

Setting the Scene, Statutory Law and the Common Law

The law, like medicine, is full of ‘ifs’ and ‘buts’, with ‘not yet determined’ in place of the medical ‘not yet known’. In that it is ‘man-made’ it is simpler than medicine, but it has the added complication that it does not remain static, being amended by Parliament and the courts as the attitudes of society change. Although some questions have a clear answer, a ‘right’ or ‘wrong’ or ‘lawful’ or ‘unlawful’, most do not. Rarely, this is because there is no law. More commonly, it is because the law could be interpreted in several ways and, as yet, there hasn’t been a relevant court case or, as will be seen, there have been many cases with different judges interpreting the law in different ways.

It is also important to recognise that our clinical decisions are influenced by many factors other than the law. The first, and most important, is clinical need, combined with the expressed wishes of the patient. Other ‘controls’ include:

- Codes of Practice, such as those relating to the Mental Health Act 1983,^{1, 2} the Mental Capacity Act 2005³ and the Mental Capacity Act Deprivation of Liberty Safeguards,⁴ and the Mental Health Act Reference Guide;⁵
- government circulars and directives, such as the Care Programme Approach and mandatory homicide inquiries;
- the General Medical Council and other regulatory bodies;
- terms and conditions of employment;
- availability of resources;
- public opinion and the media;
- fear of being sued or making a career-limiting mistake.

Note

Although England and Wales have their own Codes of Practice in relation to the Mental Health Act, the Codes pertaining to the Mental Capacity Act and the Deprivation of Liberty Safeguards are the same for England and Wales. A new Mental Capacity Act Code of Practice including, among other things, the Liberty Protection Safeguards, is imminent at the time of writing.

What Is Meant by ‘the Law’?

Statute (Parliamentary) Law

Statute laws are passed by Parliament and called Acts of Parliament. There have been many Acts relating to the care, control and treatment of mentally disordered people,

dating back as far as 1324 (a sort of early guardianship order which permitted the King to take over the estate of people with a learning/intellectual disability). Over the past 300 years, more than 40 important (at the time) Acts have been passed in this area. Thankfully, only a few are relevant today.

Unlike most other countries, the United Kingdom (UK) does not have a written constitution, but instead has an accumulation of various statutes, conventions, judicial decisions and treaties. Parliamentary sovereignty is a defining principle of the UK Constitution and as such statute law can only be changed by Parliament. However, when the UK was a member state of the European Union (EU), Parliament then accepted that in the areas of law governed by the EU, the latter's laws prevailed over UK law. In effect, there was a contract by which the UK, as a sovereign state, agreed to some limitations on sovereignty. Parliament nonetheless remains the ultimate authority given one Parliament cannot bind another. Therefore, following the UK's withdrawal from the European Union, the European Communities Act 1972 was repealed thereby European Union law no longer has supremacy over legislation passed by the UK Parliament and rulings made by UK courts. The only remaining 'higher authority' comes from the Council of Europe, distinct from the European Union, and which drew up the European Convention on Human Rights (ECHR). If a current law is judged by the European Court of Human Rights (ECtHR) to clash with this Convention, then Parliament is obliged to change the law. The European Court of Human Rights cannot, by itself, change UK law.

Before being passed by Parliament, Acts are called Bills and their paragraphs are called 'clauses'. Following Royal Assent, at the end of the Parliamentary process, when the Bill becomes an Act, paragraphs are called 'sections' (usually followed by a numeric code, e.g. section 5(2) – which, as an aside, in the Mental Health Act 1983 (MHA) authorises hospital authorities to stop an informally admitted (voluntary) patient from leaving hospital). The equivalent in the European Court of Human Rights are called 'articles'.

Acts of Parliament are also referred to as primary legislation. Scotland and Northern Ireland have their own primary legislation passed by their own legislatures (a Parliament in Scotland and an Assembly in Northern Ireland). Until 2020, Wales had an Assembly with more limited powers (see Appendix 1, section A1.1). Primary legislation passed by the Welsh Assembly was called a Measure. Wales now has a Parliament, not an Assembly, and its laws are Acts, not measures. When this book refers to Acts, or primary legislation, it is usually relevant in both England and Wales, but not in Scotland or Northern Ireland.

Note

Where the legislation and personnel differ between England and Wales, the main text of this book gives the English version. The important equivalents for Wales are given in Appendix 1. In addition, for Wales:

- for Secretary of State for Health read Welsh Ministers;
- for Clinical Commissioning Group read Local Health Board;
- for Care Quality Commission read Healthcare Inspectorate Wales;
- for Mental Health Tribunal read Mental Health Review Tribunal for Wales.

Some Acts, such as most of the Mental Capacity Act, are very easy to read. Others, such as the consent to treatment provisions for patients on Community Treatment Orders in the Mental Health Act, can, in part, be very hard going indeed.

Acts of relevance to mental health professionals in England and Wales are:

- the Mental Health Act 1983 (MHA);
- the Human Rights Act 1998 (HRA);
- the Mental Capacity Act 2005 (MCA).

Secondary Legislation, Including Statutory Instruments

These are also 'the law' and must be obeyed, but they are determined by government rather than Parliament (within a defined scope and under discretion granted by Parliament in the relevant Act). England and Wales have differing secondary legislation. The relevant text of this book relates to the secondary legislation in England, but, to assist readers, some guidance relating to Wales is included.

Examples of secondary legislation regarding healthcare include:

- the rules for being appointed as an Approved Clinician;⁶
- rules governing the functioning of First-Tier Tribunals (Mental Health);⁷ the official term for Mental Health Tribunals (see Chapter 4, 'Who's Involved?').

The Role of the Courts, Common Law and Statutory Interpretation

'Common law' is judge-made law ('common sense under a wig' was how Lord Donaldson expressed it⁸). Before the establishment of common law, England and Wales had feudal laws, trial by ordeal (e.g. walking over hot coals) and Church law. It is called common law because it is common to all England. It is a body of law made up entirely of principles developed organically from individual cases on a case-by-case basis. To return to Lord Donaldson:⁹

The common law is the great safety net which lies behind all statute law and is capable of filling gaps left by that law, if and insofar as those gaps have to be filled in the interests of society as a whole. This process of using the common law to fill gaps is one of the most important duties of the judges. It is not a legislative function or process – that is an alternative solution the initiation of which is the sole prerogative of Parliament. It is an essentially judicial process and, as such, it has to be undertaken in accordance with principle.

Judges also interpret the statutes passed by Parliament and make rulings on these. English and Welsh law operates through a system of precedents (or binding rules). Courts are in a hierarchy of authority, with the Supreme Court at the apex, the Court of Appeal below it and the High Court below that. Once a higher court makes a ruling, the courts lower in the hierarchy are bound to apply it unless they can find a reason why it is not applicable in the particular circumstances of the case in front of them. Therefore, if the Supreme Court has made a decision, all the lower courts and tribunals must follow it until the Supreme Court makes a new, different ruling.

Court judgments lay down new rules or apply existing rules from previous cases. The rule laid down in the case is called the *ratio decidendi* and remarks that relate to it or explain it further are called *obiter dicta*. The rules may be quite specific to the circumstances of the particular case and therefore applicable only in very similar circumstances, or they may be more easily generalised to other situations. Problems in deciding just what the law is include:

- ensuring that your case's circumstances are similar to the one about which the judge has pronounced; this is particularly important when there have been a number of apparently

similar cases but the different judges have given very different interpretations (e.g. a significant problem in relation to defining ‘deprivation of liberty’);

- being confident that there isn’t a later case that gives a different interpretation (to exactly the same set of circumstances or wording in an Act) or that a court higher up the hierarchy has not made a different decision;
- clarifying that the judge’s statements were not *obiter dicta*, meaning that the judge does not wish them to be used as a ‘precedent’ (i.e. a decision that must be followed in future by lower courts).

You may come across the term ‘inherent jurisdiction’ (IJ) of the High Court. This is the right of a court to hear any matter it believes it should hear unless there is a statute or rule which prevents it from doing so. For example, before the MCA, who decided whether or not a doctor could give medical treatment to a patient who lacked the capacity to consent to it? The inherent jurisdiction of the High Court gave the court the right to make that decision. That jurisdiction ceased once there was relevant statute law, in this case the MCA. The inherent jurisdiction may still be used when the person has capacity but is vulnerable or, for example, in a mental health setting when it appears that neither the MHA nor the MCA apply. We will discuss cases in which the inherent jurisdiction has been applied in subsequent chapters.

Yet another role of the High Court is that of Judicial Review. Its purpose is to keep a check on any public body carrying out a public decision-making function. If you believe that a public body has made a decision without giving proper regard to all the issues, e.g. you are refused a medical treatment on the National Health Service (NHS), then you can ask the court to order the body to review its decision. The court will determine whether the decision made was undertaken illegally, irrationally or unreasonably. Judicial Reviews are only available if there is no other right of Appeal against a decision. An example in the MHA is that the only way to challenge the decision of the Mental Health Tribunal used to be by Judicial Review. This changed in 2008 when the Upper Tribunal was established, giving a means to appeal a Tribunal decision and so removing the right to Judicial Review. However, there continues to be no other means of appealing against the decision of a Second Opinion Appointed Doctor (SOAD) and so the Judicial Review option remains. An example is that of Mr W, where the court ruled that a SOAD is required to give reasons for their decision to endorse a treatment plan (section 58 of the MHA).¹⁰

The following examples are just to illustrate how judge-made law works. How it all fits together is explained in later chapters.

Resolving an Argument

Question Can an informal (i.e. not detained under the MHA) mentally ill person who retains full decision-making capacity be restrained (other than in the same circumstances as anyone can be – to prevent the commission of a crime)?

Answer In very limited circumstances: ‘This power [common law power to restrain] is confined to imposing temporary restraint on a lunatic who has run amok and is a manifest danger to himself or to others – a state of affairs as obvious to a layman as to a doctor’.¹¹

Question If a person is symptom free, but only because they are taking medication for a disorder, can they still be described as suffering from the disorder?

Answer Yes: 'It is said, and said with much force, that so long as it is necessary for a person to be under treatment for a disease or disability, then that person must be held to be suffering from that disease or disability. In my judgement that is in general right'.¹²

Interpretation of the MHA

Question The MHA authorises treatment of mental disorder. But what is treatment for mental disorder as opposed to treatment for physical disorder? If a patient suffers from depression secondary to thyroid disease, would treatment of the thyroid problem be considered treatment for mental disorder? The particular question, in the court case *B v. Croydon Health Authority*,¹³ related to whether or not nasogastric feeding of a patient with borderline personality disorder and secondary anorexia, who was refusing to eat as an act of self-harm, was treatment for the mental disorder.

Answer The court said that a range of acts ancillary to the core treatment that the patient is receiving fall within the term 'medical treatment' as defined in section 145 of the MHA. Treatment may be considered to be ancillary to the core treatment if it is nursing and care concurrent with the 'core treatment or as a necessary prerequisite to such treatment or to prevent the patient from causing harm to himself or to alleviate the consequences of the disorder'. This judgment is discussed further in Chapter 8.

Care is required when looking at the way judges interpret the statute. Subsequent cases may lead to differing interpretation even though the wording in the Act remains unaltered.

Question Can section 3 of the MHA be renewed while the patient is on long-term leave from the hospital? Until 1986, a small number of patients detained under section 3 would be sent on long-term leave from hospital. Just before their section expired, they would be readmitted to hospital overnight, their section 3 would be renewed and then they would be sent back on leave.

Answer No, it can't. In the case of *R. v. Hallstrom*,¹⁴ the judge pointed out that when detaining a patient under section 3, or renewing the detention, the doctor was saying that the patient needed to be detained in hospital for treatment of their mental disorder. How, then, could they be deemed well enough to be sent on leave again straight away?

Leave of absence may only be revoked and the patient recalled to hospital when it is necessary in the interests of his health or safety or for the protection of other persons that he again becomes an in-patient. It is therefore unlawful to recall a patient to hospital when the intention is merely to prevent him from being continuously on leave of absence for six months and therefore ceasing to be liable to be recalled to hospital.¹⁵

The practice of recalling and renewing the section ended in 1986.

The law, and so practice, changed in 1999 following the case of *B v. Barking, Havering and Brentwood Community Healthcare NHS Trust*.¹⁶ A patient detained under section 3 was gradually being discharged from hospital. During the first week she spent one night at home and six in hospital. The next week she spent two nights at home, with the plan to increase the nights at home each week.

She had got as far as five nights at home and two in hospital when the section 3 was renewed. And so the correct answer to the question became:

Answer Yes, it can if the patient is at times an in-patient. The court decided that renewal was lawful because the patient's care plan included a requirement that she spend time in hospital.

This continued to be the law until 2002. A patient was detained under section 3 but was on long-term leave.¹⁷ She was required to attend the hospital twice a week, one day for occupational therapy and another day to see the consultant psychiatrist in the ward round. In terms of our question, the correct answer changed again:

Answer The judge said this was lawful, despite her not needing to be detained 'in hospital', because, in his opinion (and it is his opinion that counts), there is no distinction between 'in hospital' and 'at hospital'. What mattered was that 'the treatment' was to take place in/at hospital. In the first edition of this book the question was asked: 'Would a requirement for the patient to attend one day a week, or one day a fortnight be enough? We don't know. Perhaps we need another case', and continued in the following way: 'However, the use of extended leave has, perhaps, been superseded by the option of Community Treatment Orders'. Although the last comment may be true, we do have two further cases that appear to loosen the requirement to be 'in' or 'at' hospital to justify the ongoing necessity for section 3.

The first of these, the patient, detained for many weeks under section 3, was granted section 17 leave with the condition that he attend the out-patient clinic every 2 weeks. He appealed to the Tribunal (unsuccessfully), and then to the Upper Tribunal,¹⁸ that he should be discharged because his treatment plan didn't require him to be in hospital. He was again unsuccessful. As the judge said, 'It is important to note that section 145 of the 1983 Act defines "hospital" so that it includes "any health service hospital within the meaning of the National Health Service Act 2006", which in turn includes "any institution for the reception and treatment of persons suffering from illness" and any "clinics, dispensaries and out-patient departments maintained in connection with any such . . . institution"'. And so once every 2 weeks, to an out-patient clinic, is enough.

The second relates to a gentleman, Mr L, who was living outside hospital on section 17 leave (in a care home) and required to attend hospital for fortnightly psychology sessions and a monthly ward round.¹⁹ After an unsuccessful appeal to the Mental Health Tribunal, he challenged the decision. The grounds were that almost all the treatment was being delivered in the community, so he no longer justified being subject to section 3. The Upper Tribunal disagreed and confirmed that the tribunal had properly applied the correct legal test. Medical treatment includes rehabilitation under medical supervision, which meant that the section 17 leave and the rehabilitation provided outside hospital, both of which operated under medical supervision, were themselves part of his treatment plan.

This demonstrates one of the problems for clinicians. The relevant wording of the Act hasn't changed at all. And yet we've gone from no renewal of detention unless the patient needs to be in hospital, to legal renewal while the patient is on leave and the only requirement is to attend an out-patient clinic and/or a ward round.

Notes

- Common law cannot be used if there is a statutory alternative.
- Most questions have not yet been answered.

Finally, although not law in the sense used above, the United Kingdom is a signatory to the UN Convention on the Rights of Persons with Disabilities (UNCRPD) 2006. The convention obligates states to (among many other things):

- adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the present Convention;
- take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities.

To explain this further, in September 2014, the UN Office of the High Commissioner for Human Rights issued the following statement concerning Article 14 of the UNCRPD:²⁰

Liberty and security of the person is one of the most precious rights to which everyone is entitled. In particular, all persons with disabilities, and especially persons with mental disabilities or psychosocial disabilities are entitled to liberty pursuant to article 14 of the Convention.

Ever since the CRPD committee began reviewing state party reports at its fifth session in April 2011, the Committee has systematically called to the attention of states party the need to correctly enforce this Convention right. The jurisprudence of the Committee on article 14 can be more easily comprehended by unpacking its various elements as follows:

1. The absolute prohibition of detention on the basis of disability. There are still practices in which state parties allow for the deprivation of liberty on the grounds of actual or perceived disability. In this regard the Committee has established that article 14 does not permit any exceptions whereby persons may be detained on the grounds of their actual or perceived disability. However, legislation of several states party, including mental health laws, still provide instances in which persons may be detained on the grounds of their actual or perceived disability, provided there are other reasons for their detention, including that they are dangerous to themselves or to others. This practice is incompatible with article 14 as interpreted by the jurisprudence of the CRPD committee.
2. . . . The involuntary detention of persons with disabilities based on presumptions of risk or dangerousness tied to disability labels its contrary to the right to liberty. For example, it is wrong to detain someone just because they are diagnosed with paranoid schizophrenia.

In October 2017,²¹ the United Nations published the report of its last examination of how well the United Kingdom is implementing the treaty. One of the recommendations was to ‘abolish all forms of substituted decision-making concerning all spheres and areas of life by reviewing and adopting new legislation in accordance with the Convention to initiate new policies in both mental capacity and mental health laws’. The UK Government strongly disagreed with the conclusions reached²² and at the time of writing and, we suspect, for the foreseeable future, the United Kingdom will not comply. In fairness, we should add that we are not aware of any country which has law compliant with the UNCRPD.

On a personal note, we must mention that one of us (T. Z.), as long ago as 1998, wrote that the Royal College of Psychiatrists ‘should consider campaigning for the abolition of a distinct mental health act which only adds to the stigmatisation of the mentally ill’.²³

To conclude, we will encounter further examples of how decisions in the court have resolved issues that have vexed both practitioners and the courts, with greater or lesser

impact. For example, what constitutes a deprivation of a person's liberty? What constitutes treatment for mental disorder? Ultimately, clinicians need to be vigilant about whether the court's intervention is required because there is dispute or a specific legal requirement in relation to their patient. The circumstances may arise when it is necessary to obtain authority from a court as the lawfulness of a treatment (either to be given or withdrawn) when a patient refuses, lacks capacity or there is a difference of opinion regarding best interests. In other cases, a judgment from the court may protect a clinician from claims that he or she has acted unlawfully. The court is also there to safeguard the welfare of the patient.