TRIBUNALS
JUDICIARY

COMPULSORY MENTAL HEALTH TREATMENT:
WHEN SHOULD JUDGES GET INVOLVED?

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First-tier Tribunal (Health Education and Social Care Chamber)

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Thank-you very much for inviting me. When I first came here, 30 years ago, Hong Kong was a different place entirely. In those days, as some of you may know, you could see people inside their apartments as you came in to land at the old airport. Today, Hong Kong has transformed itself, although some of the colonial legacy remains. You even have your waxworks on show in Madame Tussaud's at the top of the Peak. In England, some people think we keep our waxworks in judicial wigs and gowns and sit them on the bench! And yet we're changing too. The new President of the Supreme Court, Baroness Hale, is the first woman to be appointed at that level. I gather she came here, recently, to speak. So you may be aware that she is a person with a strong interest in mental health law, and a strong commitment to securing the fairest and the most proportionate relationship between judges and mental health services that we can devise. That is tremendously good news for all of us in the UK.

And yet I do not think we have it 100% right. For us, change has been slow and ponderous - and for me, as the senior judge in day-to-day charge of the mental health tribunal jurisdiction in England, the sense of inertia can be a little frustrating.

Having said that, I do sense around the world a real desire to look afresh at how we can better understand the needs of people with a mental disorder or diminished mental capacity, and how we can better provide individual care. That, too, is very good news.

In England there have been three key stages in the development of the current system of tribunals dealing with the legal ramifications of serious mental disorders.

The first was the establishment of Mental Health Review Tribunals in England and Wales by the Mental Health Act 1959, following the recommendations of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency.

The second stage began with the reform of judicial powers by the Mental Health Act 1983, and the introduction of the tribunal's Rules which, some argue, advanced a more "due process" model of decision-making. Amongst the reforms made were those whereby many of the practical limitations on the ability of patients to participate in tribunals were removed, most notably by guaranteeing the right of legal representation and (save in exceptional circumstances) access to information in reports.

The 1983 changes were accompanied by the introduction of non means-tested and non-merits tested legal aid to cover all tribunal representation – which was crucial to participation since the legal representative would usually have access to information which might be withheld from the patient. Only with legal representation could such information be effectively tested before the tribunal within the statutory framework.

The 1983 Rules also required tribunals to provide reasons for their decisions, and the requirement for adequate and cogent reasons has been subsequently developed in case-law, so that most tribunal decisions today are several pages long, and set out not only the statutory criteria, but explain in some detail what the tribunal made of the written and oral evidence presented, and why it made the decision it did.

The third stage arose in 2007 and 2008 with amendments to the Mental Health Act 1983 (including the creation of Community Treatment Orders), and the abolition of the Mental Health Review Tribunal with the creation of the First-tier Tribunal which absorbed a number of different jurisdictions, including mental health, and (where

appropriate) grouped them together with similar or compatible jurisdictions in Chambers, within an overarching and coherent judicial and administrative framework.

Thus, the Health, Education and Social Care Chamber deals with mental health cases as well as cases involving children with special educational needs, cases about doctors providing services under the National Health Service, and cases about professional standards in some of the caring sectors and professions.

In this Chamber of the First-tier Tribunal there are two Deputy Chamber Presidents and, as I say, I am the one with day-to-day responsibility for the mental health jurisdiction in England - which is, by far, the largest jurisdiction in the Chamber. At present, every mental health tribunal, no matter how urgent or straight-forward the case may be, must comprise a panel of three people – a judge who is a lawyer, a Consultant Psychiatrist, and a specialist lay member who has some wider knowledge or professional experience of mental health issues and treatment.

Until recently, all cases had to involve a full oral hearing, but in the last couple of years it has become possible to decide certain cases on the papers, if the patient agrees, although the tribunal can still order a hearing. It is also no longer necessary in all cases for the tribunal doctor to go off and examine the patient in advance, in order to form a snapshot preliminary view about the patient's mental condition that day.

These evolutionary changes, from 1959 up to the present time, coupled with the advent of legal aid, have radically changed the tribunal. It has transitioned from a primarily inquisitorial model organised within a number of autonomous regions, to the more adversarial concept of a case between parties, with the tribunal adjudicating upon the dispute, under a national structure and with clear judicial leadership.

The switch to a more adversarial approach has helped to clarify a number of issues (such as placing the onus of proof upon the detaining or responsible authority) and it has enabled a far greater focus upon the due process safeguards that usually accompany an adversarial judicial process. On top of that, the creation of a Presidential structure of judicial leadership has enabled policy and practice to be streamlined and made more consistent – although there are those who regret the new focus upon a legalistic but fairly narrow analysis of the statutory tests for intervention.

Either way, the principal function of the tribunal in relation to detained patients was and remains to provide a mechanism to review the continued need for compulsory detention in hospital for the assessment of, and medical treatment (including compulsory treatment) for, any serious mental disorder. A subsidiary function, at least historically, has been to offer oversight of the patient's treatment and care package. But as time has gone on, we have retreated from that role somewhat, focussing instead on the legal questions that must be asked whenever a person has their liberty interfered with in the name of medical treatment, and in the hope of supporting recovery whilst, at the same time, protecting others from the risk of serious harm.

As it happens, uptake of the right to judicial oversight was initially slow. In the first thirteen months of the tribunal's existence following the 1959 legislation it heard only 850 cases and, even 20 years later, the Council on Tribunals' Annual Reports show that the tribunal disposed of only 709 cases in 1980, 708 in 1981 and 858 in 1982. In fact, the low take-up rate was seen as a major concern from the outset – at least until key changes were brought in by the 1983 Act.

This legislation, when it finally came, reduced the duration of periods of detention, created the entitlement of patients to a tribunal hearing if they were admitted for 28 days for assessment of any mental disorder, and also gave panels a power to direct the conditional or absolute discharge of restricted patients (that is to say, forensic or criminal patients with restrictions placed upon their discharge from hospital).

These reforms all meant that there was a dramatic increase in the tribunal's case-load from 1983 onwards. The increase was further fuelled by provision for the automatic referral of the cases of patients who had not made an application within the first six months of detention, and also of patients whose detention is renewed and whose cases have not been considered by a tribunal within the last three years.

Fast forward, now, to 2007 and the introduction of Community Treatment Orders – with a right of recourse to the tribunal, and the annual number of hearings began to rocket until the figure in 2015-2016 was 22,000 hearings and 30,000 case receipts. And the latest 2016-17 figures suggest that there were over 32,000 applications and automatic referrals received, and around 25,000 cases listed, at over 1,000 venues.

Likewise, the volume of case law from the superior appellate courts and tribunals on the Mental Health Act has increased dramatically since 1983. For example, there were only two appeal cases from the superior courts between 1959 and 1983. In the 24 year period between 1983 and the Mental Health Act 2007 there were just over 100 judicial reviews of tribunal decisions – about 4 or 5 a year. But nowadays, there are about 100 applications for permission to appeal each year – still a very small number given the overall caseload of the tribunal, and very small compared to other tribunal jurisdictions. Of these, about half are without merit, and some involve such a clear error that we can put it right ourselves. The rest go to the Upper Tribunal. And so the number of key decisions, with ramifications beyond the immediate case and providing future guidance, hovers at around 10 a year, which is sufficient for any jurisdiction.

I will look at one or two of these decisions shortly but, before I do, I would like to briefly compare the UK model with what I have learned operates here in Hong Kong. Interestingly, the Hong Kong Mental Health Ordinance has some strong similarities with UK mental health legislation over the years, but also some big differences. The similarities are to be found in the criteria for detention. The differences lie in the practical administrative process for locking someone up and forcibly treating them.

Section 1 of the amended 1983 Act defines mental disorder as any disorder or disability of the mind – a very wide definition indeed. However, there are some savings that prevent the definition from becoming too all-encompassing.

A person with learning disability will not be considered, by reason of that disability, to be suffering from mental disorder – or requiring treatment in hospital for mental disorder – unless the learning disability is associated with abnormally aggressive or seriously irresponsible conduct. Who decides what those words mean? In the first instance, it will be the doctors and mental health professionals who know the patient and the facts of the case. Ultimately, it will be the judges. Similarly, dependence on alcohol or drugs is not considered to be a disorder or disability of the mind in itself but, as we know, such dependence often provides the background and trigger for the onset of mental disorder, and also for relapse following successful medical treatment. Subject to that definition, the 1983 Act allows for compulsory detention and treatment through what is commonly known as ‘sectioning’.

You heard yesterday something about the grounds for compulsory admission to hospital of a person with a mental disorder, but what about the procedures? Unlike Hong Kong (and, indeed, unlike Scotland) the England and Wales regime for 'sectioning' does not involve the tribunal or a District Judge at the admission stage. Instead, an Approved Mental Health Professional (AMHP) takes the lead. I very much commend this approach. Judges should stand apart and let practitioners on the ground, some of whom should know the patient, make the initial decisions, even if they involve removing or curtailing liberty. Tribunal judges are an independent backstop and a safeguard, providing a speedy review and remedy. But, in my view, judges should not routinely commence the medical or administrative process. And they should certainly not allow themselves to be little more than a "rubber stamp".

On the ground, AMHPs are approved by local social services authorities, and they include social workers, nurses, occupational therapists, and psychologists. Medical practitioners, however, are expressly excluded as AMHPs – so that there will always be a mix of professional perspectives at the point when a decision is made regarding a patient's detention. And even though all the personnel involved may be employed by the same organisation (e.g. the National Health Service Trust) the skills and training required of AMHPs ensures that they provide an independent social perspective.

Section 2 of our 1983 Act provides the grounds for short-term detention for assessment, or assessment followed by medical treatment, for up to 28 days. As you know, in the Hong Kong Ordinance, it is referred to as detention for observation and, if you make a comparison, the grounds are strikingly similar – which is perhaps not surprising given its likely provenance. Section 3 of the Act provides the grounds for long-term detention for treatment, and Section 3 can be extended repeatedly.

The application for admission under Section 2 or Section 3 is made to the managers of the hospital where it is intended that the patient will be detained. The managers are involved because it is they who will have to find a bed, but it is the AMHP who is the real arbiter of whether it is right and necessary to go down this road. The application must, however, be supported by the recommendations of two registered medical practitioners who have personally examined the patient either together or separately.

And where they have examined the patient separately, not more than five days must have elapsed between the days on which the separate examinations took place.

In addition, of the medical recommendations given, one must be given by a registered medical practitioner who is approved as having special experience in the diagnosis or treatment of mental disorder; and unless that doctor has previous acquaintance with the patient, the other such recommendation shall, if practicable, be given by a registered medical practitioner who has such previous acquaintance with the patient.

So, the way it works is this. If a local social services authority thinks that an application for hospital admission may have to be made in respect of a patient within their area, it must make arrangements for an AMHP to consider the patient's case. It is then the AMHP, and not the doctors, who can decide to initiate the legal process.

Before doing so, the AMHP must interview the patient in a suitable manner and satisfy himself or herself that detention in a hospital is, in all the circumstances of the case, the most appropriate way of providing the care and medical treatment of which the patient is in need. The AMHP must also have regard to (but is not bound by) any wishes expressed by the close relatives of the patient. The AMHP must also consider any other relevant circumstances. In fact, the Mental Health Act Code of Practice states that in addition to medical opinion and the statutory criteria, the AMHP should also consider relevant past history, present condition, social factors, and family views.

If the AMHP is then satisfied that an application to admit a patient should be made, is satisfied that the statutory grounds for making an application are established, believes that there is no effective and realistic alternative and considers that it is necessary or proper to do so, he or she will then proceed. And at that stage, there is no judicial involvement whatsoever. This means that, at admission stage, with non-forensic patients, the judiciary of England and Wales is fairly 'hands-off'. However, once the patient has been detained for assessment under Section 2, or detained for treatment under Section 3, the patient can immediately apply to the tribunal to be discharged or, in relation to some aspects of the case, can ask for a statutory recommendation.

For Section 2, time is of the essence. The application must be made within the first 14 days of the 28 day period, and the tribunal must then try to hear the case within 7 days

of receiving the application. On average, therefore, only about 14 days will be left to run by the time a tribunal convenes. If a patient has been admitted under Section 3 (under which he can be detained for up to six months, and then another period of six months, and then a year at a time, repeatedly) the patient can apply to the tribunal to be discharged. The right to apply arises once during each of those periods, and if no application is made, the patient's case will still be periodically referred to the tribunal, in order to make sure that no-one gets lost in the system or slips through the net.

So, what does the tribunal do when it considers a case? I want to stress a couple of things that the tribunal does not get involved with. The tribunal does not decide if the original detention was right or wrong. If that's what the case is about, then the patient or his or her family will have to challenge the original detention in the High Court by way of judicial review. So the application to the tribunal is not an appeal against the original detention. It is simply a request made to the tribunal to consider the statutory criteria as at the date that the panel convenes. It is more than possible that the original detention was right, but that the patient should no longer be detained as at the date of the tribunal hearing, and should be discharged. It is even possible that the original detention was wrong, but that the statutory criteria are fully made out as at the date of the hearing and the patient will not be discharged.

Second, in contrast to involuntary detention, the 1983 Act does not provide any recourse to the tribunal to challenge a decision to force compulsory medical treatment upon a resistant patient. Presently, treatment challenges also go to the High Court.

So what the tribunal does do, either on application or if the case is referred, is decide whether the grounds for continued detention are made out, at the date of the hearing. If the Responsible Authority does not prove its justification for continued detention, then the tribunal must discharge the patient. The onus is firmly upon the detaining authority to demonstrate, by written and oral evidence, that the criteria for continued detention are established. And the standard of proof is the balance of probabilities.

The only technical exception is if the tribunal thinks that a non-forensic patient can or should leave hospital, but only if subject to a Community Treatment Order. In such a case, the tribunal will not discharge the patient but may recommend that the patient's doctor consider making a CTO.

The tribunal also has power to recommend, with a view to the discharge on a future date of a non-forensic patient, a transfer to a different hospital, or the grant of leave of absence. And the tribunal can reconvene and re-decide the entire case from the beginning if, for no good reason, its recommendation is not complied with.

Since 2008, decisions from the First-tier Tribunal go on appeal to the Upper Tribunal. There is no automatic right of appeal – permission has to be given either by the First-tier Tribunal or by the Upper Tribunal itself - and from those appeals there has been some interesting jurisprudence handed down, which is binding on us.

In MD v Nottinghamshire Health Care NHS Trust [2010] UKUT 59 (AAC) the Upper Tribunal said that the First-tier Tribunal must direct the discharge of a patient liable to be detained for treatment if the tribunal has *not* been satisfied (amongst other things) that appropriate medical treatment is available.

"Medical treatment" includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care. It includes the benefits of the hospital ward milieu, and it is sufficient if the medical treatment is for the purpose of preventing a worsening of the symptoms or manifestations (which envisages that the treatment may not actually *reduce* the risk posed by the patient). It is also sufficient if the treatment will only alleviate some of the symptoms or manifestations, and even if there will be no reduction in the risk posed by the patient.

Although the tribunal should not get involved in giving a second opinion on the detail of the day-to-day treatment plan, the broad question whether treatment is "available" or "appropriate" and the boundary between 'containment' and 'treatment' are matters of fact and judgment for the tribunal, acting as an expert judicial panel.

The issue in SH v Cornwall Partnership NHS Trust [2012] UKUT 290 (AAC) was whether treatment given without the patient's consent could be regarded as "appropriate" if the patient refused to have it. The patient was on a Community Treatment Order and when the patient attended for his depot injection, he said that he did not consent to it. It was argued that, as a consequence, the treatment was not appropriate. The Upper Tribunal disagreed and held that it was appropriate – even if refused by the patient.

Moreover, as a statutory body, the tribunal only has the powers conferred on it by law. It can order the discharge of a CTO patient, but no more. It does not have power to direct any steps in respect of the patient's treatment, and it should not get involved in issues around consent. Clearly, the tribunal cannot keep someone locked up and subject to compulsory treatment if what's on offer is not appropriate. But, even if administered without consent, or even if it cannot take place without consent and engagement, treatment can be both available and appropriate. Even counselling and psychological therapies (which cannot be forcibly imposed in the same way as, say, a depot injection) can be regarded as both available and appropriate, even where a patient apparently refuses to engage with them.

Finally, on the question of risk to others, the Upper Tribunal said in MD v Mersey Care NHS Trust [2013] UKUT 127 (AAC) that risk is not only relevant to whether or not giving medical treatment is necessary for the health or safety of the patient or for the protection of other persons, but also to the question of whether the mental disorder is of a nature or degree which makes it appropriate for the patient to be liable to be detained in a hospital for such treatment, and even whether appropriate medical treatment is available for a patient. Echoing the ruling in SH, the tribunal held that lack of engagement does not mean that the disorder is not susceptible to treatment, and does not mean that available treatment is not appropriate.

Where a patient with, say, a certain type of personality disorder refuses to engage, the argument may be that the threat of permanent non-engagement - in itself - makes the treatment inappropriate. But then the question may arise: 'How long should clinicians, or the tribunal, wait before giving up hope of achieving cooperation from the patient?' The Upper Tribunal said that both the high likelihood of harm occurring, and the grave consequences of such harm if it did occur (especially when considered together) are factors highly relevant. Indeed, there are some patients who present such a grave danger that it would be quite wrong to ever give up hope of engaging them so long as potentially effective medical treatment is available for the mental disorder in question, including psychological therapy or counselling. Patients should not be able to precipitate their own discharge from hospital by pursuing a manipulative strategy of wilful refusal. That would merely encourage disengagement, and be perverse.

I should now like to reflect on how – in England – we might further refine judicial involvement in the mental health regime. The current legislation is over 30 years old and it has not been significantly amended for 10 years. Does it, I ask, embody the sort of respect and regard for modern principles of non-discrimination, autonomy, personal choice and self-determination that, in this day and age, should underpin the way we look at someone with a mental health problem? I raise this only so that you do not necessarily take the England & Wales Mental Health Act as a template.

The UK charity 'MIND' – which represents and campaigns for people with a wide range of mental health difficulties argues that by using mental disorder as a basis for detention, there is an assumption that a person does not have capacity and so no, or at least insufficient, consideration is given to whether they actually consent to treatment.

In a paper published last May in the Legal Action Group Bulletin, Felicity Auer and Joanna Dean argue that treatment is often imposed in a paternalistic manner by attaching weight to the professional's view rather than sufficiently respecting the patient's autonomy. I am sure that you can see their point. Suppose someone with terminal cancer refuses treatment. We would not usually force treatment on someone with capacity to refuse it, even if their decision was objectively unwise, and detrimental to their health. So the question is raised - is mental health legislation that hinges largely on 'medical diagnosis' as the basis for restrictive care and coercive treatment the most appropriate way forward? Is it truly the best and most proportionate way to respond to the needs of people with mental health problems?

Whilst someone's consent to treatment should always be sought, Section 63 of the Mental Health Act 1983 gives the treating team authority to forcibly treat patients without consent when someone is detained under certain sections of the Act. This is irrespective of whether or not they are thought to have the capacity to make a decision giving or refusing their informed consent. Removing "mental disorder" from the legal criteria for detention and compulsory treatment, and replacing it with a requirement that patients should lack capacity to decide such matters for themselves would (it has been argued) better achieve parity with how physical health problems are managed, and place far greater emphasis on the patient's right to choose for himself or herself.

As you have heard earlier in this conference, the UN Convention on the Rights of Persons with Disabilities is the gold standard of international human rights protection for people with disabilities, and under the Convention involuntary treatment could constitute a range of human rights violations. Of particular interest to me is the effect of Article 12 (equal recognition before the law), whereby people with disabilities, including mental health problems, are recognised as having full and equal rights, and even those who need support in decision-making and in exercising their legal capacity as a consequence of their disability are to be treated fairly and equally with others.

To see how this may work in practice in the UK, let's go north of the border from England. The Scottish equivalent of the Mental Health Act 1983 includes an additional requirement of significantly impaired decision-making in relation to treatment for mental disorder. This seems like a step in the right direction although, in Scotland, the tribunal is involved in the sectioning process which, I argue, brings the tribunal into the arena too soon. So lets go off to the west - the Mental Capacity Act of Northern Ireland, passed in 2016 but not yet in force, might also provide a route to follow. It is the first true example in the world of legislation that places mental capacity (or lack of it) at the heart of decisions surrounding the compulsory detention and medical treatment of people with mental health difficulties.

But an overly simplistic 'capacity model' could find itself glossing over the need to address dangerousness to others. What if a person with a mental disorder presents a grave risk, not so much to themselves, but to the people around them, or to the public? And what if that person still has capacity to refuse to stay in hospital or accept medical treatment because their mental disorder has not so skewed their insight and understanding of reality as to take away their ability to weigh up the pros and cons, and so has not extinguished or curtailed their right to personal autonomy?

For many psychiatrists, focussed as they must be on the recovery of their patients and yet supportive of their patients' right to self-determination and respect for their wishes, the use of compelling and coercive powers in the interests of persons other than the patient causes concern and difficulty. They do not want to be psychiatric policemen or policewomen – especially where the crime has not yet been committed. And so for them, and for society generally, there lies the dilemma that we now face.

Whilst society clearly must have a way of managing people who break its laws, it seems strange to some engaged in this debate that a patient with a mental health problem may be confined in the same way as a criminal or an illegal immigrant facing deportation. Commentators from this school of thought question whether it is acceptable to put someone away as a response to a mental health problem when they have not (or not yet) committed a crime – especially where that person has capacity to refuse consent to treatment, and is making that choice.

According to MIND, this is particularly problematic given that there are lots of perfectly well people who present the same level of risk to others, or possibly greater risk, but who do not have a ‘mental disorder’ and so (generally speaking) are not likely to be detained against their will before any crime is actually committed. Is this not a sort of discrimination, since a good person with a mental health problem is put at a substantial disadvantage compared with a potentially bad person without one?

Society generally draws back from pre-emptive interventions in the name of crime prevention and MIND would suggest that singling out those with mental health problems for pre-emptive action involving enforced loss of liberty and compulsory medical treatment is unfair, discriminatory and disproportionate, and originates from popular but discredited assumptions about links between mental health and violence.

Speaking for myself, whilst I see the ethical problems in allowing, for example, someone with cancer to decide to die, whilst forcibly intervening when someone with anorexia or bipolar depression threatens to harm themselves, I think that humanity forces us to strike a careful balance. Yes, if honestly and truly we can say that the person’s mental disorder has not seriously and significantly affected their capacity to make a decision about whether or not to accept treatment, then - so long as we consider dangerousness to others - it may be possible to stand back and allow the patient to determine for themselves whether to engage.

But if the anorexic schoolgirl, with her whole life ahead of her, looks in the mirror and sees a distorted and untrue vision of herself, and that distortion is a direct consequence of a serious mental disorder, I see no reason why it would not be ethically acceptable to step in and act in the girl’s best interests, even if against her wishes. And it might, indeed, be morally reprehensible not to do so.

As a society, whilst we cannot routinely lock people up to pre-empt violent crime, we can and perhaps we should try to save people from themselves and, recognising the relevance of dangerousness, we must surely take all reasonable and proportionate steps to not only look after the sick, but to nurture and protect each other. After all, serious mental disorders insidiously twist reality and distort truth. They can destroy insight and create fear, anger, delusion and pain. The disordered mind can see threat and conspiracy where, in reality, the world is offering help, support and relief.

Fear, suspicion and the innate urge to either fight or flee from perceived danger can all too easily damage someone’s life and undermine a perfectly good treatment plan and care pathway. And that is why we should be cautious about creating a framework that could deny a capacitous patient the essential medical treatment that they need, treatment that really could bring back some calm reality into their lives, give enduring relief from symptoms, and provide some long-lasting emotional peace.

In England we have, maybe, over-prioritised the nature and degree of the apparent mental disorder, and seen the potential risks to the patient and others as sound legal justification for judicial intervention. We have, perhaps, given insufficient attention to the right of people who have capacity to weigh up the pros and cons and make important decisions for themselves - and we have, possibly, failed to sufficiently respect a person’s right to self-determination, even if their decisions seem unwise.

But if we had a blank piece of paper, and could begin again, I fear that getting the balance right would be as ethically difficult and legally challenging now, as it was when we started down this road, nearly sixty years ago.