision is made of a range of hospital accommodation with the appropriate levels of security and community-based forensic psychiatric services. In this respect, it was underlined that many countries have people with mental disorders detained in prisons who require treatment in hospital. The failure to transfer them may involve failure to identify them within the prison population but also insufficient or inappropriate secure hospital accommodation or the reluctance of local mental health services to accept them. The Working Party therefore felt that Member States should put into place mechanisms to overcome these infringements of individuals' human rights".[164]

UN Principles

MI Principle 20 applies to "persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it

[158] Prior, P.M. 'Protective Europe: does it exist for people with mental disorders?'. *Journal of European Social Policy*, vol. 11(1), 2001, pp.25-38.
[159] Gostin, L.O. 'Human Rights of Persons with Mental Disabilities: The European Convention on Human Rights. *International Journal of Law and Psychiatry*, vol. 23, No. 2, 2000, pp.125-159.
[160] Macgregor-Morris *et al.* 'Potential impact of the Human Rights Act on psychiatric practice: the best of British values?'. *British Medical Journal*, vol. 322, 2001, p849.
[161] *Keenan v UK* (2001) 33 EHRR 38.
[162] Macgregor-Morris *et al.* 2001, p.850.
[163] *Paul and Audrey Edwards v UK* (2002) 35 EHRR 487.
[164] Steering Committee on Bioethics of the Council of Europe. *White Paper on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment.* Council of Europe, 2000, pp.13-14.

is believed may have such an illness". It asserts they "should receive the best available mental health care" and allows that "domestic law may authorise a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility".[165]

6.3 Law, Policy and Practice in Northern Ireland

In Northern Ireland the Mental Health (NI) Order 1986 provides a range of powers for the courts to seek more information about a person's mental health and, if appropriate, divert or transfer them from prison to hospital. The most frequently used power is a Hospital Order (under Article 44) which enables the Court to detain a person who has been convicted of an offence in hospital or (rarely) place them under guardianship rather than sending them to prison. The specific powers available to the Courts are:

- Remand to hospital for a report on the accused's mental condition (Article 42).
- Remand to hospital for treatment (Article 43).
- Order hospital admission or guardianship for people who have been convicted (Article 44) or impose an interim hospital order (Article 45).
- Restrict discharge from hospital (Article 47).

People may also be treated by mental health services as a condition of probation.

The current policy context for this group was set out in the Regional Strategy for 1997-2002 which stated that "By 2002 a medium secure unit should be established in Northern Ireland and comprehensive arrangements should be in place so that, where appropriate, people with mental illness can be diverted from the criminal justice system".[166]

Services for this high need group in Northern Ireland are inadequate.[167] At present if a person needs to be detained in a more secure environment than a local psychiatric intensive care unit (usually a locked ward in a psychiatric hospital) then they have to be transferred to the State Hospital at Carstairs in Scotland. A medium secure unit is

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[165] United Nations. *Principles for the protection of persons with mental illness and the improvement of mental health care.* Adopted by UN General Assembly resolution 46/119 of 17 December 1991.

[166] *Health and Wellbeing into the Next Millennium: Regional Strategy for Health and Social Wellbeing 1997-2002.* Department of Health and Social Services (NI), 1996, p.90.

[167] The current services for are made up of: Prison Health Care Services which include primary care, mental health support, CPN and in-patient care. Prison health care centres are not hospitals and prisoners who are very unwell and do not comply with medication cannot be compulsorily treated. The two consultant forensic psychiatrists also work in the Prison Service together providing 1.2 Whole Time Equivalent (WTE); probation does provide assessment and treatment for all offenders but does not have any specific services for MDOs; one of the consultant forensic psychiatrists is based at Knockbracken and provides 0.3 WTE mainly in 'Avoca', the male psychiatric intensive care unit; the other consultant forensic psychiatrist is based at the Tyrone and Fermanagh Hospital and along with a staff grade forensic psychiatrist, intensive care unit beds mainly to facilitate transfers from prison and Carstairs, a forensic nurse co-ordinator and some OT input provides the WHSSB forensic service; in the SHSSB area there is only the forensic CPN employed by Craigavon and Banbridge Trust; in the NHSSB area, there are no specific services for mentally disordered offenders although the consultant forensic psychiatrists do provide assessments and advice; the Musgrave Street Pilot. This started in June 1998 and has now been extensively evaluated by the Health and Social Care Research Unit at Queens University, Belfast and made permanent.

now being built in Knockbracken Health Care Park near Belfast and should be operational in 2004-2005. Plans for the comprehensive community forensic services needed to support this unit have still to be agreed and funded. Even when the medium secure unit is built if a person requires a highly secure setting they may still have to be transferred out of Northern Ireland.[168]

A major practice issue is estimating the level of need for services for this group in Northern Ireland. There is some data about the needs in Northern Ireland. A survey carried out by probation officers found that of 290 probation clients surveyed 34% were identified as experiencing mental health problems and 19% had a formal diagnosis, the most common of which was substance abuse.[169] A survey of newly sentenced prisoners (other than those convicted of terrorist offences) found that "more than half of the study population (52%) admitted to problems associated with a high intake of alcohol…5% of those assessed were found to have a major psychotic illness…28% of the prisoners had a classifiable disorder of personality".[170] Despite the limited local data on the level of need it is reasonable to assert from this and other UK studies[171] that there are people with mental health problems who are currently inappropriately detained in prison.

6.4 Potential Human Rights Violations

It appears that not all people with mental health problems are receiving the care and treatment they need in appropriate settings in Northern Ireland. This raises the issue of possible breaches of Article 5(e) as established in *Aerts v Belgium* and of Articles 2 and 3 as established in *Edwards v UK* and *Keenan v UK* respectively. There are particularly concerns when people with mental health problems are inappropriately detained in prison. "Some of the most difficult psychiatric patients in the country are assessed and treated entirely within prisons, which are not designed for the purpose and cannot match the standards of hospitals".[172] Imprisonment, itself can add considerable psychological stress due to factors such as the disruption of relationships, the deprivation of autonomy/control and the absence of participation in and contribution to family and community life.[173]

The difficulties involved were recognised by the then Chief Inspector of Prisons in his annual report for 1995-96. "We are concerned in particular about the number of prisoners with mental health problems, whose condition prison is more likely to worsen than improve…it has to said that, although many health care staff in prisons can demonstrate an ever wider range of qualifications and flexibility in their work and working practices, the overall service provided across all establishments does not

[168]This is also an issue for children who are severely disturbed who are currently placed in specialist units in Newcastle-on-Tyne and in Kent.
[169] Probation Service for Northern Ireland. In McDaid, C. *Mentally Disordered Offenders: A Northern Ireland Perspective. Conference Report*. NIACRO, 1994.
[170] Bownes, I. In McDaid, 1994, p.13.
[171] Gunn, J. *et al.* 'Treatment Needs of Prisoners with Psychiatric Disorders'. *British Medical Journal,* vol. 303, 1991, pp.338-341; Singleton, N. *et al. Psychiatric morbidity among prisoners in England and Wales.* The Stationery Office, 1998.
[172] Brooke, D. *et al.* 'Point prevalence of mental disorder in unconvicted male prisoners in England and Wales'. *British Medical Journal,* vol. 313, 1996, p.22.
[173] Bownes. In McDaid, 1994.

match up to NHS standards…unless proper care is provided, prison can exacerbate mental health problems, which has a long-term impact on the individual concerned and the community into which he or she may be released".[174]

In prison, unlike in hospital, it is not possible for people to be treated against their will under mental health legislation. This means that if there are delays in transferring from prison to hospital, or if transfer is not even attempted, a person may not be receiving the treatment they need even if they are acutely unwell. Research on suicides in prison further emphasise why change in this area is needed. "In research carried out by Dooley the records of prison suicide in England and Wales between 1972 and 1987 were examined. He found that:

- 'mental disorder was among the reasons for suicide in 22% of cases,
- over a third of prisoners committing suicide had a previous history of psychiatric contact and over a quarter had previous in-patient admission,
- 23% had received some form of psychotropic medication in the months before suicide'".[175]

Other studies[176] support the connections between mental health problems and self-harm or suicide in prison. Failure to properly divert people with mental health problems from prison to health and social services therefore may expose them to a greater risk of self-harm and suicide.

People with mental health problems in the prison service are only one aspect of the problem but highlight the human rights concerns which may also apply to people in community and hospital settings who are not receiving the appropriate level of care and support.

6.5 Other Jurisdictions

In England, in 1992, the Reed Committee, that had conducted a review of services for this group, published its report. It concluded that "the essential task here is to ensure that mentally disordered offenders who need specialist health and social care are diverted from the criminal justice system as early as possible, this requires close co-operation between all the local agencies concerned".[177] It specifically recommended that "there should be nation-wide provision of properly resourced court assessment and diversion schemes" and that "purchasers and providers of health and social services must regard the availability of assessment and diversion schemes as part of a standard service".[178]

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[174] Chief Inspector of Prisons. In Cavadino. In Webb, D. and Harris, R. (eds.) *Mentally Disordered Offenders: Managing people nobody owns.* Routledge, 1999, p.55.
[175] Dooley. In Cavadino. In Webb and Harris, 1999, p.56.
[176] Liebling, A. and Krarup, H. *Suicide Attempts in Male Prisons.* Home Office, 1993. See also: HM Prison Service. *Women in Prison: A Thematic Review by HM Chief Inspector of Prisons.* Home Office, 1997.
[177] Reed, J. (Chair) *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services: Final Summary Report.* HMSO, 1992 (CM2088), p.42.
[178] *Ibid.* p.14.

The Reed Report also set out the guiding principles for services for this group. It recommended that people who require treatment and support because of their health care needs should be cared for and treated:

- With regard to the quality of care and proper attention to the needs of individuals;
- As far as possible in the community rather than in institutional settings;
- Under conditions of no greater security than is justified by the degree of danger they present to themselves or others;
- In such a way as to maximise rehabilitation and their chances of sustaining an independent life;
- As near as possible to their own home or families, if they have them.[179]

These principles appear to address the human rights concerns raised and could provide an excellent basis for the law, policy and practice in Northern Ireland.

As mentioned above it is currently not possible to compulsorily treat people in prisons. The main proposed change relating to mentally disordered offenders in the Draft Mental Health Bill for England and Wales is to introduce this as a possible option. The Mental Health Act Commission in its response to the Draft Bill stated: "the Commission is strongly of the view that, for compulsory treatment within prisons to be legally or ethically justifiable, the level of service provision and support to prisoner-patients should be at least equivalent to that which would be available elsewhere"[180] and "we do not believe that there is a realistic short or medium-term prospect of establishing adequate NHS prison-based services to enable compulsion to be used within prisons in the immediate future" so "transfer from prison to a hospital environment must remain the primary and preferred option for all prisoners".[181] This view was reinforced by the Joint Committee on Human Rights which asserted, with reference to *Aerts v Belgium*, that "compulsorily treating offenders who have been detained for psychiatric treatment in a prison psychiatric wing without an appropriate therapeutic environment and an appropriate level of specialist psychiatric expertise violates ECHR Article 5".[182]

A case in Scotland which is of particular relevance to the detention of people in this group is that of *Anderson, Doherty and Reid v The Scottish Ministers and the Advocate-General for Scotland*.[183] In 1999 Noel Ruddle, who had previously killed a neighbour with a Kalashnikov rifle, was released from hospital having successfully argued his personality disorder was untreatable and so he could no longer be detained. The new Scottish Parliament then passed the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 which allowed detention on the basis of treatment being likely to prevent deterioration. Anderson at al argued this breached Article 5.1(e) but this was rejected first by the Court of Session in 2000 and then at appeal by the

[179] *Ibid.*
[180] *The Mental Health Act Commission Response to the Draft Mental Health Bill Consultation.* Mental Health Act Commission, 2002, p.26.
[181] *Ibid.* p.25.
[182] Joint Committee on Human Rights. *Draft Mental Health Bill.* 25th Report of Session 2001-02. The Stationery Office, 2002 (HL Paper 181, HC 1294), p.25.
[183] *Anderson, Doherty and Reid v The Scottish Ministers and the Advocate-General for Scotland*, Court of Session, 16 June 2000.

Judicial Committee of the Privy Council in 2001 who agreed with the previous ruling that restricted patients could remain detained in the interests of public safety even if their condition was not susceptible to treatment. Liberty has argued "there are cogent arguments against the Privy Council's conclusion that it is neither arbitrary nor disproportionate to detain a person in hospital who cannot be treated".[184]

6.6 Recommendations

1. An inter-agency group should devise clear policy and guidance on this area.
2. Inter-agency training should be established to develop expertise and encourage communication and co-operation.
3. Adequate services should be in place to allow for the transfer of people with mental health problems to the appropriate level of security and care.
4. Current arrangements to facilitate visiting to secure settings should be kept under review to ensure compliance with Article 8 of the ECHR especially if high security is not provided locally.
5. People with mental health problems should be diverted from the criminal justice system to health and social services at the earliest point possible.
6. Health and social services should provide an in-reach service to people with mental health problems in prison to facilitate transfer, continuity and resettlement.
7. Prisons and prison health care centres are not hospitals and do not have the specialist staff or facilities to provide compulsory mental health care and so these powers should not be extended to prisons.
8. Additional safeguards such as mental health advocates and automatic access to a tribunal should also be available to people with mental health problems who have committed offences.

[184] *Liberty's Response to the Department of Health Consultation on the Draft Mental Health Bill.* Liberty, September 2002, p.5, para. 12.

7: PROTECTION AND EMPOWERMENT

7.1 Introduction

People who have the capacity to make decisions about their everyday life should be encouraged to make these decisions. This is consistent with the right to respect for private life, the right to freedom of expression and association and the right to marry and found a family. Those who do not have capacity also have these rights but may require assistance in exercising them and in order to prevent abuse, there is an obligation on public authorities to provide appropriate protection.

In Northern Ireland at present there is a vacuum in law as regards decision-making for people with incapacity. There is no protection of their autonomy, a lack of clarity for those seeking to make decisions and a lack of access to justice when disputes arise. A particular area of concern is decision-making about sexual relationships. There is also a potential gap in practice as regards protection by the criminal justice system for those with learning disabilities due to presumptions being made about their capacity and a failure to make appropriate adjustments.

7.2 International Standards

European Convention on Human Rights

Everyone has the right to respect for his or her private life, which includes their sexual activity, as protected by Article 8 of the ECHR. Article 14 prohibits discrimination on the basis of disability in the protection of rights without reasonable and objective justification. Other relevant rights include the right to freedom of association (Article 11), the right to freedom of expression (Article 10) and the right to marry and found a family (Article 12).

This can be interpreted as the need for states to ensure that people are appropriately protected from physical and sexual abuse. This extends to ensuring that everyone can vindicate their right to respect for private life through the courts on an equal basis.[185] The right not to be subjected to degrading treatment contained in Article 3 also imposes a positive duty on the state to arrange protection where necessary.

Articles 8, 10, 11 and 12 can also be regarded as amounting to an obligation on states not to interfere with decisions made about sexual activity. If the approach of the state towards those with less capacity is different then that practice must be justified in accordance with Article 14.

UN Principles

MI Principle 1 provides that all persons with a mental illness have the right to protection from economic, sexual and other forms of exploitation, physical or other

[185] See: *X and Y v Netherlands* (1985) 8 EHRR 235.

abuse and degrading treatment. It also states that people with mental illness are entitled to exercise all human rights.

Paragraph 6 of Principle 1 states that any decision that a person lacks legal capacity shall be made only after a fair hearing by an independent and impartial tribunal.

UN Convention on the Rights of the Child

Article 23 provides that a child with mental health difficulties should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

7.3 Law, Policy and Practice in Northern Ireland

At present the common law is the basis for non-financial decision-making on behalf of most people with mental incapacity. There is no legislation dealing with decision-making in relation to people with incapacity. Disputes which arise can be settled in the High Court by way of a declaration as to what is the best decision in terms of common law, or by judicial review. The person with incapacity may be represented by the Official Solicitor. This is an expensive and cumbersome way to resolve disputes and can in reality only be accessed by those who are able to claim legal aid or those with sufficient independent means.

As regards protection from crime of those with mental disabilities, there is a general obligation to report arrestable offences to the police.[186] Victims with learning disabilities are often reliant on care workers to help them report an offence to the police.[187]

The Mental Health Order provides that sexual intercourse with a woman with a severe mental handicap is an offence.[188]

The Department of the Director of Public Prosecutions for Northern Ireland sought to take account of the needs of vulnerable witnesses. The Department (superseded by the Public Prosecution Service) has highlighted the need to take great care when the witness or victim may experience difficulties in giving evidence on the basis of illness or mental incapacity.[189] An initial decision is made by the professional officer or counsel as to the competence of the witness to give evidence and the advice of a doctor or psychologist may be taken.

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[186] *Criminal Law Act 1967*. s.5.

[187] Some research in England has indicated a concern that decisions about the seriousness of an offence or the credibility of the victim or witness are not reaching the police and being filtered out at an earlier stage due to the lack of clear policy for care workers or others working with people with mental disorder. See: Boateng, P. 'Speaking up for Justice: Improving the Treatment of Vulnerable or Intimidated Witnesses in the Criminal Justice System'. *Ann Craft Trust Bulletin,* 26, 5-9; Williams, C. *Invisible Victims: Crime and Abuse Against People with Learning Difficulties.* Jessica Kingsley, 1995; Sundrum, C.J. and Stavis, P.F. 'Sexuality and Mental Retardation: Unmet Challenges'. *Mental Retardation*, 1994, 32 (4) pp.255-64.

[188] *Mental Health (Northern Ireland) Order 1986.* Article 122.

[189] 'Victims, Witnesses and the Prosecution'. Director of Public Prosecutions for Northern Ireland, 1997 (internal staff circular).

New guidance is being drawn up in anticipation of the implementation by the end of 2003 of the vulnerable witnesses provisions of the Criminal Evidence (NI) Order 1999. This will set out particular measures which can be taken to assist vulnerable witnesses, such as the giving of evidence through an intermediary.

The new guidance will need to be drawn up in the context of the duty under section 75 of the Northern Ireland Act 1998 to have due regard to the need to promote equality of opportunity between those with a disability and those without a disability.

The Criminal Evidence (NI) Order sets out a test for assessing the competency of a witness to give evidence. Any party can raise the question of a witness's competence. The court is the final arbiter of the person's competence however it is for the person seeking to call the witness to show on the balance of probabilities that the person is competent to give evidence.

7.4 Potential Human Rights Violations

Unaccountable decisions about capacity can be made by doctors in Northern Ireland which impact very seriously on the autonomy of people with mental health difficulties. There is a lack of procedure which allows people or their representatives to consider the test applied and the reasons for the decision. There is no appeal process.

Once a person is considered incapable, there is no legislation which states how the interests or views of the person are to be taken into account when making a decision. Where the person does not actively disagree with the decision, such as with whom he or she can have contact, or where he or she should live, then it is very unlikely that there will be any check on those making the decisions.

Even if the person does object unless he or she has an advocate the objections may not be properly considered. Other disputes which arise may be between family members or between family and social services. A negotiated settlement of such a disagreement may not necessarily be in the best interests of the person with incapacity as there is no formal decision-making procedure to be followed.

It is all the more important in the absence of a legislative framework that those working with people with mental incapacity need to be conscious of the human rights implications of decisions which impact on the private life of the person, their relationships and their day to day activities. The administrative convenience of an institution or the concerns of a perhaps overprotective parent would not be a basis under Article 14 of the ECHR for treating those with a low level of capacity in a detrimental way as regards their autonomy.

The current legislation which is aimed at protecting women from sexual abuse may be incompatible with Articles 8 and 14 of the ECHR in that it fails to respect the private life of those women who can consent to a sexual relationship. There is an equality of opportunity failing in this regard. It also leaves care workers in a very difficult position as regards complying with the law and respecting the autonomy of those with whom they work.

As well as seeking to promote autonomy and equality of opportunity there is also a need to protect. All those working with vulnerable people need to be clear about the reporting of crime without making judgments.

The system of mixed wards in psychiatric hospitals in Northern Ireland can leave female patients, in particular, vulnerable to abuse and could be challenged under Article 8 of the ECHR.

There is a fair hearing issue as regards the decision not to proceed with prosecution on the basis of the lack of competence of a victim or witness to give evidence. At present this decision may be made by a lawyer with no need for expert advice or representations from the person or his or her representative.

The requirement on a person leading a vulnerable witness to prove that he or she is competent to give evidence is contrary to the common law presumption of competence, with the burden being on the person seeking to show incompetence to do so. This makes it more difficult for a victim or a witness to participate in the justice system and can leave them in the vulnerable position of trying to overcome prejudice to prove that they are competent.

The treatment of victims or witnesses with learning disabilities or mental health difficulties may be in contravention of section 75 of the Northern Ireland Act 1998 as there is not due regard paid in current procedures to their equality of opportunity with those who do not have a disability.

7.5 Other Jurisdictions

Mental Incapacity legislation for England and Wales was published in draft form in June 2003.

In Scotland the Adults with Incapacity (Scotland) Act 2000 established a welfare power of attorney who can take day to day welfare decisions on behalf of the person with incapacity subject to a defined 'benefit' test. This is only of relevance to those who at some stage have sufficient capacity to set up such a legal instrument.

For cases where there is no welfare attorney, there is a procedure whereby an application can be made to a court for an intervention order to allow a welfare decision to be made on behalf of the person with incapacity. This is an order regarding a particular decision and is not as significant an intervention as guardianship. The decision then made under the order must be taken in accordance with the statutory benefit test.

The benefit test involves a number of steps. The decision must benefit the incapable adult, and that benefit must not be able to be achieved without taking the decision on their behalf. The decision which is taken must be the least restrictive option in terms of the person's freedom. The decision must be made in light of the present and past wishes of the person, so far as they can be ascertained, and the views of the nearest relative, primary carer and other people with an interest so far as it is reasonable and practicable to do so. Any decision that a person is mentally incapable can be appealed

to the Sheriff Court. There is a best interests test in the Republic of Ireland's Mental Health Act 2001 but it is not as comprehensive as the Scottish model.

7.6 Recommendations

1. More comprehensive legislation governing people with incapacity should be introduced as a matter of priority.
2. Regulations should provide for a standard capacity assessment procedure. The assessment should make allowance for educational and cultural differences. The level of capacity required should vary according to the nature of the decision to be made. Any decision that a person does not have capacity should be recorded on a standard form with reasons. A decision-maker should be named on the form. The Mental Health Commission should have a monitoring role.
3. The incapacity legislation should ensure an appeal procedure for any decision on incapacity. The appeal should be to a court or tribunal which is accessible in terms of cost and time.
4. The new legislation might include an extension to the enduring power of attorney concept to include welfare decisions subject to a statutory benefit test, as in Scotland, with monitoring by the Mental Health Commission.
5. The new legislation should allow for a tribunal appeal where there is a welfare dispute.
6. Once a decision on incapacity has been made, there should be a record of welfare decisions made on behalf of a person with incapacity by the named decision-maker and a periodic review of those decisions by the local social services trust, with monitoring by the Mental Health Commission. An obligation might be imposed upon the decision maker to show that the statutory benefit test was applied.
7. Guidance should be issued to all those working with people with mental disorders on the importance of reporting criminal offences.
8. The Public Prosecution Service should take expert advice before deciding that a witness (including a victim) does not have capacity to give evidence. The person or their representative should be given time to make any observations and produce evidence to rebut the incapacity decision.
9. Legislation should ensure that if a person's capacity to give evidence is challenged in court, then the burden of proof should be on the person seeking to question capacity.
10. A specific audit of legislative provision prohibiting sexual relationships with women with a severe mental handicap should be carried out to ensure compliance with Articles 8 and 14 of the ECHR.
11. Trusts should ensure that choice of a single sex environment for residential users should be available for all.
12. Training should be provided for those who work with people with mental health difficulties on the human rights implications of placing restrictions on sexual relationships.

8: RECOMMENDATIONS

This Chapter presents all of the recommendations contained in the report.

Recommendations from ***2: The Assessment and Civil Detention of People with Mental Health Problems:***

The Definition of 'Mental Disorder'

1. The concept of 'mental disorder' should be clearly defined in legislation, not just in a code of practice.
2. The concept of mental disorder must be defined sufficiently narrowly to be compliant with Article 5 of the ECHR.
3. Careful consideration should be given to whether the current statutory exclusions, including the concept of personality disorder, should be retained.
4. In light of the on-going difficulties people with a diagnosis of personality disorder face in accessing appropriate services, there should be detailed guidance to require:
    (1) the comprehensive assessment of the needs of both the person concerned and their carer;
    (2) the compilation of a care plan; and
    (3) the provision of care and treatment, as appropriate.
5. A determination of 'mental illness' should be made by a medical practitioner with specialist training in this area, namely, a psychiatrist. Ideally two medical opinions would be required, one from a GP who knows the person and one from a psychiatrist before detention can be considered.
6. The Government Review of Mental Health and Learning Disability should commission a more detailed examination of the human rights issues involved in the areas of mental health, learning disability, brain injury and dementia.

The Process of Assessment and Civil Detention

1. All compulsory admissions for assessment should be considered by a Mental Health Review Tribunal, within the assessment period, to independently determine the lawfulness of detention.
2. The assessment period should be extended, possibly to a period of 28 days, to ensure independent judicial scrutiny of the assessment before a person is detained for treatment.
3. Community services, especially for young people[190], should be further developed to reduce the need for hospital admission.
4. Where admission is necessary, children should be detained separately from adults and in an environment which recognises and accommodates their needs as children.
5. The protection of Article 10 of the Mental Health (Northern Ireland) Order 1986 should be extended to maximise the protection for persons who have

[190] Australia has been particular progressive in developing and researching services in this area see the *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000, A Joint Commonwealth, State and Territory Initiative under the Second Mental Health Plan.* Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, 2000.

been admitted for assessment but not detained for treatment from stigmatisation, prejudice and discrimination.

Voluntary Patients

1. That adoption of the proposals for protection of incapable adult patients contained with the Draft Mental Health Bill for England and Wales be considered for Northern Ireland.
2. Consideration should be given to the extension of such proposals to include children and those in residential care.
3. Guidance and training should be provided for all relevant staff on the test to be applied before a person is deemed incapable of consenting to a placement and/or treatment.

The Role of the Nearest Relative

1. The nearest relative should no longer be able to act as applicant but relatives should continue to be able to request an assessment.
2. People should be permitted to nominate a person who can look out for their interests, rather than have this role determined according to a prescribed nearest relative definition.
3. If there is no nominated person, and the person is unable to nominate, a set order should be followed which does not discriminate against same-sex relationships and clarifies what constitutes a 'caring' relative.
4. The duty to consult should be retained.

Access to Information and Representation

1. The means by which the duty to inform is fulfilled should be examined and standardised. A standard procedure could be outlined in the Code of Practice.
2. Independent, specialist advocacy should be available to all detained patients.
3. Information on relevant statutory provisions and a patient's rights should be provided to all people who are admitted to mental health in-patient care.
4. The above information should be made available for children admitted to mental health in-patient care in an accessible form. Information should also be available in other languages in use in Northern Ireland as appropriate.

Compulsory Powers in the Community

1. In the event that CTOs are considered by the Review careful consideration should be given to their potential to both violate human rights and have a counter-therapeutic impact.

Recommendations from **3: The Mental Health Review Tribunal**

1. An automatic review of detention decisions by an independent tribunal should be introduced. This review must take place at the earliest practical opportunity and within 28 days.

2. The rigid restrictions should be lifted on applications to the tribunal to allow further applications if a change of circumstances can be shown on the face of the application.
3. There should be increased resourcing of the tribunal system together with a time limit within which a hearing can be expected in order to tackle delay.
4. There should be funding for specialist independent and accessible mental health legal advice and representation. This should include children and should take account of their particular needs. Advice and representation funding needs to take account of the need for translation and interpreting services for those from minority ethnic backgrounds.
5. Greater transparency should be introduced in the role of the medical member by requiring the disclosure to the parties of the basis upon which the opinion is given.
6. The current burden of proof at tribunal hearings should be reversed as required by the European Convention on Human Rights.
7. The tribunal rules should be amended to meet UN standards on the withholding of documentation from patients.
8. Consideration should be given to the provision of independent premises for the Mental Health Review Tribunal.
9. A free, statutory aftercare duty should be introduced as in England and Wales, together with funding, in order to allow discharge by the tribunal without delay on the grounds of inadequate care arrangements.
10. Monitoring should be carried out of the experience of tribunal users from a minority ethnic background and all other section 75 groups to assess whether there is evidence of unequal treatment and to ensure any access and communication issues are being adequately addressed, for example the provision of sign language interpreters.
11. Equality training should be provided for all those involved in the tribunal system.
12. Specific provision should be made for children and young people within mental health legislation.
13. Children and young people should be afforded a right to an automatic review of detention.

Recommendations from **4: The Mental Health Commission**

1. The remit of the Mental Health Commission should be reviewed against international standards which clearly require an independent, specialist body to monitor mental health services.
2. The Mental Health Commission should receive adequate funding to ensure that it can effectively exercise its functions.
3. As highlighted in the Commission's strategic plan, it should be considered whether the Commission might be more effective and independent if a number of full-time Commissioners were appointed on a one or two yearly basis; perhaps seconded from their normal employment.
4. There should be more service users and/or carers appointed as Commissioners and involved in the running of the Commission.
5. Non-medical Commissioners should have access to whatever records they need to investigate any concerns.

6. The Commission should take the lead in providing information on the roles of service providers including the Commission itself, the police and the Ombudsman in relation to concerns and complaints.
7. The Commission should review the current practice of providing advice to service providers.
8. Due to the particular concerns about the admission of young people to adult psychiatric wards any admission of a young person under 18 should be automatically referred to the Commission and an urgent visit completed.[191]

Recommendations from **5: Treatment**

1. Legislation should ensure that people with capacity to refuse treatment are no longer treated against their will, except in very limited circumstances.
2. Legislation governing non-consensual treatment should be premised on the presumption that intervention must be consensual. Legislation should set out the circumstances where intervention is permissible, including appropriate safeguards to protect both competent and non-competent patients, as people without capacity retain their right to physical and psychological integrity.
3. Legislation should require that all compulsory treatment accord with a treatment plan, and that the plan be subject to authorisation and review by an independent person or organisation. Treatment considered necessary which is not contained within the plan would require independent review before being carried out, other than in an emergency. Users should be involved in the planning process and be informed of this right.
4. Legislation should require a decision to be made about capacity before a treatment decision is made, either in the community or in hospital. The guidance should emphasise the need to take appropriate steps to ensure that the diagnosis, particularly in relation to children and older people and where cultural issues are felt to be important, accurately assesses the patient's capacity.
5. Every determination of incapacity should be recorded in writing with reasons. Such determination should be subject to monitoring and regular review. There should be a right of appeal to a court or tribunal in relation to an incapacity determination.
6. Consideration should be given to whether legislation should prohibit, or at least restrict the use of, psychosurgery for mental disorder, in line with the UN MI Principles.
7. Detailed research should be carried out on the use of ECT and other potentially irreversible treatments, involving the psychiatric profession and users.
8. Legislation should introduce an enduring welfare power of attorney instrument to allow treatment decisions to be made by an appointed person in accordance with the wishes of the donor and/or his or her benefit. The Office of Care and Protection should have a role in monitoring the use of the enduring welfare power of attorney.
9. Legislation should regulate the use of advance directives.

[191] It is likely that this situation would also be of interest to the Children's Commissioner and there may also be a role for the planned Health and Social Services Regional Inspection Authority.

10. Additional funding should be provided for mental health promotion, prevention, early intervention services and community mental health and learning disability services with a view to reducing the need for compulsory treatment.
11. Legislation should require the provision of accessible treatment for people diagnosed as having a personality disorder.
12. Legislation should ensure that the particular needs of children and young people in relation to treatment are encompassed, including a framework which takes account of their best interests and their health requirements as well as recognising and as far as possible safeguarding their autonomy in matters of consent to treatment.
13. A priority should be given to improving services for children and adolescents, in particular, commitment to a regional Child and Adolescent Mental Health Service Programme.
14. Additional funding should be provided for community mental health and learning disability services for training in relation to cultural differences.

Recommendations from **6: Mental Health and the Criminal Justice System**

1. An inter-agency group should devise clear policy and guidance on this area.
2. Inter-agency training should be established to develop expertise and encourage communication and co-operation.
3. Adequate services should be in place to allow for the transfer of people with mental health problems to the appropriate level of security and care.
4. Current arrangements to facilitate visiting to secure settings should be kept under review to ensure compliance with Article 8 of the ECHR especially if high security is not provided locally.
5. People with mental health problems should be diverted from the criminal justice system to health and social services at the earliest point possible.
6. Health and social services should provide an in-reach service to people with mental health problems in prison to facilitate transfer, continuity and resettlement.
7. Prisons and prison health care centres are not hospitals and do not have the specialist staff or facilities to provide compulsory mental health care and so these powers should not be extended to prisons.
8. Additional safeguards such as mental health advocates and automatic access to a Tribunal should also be available to people with mental health problems who have committed offences.

Recommendations from **7: Protection and empowerment**

1. More comprehensive legislation governing people with incapacity should be introduced as a matter of priority.
2. Regulations should provide for a standard capacity assessment procedure. The assessment should make allowance for educational and cultural differences. The level of capacity required should vary according to the nature of the decision to be made. Any decision that a person does not have capacity should be recorded on a standard form with reasons. A

3. The incapacity legislation should ensure an appeal procedure for any decision on incapacity. The appeal should be to a court or tribunal which is accessible in terms of cost and time.
4. The new legislation might include an extension to the enduring power of attorney concept to include welfare decisions subject to a statutory benefit test, as in Scotland, with monitoring by the Mental Health Commission.
5. The new legislation should allow for a tribunal appeal where there is a welfare dispute.
6. Once a decision on incapacity has been made, there should be a record of welfare decisions made on behalf of a person with incapacity by the named decision-maker and a periodic review of those decisions by the local social services trust, with monitoring by the Mental Health Commission. An obligation might be imposed upon the decision maker to show that the statutory benefit test was applied.
7. Guidance should be issued to all those working with people with mental disorders on the importance of reporting criminal offences.
8. The Public Prosecution Service should take expert advice before deciding that a witness (including a victim) does not have capacity to give evidence. The person or their representative should be given time to make any observations and produce evidence to rebut the incapacity decision.
9. Legislation should ensure that if a person's capacity to give evidence is challenged in court, then the burden of proof should be on the person seeking to question capacity.
10. A specific audit of legislative provision prohibiting sexual relationships with women with a severe mental handicap should be carried out to ensure compliance with Articles 8 and 14 of the ECHR.
11. Trusts should ensure that choice of a single sex environment for residential users should be available for all.
12. Training should be provided for those who work with people with mental health difficulties on the human rights implications of placing restrictions on sexual relationships.

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