CHAPTER 1

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 lots of 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 2005[4] and the Mental Capacity Act Deprivation of Liberty Safeguards,[5] and the Mental Health Act Reference Guide[3]
- government circulars and directives, such as the Care Programme Approach (CPA) 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 Mental Health Act Code of Practice for Wales is being reviewed at the time of writing this book), the Codes pertaining to the Mental Capacity Act and the Deprivation of Liberty Safeguards are the same for England and Wales.

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 other countries, the UK doesn't have a written constitution to limit the powers of Parliament. Statute law can only be changed by Parliament, which rules supreme. However, Parliament has decided that there are two 'higher authorities'. First, the UK has signed up to international treaties (also called Conventions) in Europe. As the UK is a member state of the European Union (EU), Parliament has accepted that, in the areas of law governed by the EU, the latter's laws shall prevail over UK law. Furthermore, there are circumstances in which a UK law will not be enforced because it conflicts with a 'higher' law of the EU. Judgments of the European Court of Justice (the court of the EU) about European law are binding on UK courts. Second, there is the Council of Europe, which drew up the European Convention on Human Rights. If a current law is judged by the European Court of Human Rights to clash with this Convention, then Parliament will change the law. The European Court of Human Rights cannot, by itself, change UK law.

Parliament nonetheless remains the ultimate authority because, given that one Parliament cannot bind another, Parliament can, at any time in the future, decide it does not wish to continue to comply with European Law or the European Convention on Human Rights (although this would mean tearing up the treaties and probably leaving the EU).

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 MHA authorises hospital authorities to stop an informally admitted (voluntary) patient from leaving hospital). The equivalent in the European Convention on 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). Wales has an Assembly with more limited powers (see Appendix 1, section A1.1). Primary legislation passed by the Welsh Assembly is called a Measure. 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
- 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 (the MHA)
- the Human Rights Act 1998 (the HRA)
- the Mental Capacity Act 2005 (the 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 p. 38).

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 it[8]). 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.

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).

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'.[9]

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'.[10]

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*,[11] 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*,[12] 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.'[12]

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*.[13] 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.[14] 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 another case, and this gives a different answer.

Answer This time 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 two weeks. He appealed to the Tribunal (unsuccessfully), and then to the Upper Tribunal,[15] 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 two weeks, to an out-patient clinic, is enough.

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.

It should be noted that judges sometimes appear to get the law wrong. Sir Thomas Bingham (as he then was), in the case of *Airedale NHS Trust (Respondents) v Bland*[16] (Mr Bland had been seriously injured at the Hillsborough football stadium and was in a persistent vegetative state) said 'A medical practitioner must comply with clear instructions given by an adult of sound mind as to

the treatment to be given or not given in certain circumstances, whether those instructions are rational or irrational'. Although it is true that, in the circumstances described, we must comply with a refusal of treatment, no patient can instruct clinicians to give particular treatment. Clinicians must only give medical treatment that they believe is appropriate for their patient's condition (and which is lawful).

To return to Lord Donaldson:[8]

> '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.'

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 UK is a signatory to the United Nations Convention on the Rights of Persons with Disabilities 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, the United Nations High Commissioner for Human Rights[17] said 'Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished. […] This should not be interpreted to say that persons with disabilities cannot be lawfully subject to detention for care and treatment or to preventive detention, but that the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis' (para. 489).

At the time of writing and, we suspect, for the foreseeable future, the UK will not comply.

On a personal note, we must mention that one of us (T. Z.) wrote in 1998 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'.[18]