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CAPACITY, THE ROLE OF A WELFARE DEPUTY AND AN EFFECTIVE REMEDY FOR PATIENTS DETAINED UNDER THE MENTAL HEALTH ACT

The Upper Tribunal has now determined, in *AMA v Greater Manchester West Mental Health NHS Trust and Others* [2015] 0036 UKUT (AAC), that a Court of Protection order appointing a deputy to make general personal welfare decisions does not authorise a deputy to act as the patient's representative in proceedings under the MHA unless the order expressly so provides (para.50). In the circumstances of the case as outlined below, Mr Justice Charles found that the First-tier Tribunal erred in law by granting a welfare deputy's application to withdraw a patient's tribunal because the order appointing her as deputy did not expressly give her that right. He suggests that the correct approach would have been for the FtT to refuse to consent to the withdrawal and appoint a representative for the patient under Rule 11(7)(a) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 and proceed with the appeal. The judgment also delivers guidance on the role of the FtT, emphasising its importance in fulfilling the substantive and procedural requirements of Art.5(4) of the ECHR, and on the approach to be taken when assessing a patient's capacity to appoint a solicitor and conduct proceedings before the FtT. However, we fear that the judgment, in particular the complex guidance on capacity, may have set a dangerous precedent which could leave detained patients without an effective remedy to challenge their detention under the MHA.

The Facts of the Case

We acted on behalf of AMA, who was detained under s.2 of the Mental Health Act. He told nursing staff that he did not want to be in hospital so the hospital submitted an application to the FtT on his behalf. AMA met with a solicitor member of the Law Society Mental Health Accreditation Scheme from this firm and confirmed that he wished to be discharged from his section. As the relevant decision maker, the solicitor was required to determine whether he was able to accept instructions. In so doing, he applied sections 1, 2 and 3 of the Mental Capacity Act 2005 and had regard to the fact that the threshold for capacity to apply for a MHT is very low (see *MH (by her litigation friend, Official Solicitor) (FC) v. Secretary of State for the Department of Health and others* [2005] UKHL 60 discussed further below). Having applied the relevant legal test and principles for establishing capacity, the solicitor reached the decision that AMA had the capacity to apply for a tribunal and instruct a legal representative.

On the morning of the hearing AMA, having discussed the matter with his mother, his nearest relative, told staff that he wished to withdraw his tribunal application. His solicitor was concerned that his reasons were that he had been granted home leave and was told that he would be discharged in 3 days. He noted that AMA's mother firmly believed her son should remain in hospital. After exploring the issues including the fact that mere days

remained for reapplying for a tribunal if things did not work out, that AMA was willing to remain as a voluntary patient and that the only written evidence before the FtT (the nursing report) concluded that further detention was not necessary, AMA accepted advice to continue with the appeal. The solicitor was satisfied that the issues as to whether AMA would stay voluntarily for the few days it was said he needed testing on leave, were not too complex. Having been assisted to make his decision, he had the capacity to do so.

AMA's mother was unable to attend but shortly before the hearing she sent a written notice of withdrawal in purported exercise of her power as his welfare deputy. The FtT raised three preliminary issues. First was whether AMA had capacity to instruct a solicitor, second whether he wanted to withdraw and third whether the welfare deputy had power to exercise her son's power to withdraw. The medical member was of the view that AMA lacked capacity on the basis that he had changed his mind several times as to whether to proceed and had told her clearly that he wanted to withdraw. The solicitor submitted that it was inappropriate to rely on the medical member's assessment of capacity as the manner in which it had been conducted could not be tested, that he was the decision maker, he had instructions and the tribunal should proceed. Alternatively, if there were doubts over capacity, the hearing should be adjourned to explore the issues fully. Even if the tribunal were of the view that AMA lacked capacity, the solicitor disputed that a welfare deputyship order authorises a deputy to withdraw a tribunal on behalf of a detained patient.

The FtT decided that AMA did not have capacity (without specifying what he lacked capacity to do), that a welfare deputy could withdraw a tribunal on behalf of a patient and the written application of his mother would be granted. In consequence no examination as to whether there was evidence to justify AMA's detention was undertaken.

Notwithstanding the fact that AMA had subsequently been discharged we were granted permission to appeal to the Upper Tribunal due to the clear need for guidance as to how the FtT should proceed when faced with a dispute over capacity and on the powers of a welfare deputy in relation to tribunal proceedings. The grounds were that (1) the FtT should not have concluded that the patient lacked capacity; (2) a welfare deputyship does not authorise a deputy to withdraw a tribunal on behalf of a patient; (3) if the patient lacked capacity, the FtT should have appointed the solicitor to represent the patient under Rule 11(7)(b) and proceed to determine whether the detention criteria were met; and that in consenting to the withdrawal the FtT; (4) did not deal with the case fairly and justly contrary to the overriding objective contained in Rule 2(1) and; (5) acted in a way which was incompatible with AMA's rights under Art.5(4).

The Decision

Mr Justice Charles firstly dealt with the issue of capacity and rejected our submission that the threshold for capacity in the FtT is extremely low because "such a generalised statement does not fit with the fact sensitive decision, issue or activity specific approach that is required" (para.38). Whilst he accepts (para.41) that "the capacity simply to instruct a solicitor to challenge a continuation of a detention on all available grounds can be described as very low or a very limited capacity", he distinguishes between (a) the capacity to appoint a solicitor and (b) the capacity to conduct proceedings himself (litigation capacity). In relation

to the latter, he held that different and more complex factors will be relevant and a best interests approach will likely arise in certain cases, for example, "cases concerning compliance with a voluntary admission", "applications to withdraw", and when "the wishes of the patient do not accord with the views of his representative as to what will promote his best interests and/or do not found arguable points" (para.42).

In AMA's case he found that there was strong evidence to suggest that he lacked the capacity to understand, retain or weigh the factors relevant to the decisions of whether to withdraw or continue with his tribunal or whether or not to remain in hospital as a voluntary patient. He makes no finding as to whether AMA had capacity to appoint a solicitor in the context of an application to the FtT in the first place (which he accepts can be described as very low) although it is interesting that, having found that AMA lacked the capacity to decide whether or not to withdraw and that his deputy did not have the authority to make that decision on his behalf, he suggests that the FtT should have appointed a legal representative under Rule 11(7)(a) and proceeded to determine the competing arguments. Rule 11(7) only applies when a patient has not already appointed a representative and (a) if the patient has stated that they do not wish to conduct their own case or that they wish to be represented, or (b) if the patient lacks the capacity to appoint a representative but the tribunal believes that it is in the patient's best interests for the patient to be represented. AMA had already appointed a solicitor who had determined that he was able to accept instructions so unless it was established that AMA lacked the capacity to appoint a representative in the first place, Rule 11 would not apply (see further below).

Although Mr Justice Charles found that the FtT erred in law by granting the withdrawal he did not address our arguments that in so doing they acted contrary to the overriding objective of the Tribunal Procedure Rules and in a way which was incompatible with AMA's rights under Art.5(4). On the facts of the case the error was that the COP order did not expressly give AMA's deputy the right to act as his representative in proceedings under the MHA rather than it being in breach of his Art.5(4) rights to allow her to do so. In relation to whether a welfare deputyship can ever authorise a deputy to withdraw a tribunal on behalf of a patient, he states that, "The extent of what a deputy or attorney can or should be authorised to do under the MHA or in respect of proceedings under the MHA on behalf of a patient by the original order of appointment, or any further order, is outside the ambit of this judgment" and that "it is dangerous to make general assertions about the relationship between the application of and the roles of persons under the statutory regimes of the MHA and the MCA" (para.47).

The judgment also gives guidance on the role of the FtT in fulfilling the substantive and procedural requirements of Art.5(4). He emphasises "the underlying purpose and importance of the review and so the need to fairly and thoroughly assess the reasons for the detention" and that "care needs to be taken not to embark on unnecessary assessments [of capacity] and to maintain flexibility to achieve the underlying purpose, namely a practical and effective review of a deprivation of liberty in an appropriate timescale" (para.35). There is a danger, however, that the judgment may in fact frustrate the underlying purpose.

Commentary

Mr Justice Charles leaves open the possibility of a welfare appointment giving power to a deputy to frustrate a patients wish to seek a MHT but it is difficult to see how this would ever be justified or lawful. In *M.H. v The United Kingdom* (Application no. 11577/06), the Government argued that the right of a section 2 patient to apply for a tribunal for discharge "had to be read together with safeguards seeking to facilitate access to the Tribunal", including "the fact that the Secretary of State or a hospital manager might refer a case'' and ''even where the patient's nearest relative had no independent right of application to a Tribunal, he or she could still help put the patient's case before a judicial authority" (paragraph 69). They argued that an incapacitated section 2 patient's Art 5(4) rights were "practicable and effective" because of the role of the nearest relative who could order the patient's discharge. If met with a 'barring order' under section 25(1) and an application to displace her under section 29 the patient's case could be brought 'speedily' before the County Court. Finally it was argued that the SoS could be invited to refer the patient's case to the tribunal under section 67.

The European Court were unimpressed and emphasised that Article 5(4) ''guarantees a remedy that must be accessible to the person concerned" and that Article 5 requires ''safeguards against arbitrariness" (para 76).

They found (para 86) that "Neither the applicant nor her mother acting as her nearest relative was able in practice to avail themselves of the normal remedy granted by the 1983 Act to patients detained under section 2 for assessment" and so there was a violation of Art.5(4) in the first 27 days of her detention. It must follow, therefore, that allowing a welfare deputy to withdraw a tribunal removes the patient's guarantee of an effective remedy accessible to the person concerned.

The court found that there was no violation of Art 5(4) in the period after the patient's detention was extended by operation of section 29(4) because her case was in fact brought speedily before the tribunal after her mother had requested a SoS referral. However, the court raised the crucial question "whether such a hearing could have taken place had the applicant not had a relative willing and able, through solicitors, to bring her situation to the Secretary of State" (para 95).

In AMA's case the availability of the SoS reference procedure would not have provided a safeguard to the patient, whom the FtT determined lacked capacity, as his deputy and nearest relative wished for him to remain detained. As a result of the FtT's decision, AMA was put in the position of an "incapacitated and un-befriended" patient with no means available to him to challenge the lawfulness of his detention. The UT has unfortunately left open the possibility of other patients being put in such a position in view of the guidance given on establishing capacity to which we now turn.

The tribunal provides an essential safeguard to ensure that detained patients can access an independent legal body to review the lawfulness of their detention. It is for that reason that the threshold for capacity to apply for a tribunal and instruct a legal representative has always been considered to be very low by mental health practitioners. Baroness Hale of Richmond (with whom the other four law lords concurred) set out a number of safeguards in *MH (by her litigation friend, Official Solicitor) (FC) v. Secretary of State for the Department of Health and others* [2005] UKHL 60; to ensure that a patient's rights under Art.5(4) are "practical and effective", "every sensible effort should be made to enable the patient to

exercise that right if there is reason to think that she should wish to do so…..that is why our system tries hard to give patients and their relatives easy access to the tribunal which is itself designed to meet their needs…[Mental health review tribunals] are designed to be user-friendly and to enable the patient and her relative to communicate directly with the tribunal…The common law presumes that every person has capacity until the contrary is shown and the threshold for capacity is not a demanding one. These principles have recently been confirmed by Parliament in the Mental Capacity Act 2005" (paras 23-26).

Whilst Mr Justice Charles accepts that the capacity to appoint a solicitor to challenge a continuation of a detention before a tribunal can be described as very low, it is worrying that a 'best interests approach' has been introduced into MHT proceedings. Of particular concern is the example he gives of, "cases in which the wishes of the patient do not accord with the views of his representative as to what will promote his best interests and/or do not found arguable points".

It must be remembered that the strict statutory criteria for detention is that it is necessary and not whether it is in the patient's best interests. Also, that there is a difference between being discharged from hospital and being discharged from liability to be detained, a distinction which, from experience, both patients and their relatives do not fully appreciate or understand until advised by an experienced mental health advocate. Neither do they appreciate that tribunals are not just about seeking discharge but can be vital in obtaining observations and recommendations to facilitate discharge on a future date including improvements to care and treatment plans. In our application to appeal we argued that, having concluded that a deputy could exercise a patient's right to withdraw, it was not appropriate for the FtT to consent to the withdrawal without enquiring as to whether the deputy was in possession of all of the relevant facts, the reason for the deputy seeking to withdraw and as to whether she had the opportunity to obtain legal advice. In particular, whether she was aware that a section 2 patient may only apply for a tribunal in the first 14 days or whether she had sight of the nursing report indicating that detention was no longer necessary. AMA's mother may have genuinely believed that it was in his best interests to remain in hospital but whether she understood the implications of the section being discharged or upheld was not ascertained.

The judge seemed to doubt the presence of stigma in being 'sectioned' as a factor in justifying a tribunal hearing but practitioners will readily recognise it in the many 'voluntary' patients who reluctantly stay on a ward for fear of being sectioned. If a patient indicates that they do not wish to be in hospital or remain liable to be detained then they have the fundamental right to have their case heard speedily by an independent legal body regardless of whether they have the capacity to understand the purpose and need for further assessment or treatment in hospital or to consent to stay voluntarily. Whether the patient's wishes found arguable points is to be determined by the tribunal after a full examination of the evidence. Nearest relatives are given the opportunity to attend tribunals to voice their views, whether or not they accord with the wishes of the patient.

The Law Society's Practice Note: 'Representation before Mental Health Tribunals', dated 25.01.15 provides guidance on taking instructions from clients with or without capacity. They agree that the information that a patient needs to understand to appoint a solicitor in the context of an application to the tribunal is not complex and that an experienced mental health advocate will in most cases be able to decide whether the patient has the capacity to

instruct him. Thus, it is the solicitor who determines whether he can accept instructions and even if those instructions are "inconsistent, unhelpful to the case or vary during the preparation of the case, or during the hearing itself" solicitors must act in accordance with them. The Law Society's view is that "It is highly unlikely that to seek a client's discharge in accordance with his or her express wishes would not be 'properly arguable', even if it is unlikely to succeed". The Practice Note also makes the point that capacity to appoint a solicitor is not the same thing as capacity to litigate, but emphasises that "There are likely to be few cases where a client who is able to express their wish to be discharged by a tribunal will be assessed as lacking capacity to instruct you. Similarly, where a client without litigation capacity tells you they wish to be discharged from hospital, there will be few cases it will not be appropriate to argue for their discharge. This is because of the over-riding importance of the client's right under Article 5(4) to challenge the lawfulness of their detention - a right that exists without the detained individual needing to show that they have any particular chance of success in obtaining their release - see Waite v UK (2003) 36 EHRR 54".

Adopting a best interests approach when determining whether a detained patient has a tribunal at all as opposed to how the evidence and submissions are dealt with in a hearing, may result in vulnerable patients being excluded from an independent tribunal review. It is likely to lead hospital staff, grossly overworked and under pressure, to decide not to request a tribunal on the basis of lack of capacity to understand the implications of being discharged. It introduces a dangerous assumption that a tribunal has no function other than to deal with detention when the very fact of a detailed review can identify false assumptions and point to measures which could promote an early discharge or better aftercare which reduces the risk of future admissions. For some patients a tribunal might be the only opportunity they get of hearing a detailed explanation of the reason for their detention or securing leave or a transfer to a more suitable hospital. Every sensible effort needs to be made to ensure that patients can access the tribunal and embarking on unnecessary capacity assessments and best interests considerations will no doubt hamper that effort. Such an approach will be even more concerning in section 2 cases given that there is no automatic referral to the tribunal to protect patients who are considered to lack capacity. The fact that Rule 11 only applies when a patient hasn't already appointed a representative supports not only that it is the representative who decides whether the patient has the capacity to do so but also that the threshold is very low given that it does not refer to 'litigation capacity'. Rule 11 does not cover situations when the patient is considered to have the capacity to appoint a solicitor but who lacks litigation capacity because tribunals are designed to allow easy access to patients if there is any reason to believe that they should wish to do so. Saying that they do not want to be detained in hospital would appear to be a good indication.

It is to also to be noted it took longer for the tribunal to dispose of the matter by allowing the withdrawal than it would have taken to carry out a review of the detention criteria by continuing with the application.

Legal Aid

An extremely disturbing feature of this case is that, despite the clear importance this decision raised in relation to a patient's Art.5(4) rights and the unclear scope of a welfare deputy's powers, the Legal Aid Agency refused funding for the appeal.

Mr Justice Charles expressed deep concern that the Legal Aid Agency refused to grant funding leaving it to the good will of the legal profession to clarify the law in an important issue affecting the liberty of the subject. John O'Donnell represented the patient at the FtT on a standard fixed fee. In the Upper Tribunal odonnells solicitors and Simon Burrows of counsel acted pro bono. It is hoped that in future the Legal Aid Agency will accept Mr Justice Charles' invitation "to consider whether in such "guidance cases" it should factor in and so expressly deal with the view of the judge (of the FtT or the Upper Tribunal) giving permission to appeal that the case is a "guidance case" (para.4).