

The Legal Aspects of the Mental Health Care of Adolescents

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Summary

This thesis examines the complex legal framework for admission to hospital and treatment for mental disorder of adolescents, an area of potential overlap between different laws for the protection of individuals, including mental health legislation, the Children Act 1989 and the common law. There is uncertainty about the meaning and application of concepts central to determining which of these respective legal routes will apply.

The legal routes are mapped out and analysed through a 'human rights lens', based on the European Convention on Human Rights, the UN Convention on the Rights of the Child and the UN Convention on the rights of Persons with Disabilities. This compares each of the possible legal bases for intervention and the extent to which each takes into account the views of the adolescent ('the wishes versus welfare dynamic') and complies with relevant human rights standards.

The human rights focus demonstrates how the law should operate, concluding that:

The compulsory treatment provisions of the Mental Health Act 1983 do not comply with the ECHR.

In human rights terms, the wishes of adolescents are central to decisions made on grounds of their welfare. It is not clear how the courts determine the 'best interests' of the adolescent, which is the basis on which they decide whether to override adolescents' refusal of health care interventions (including psychiatric care).

Adopting the Committee on the Rights of the Child's approach to the best interests of the child and following the guidance in the MHA Code of Practice would ensure greater regard for the views of adolescents and require clearer justification why welfare concerns should override their wishes.

Parental consent can authorise the in-patient psychiatric care of adolescents aged under 16 in circumstances which, if they were adults, would be a deprivation of liberty. Greater safeguards are required to ensure that the rights of under-16s are protected.

Candidate statements

I declare that this thesis is the result of my own independent work/investigation, except where otherwise stated. Other sources are acknowledged by explicit reference. The views expressed are my own.

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Declaration of interest

The author worked as a consultant to the Department of Health in relation to the revision of the children and young people's chapter (Chapter 19) of the Mental Health Act 1983 Code of Practice 2015.

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CHAPTER 1: INTRODUCTION

INTRODUCTION

There appears to be general agreement that the law relating to the treatment of children suffering from mental disorder is in need of clarification. The current multiplicity of legal provision creates a climate of uncertainty, professionals are unsure of their authority and of the legal and ethical entitlements of children in their care.

Report of the Expert Committee, *Review of the Mental Health Act 1983*, November 1999 ('the Richardson report')¹

The 'climate of uncertainty' and the need for clarity in this area of law identified by the Richardson report over 15 years ago, forms the context and impetus for this thesis. Historically, the legal framework for the admission to hospital and treatment of mental disorder of children and young people aged under 18 years has fallen between two legal specialisms, namely mental health law and family law. Accordingly, lawyers with an expertise in mental health law may have little experience of family law and *vice versa*.² Furthermore, initially the question of how the European Convention on Human Rights (ECHR) which has been incorporated into national law by virtue of the Human Rights Act (HRA) 1998,³ applies to the psychiatric care of under 18s received little attention.⁴ However, as discussed in detail in the following chapters, this is beginning to change in the light of recent case-law.

This thesis examines the legal framework for adolescents' admission to hospital and treatment for mental disorder ('adolescent psychiatric care'). It uses the term 'adolescent'

¹ Department of Health, para. 13.1. The Committee, commissioned by the Department of Health to advise on the reform of the Mental Health Act (MHA) 1983, was chaired by Professor Genevra Richardson.

² For a notable exception, see A Harbour, *Children with Mental Disorder and the Law: A Guide to Law and Practice*, (JKP 2008).

³ The United Kingdom maintains a 'dualist' legal system meaning that legislation is needed to make a treaty part of national law; hence the need for the Human Rights Act (HRA) 1998 to incorporate the European Convention on Human Rights into UK law. See *R(SG) v Secretary of State for Work and Pensions* [2015] UKSC 16; 1 WLR 1449, [235]-[257] (Lord Kerr).

⁴ Notable exceptions being R Sandland, 'Children, Mental Disorder, and the Law' in L Gostin, P Bartlett, P Fennell, J McHale and R MacKay (eds), *Principles of Mental Health Law and Policy* (OUP 2010); J Fortin, *Children's Rights and the Developing Law*, (3rd edn, Cambridge University Press 2009) and P Fennell, *Mental Health: Law and Practice* (2nd ed, Jordans 2011).

to include young people (aged 16 and 17) as well as children (under 16 years⁵) who have reached an age and/or level of maturity when they may be able to make their own health care decisions. Its purpose is to identify the areas of uncertainty and how they might be resolved. To do so this thesis examines the legal framework for adolescent psychiatric care through a 'human rights lens' which reflects relevant international and European human rights standards, including the ECHR. Its threefold approach, which is explained in more detail in Part 2 is outlined below.

First, it focuses on the legal basis for adolescents' admission to hospital or treatment for mental disorder. This is to pinpoint the circumstances in which the non-consensual psychiatric care of adolescents is justified under national law, thereby clarifying how the law should be applied.

Secondly, it highlights the importance of taking the adolescent's views into account when determining whether taking action without the adolescent's consent is justified - thus engaging 'the wishes versus welfare dynamic'. This reflects 'the wishes versus welfare dynamic', a term that describes the tension that can arise between the imperative to protect the adolescent's welfare (in the case of adolescent psychiatric care, by admission to hospital and treatment for mental disorder⁶) and the importance of seeking the views of the adolescent, with the recognition that the adolescent's wishes (whether expressed verbally, or otherwise) may not accord with the proposed welfare-orientated action.

Such emphasis on the views of the adolescent reflects a common theme across the spectrum of human rights standards that is equally relevant to adolescent psychiatric care. Even if not determinative of the outcome and irrespective of their ability to make the decision in question, where an intervention such as admission to hospital or treatment for mental disorder is proposed, the views of the person concerned is an essential factor in the decision-making process.⁷ For adolescents, this is underpinned by the concept of the 'evolving capacities of the child', which is a core principle of two significant United Nations human rights treaties, namely the UN Convention on the Rights of the Child (UNCRC)⁸ and the UN Convention on the Rights of Persons with

⁵ The terms 'minor(s)' (see Family Law Reform Act (FLRA) 1969 s 12) and 'under 18s' are used when referring to under 18s of any age.

⁶ While there may be circumstances in which the objective of protecting the public from harm may be a justification for children and young people's admission to hospital and/or treating for mental disorder, this thesis is concerned with actions to protect the adolescent's welfare.

⁷ See for example, United Nations Convention on the Rights of the Child (UNCRC) art. 12 and United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) art 12.

⁸ UNCRC art 5 and UNCRPD art 3(h).

disabilities (UNCRPD). This concept ‘implies a transfer of responsibility for decision-making from responsible adults to children, as the child acquires the competence, and of course willingness, to do so’.⁹ It therefore highlights another important aspect of this area of law, namely the circumstances in which parental consent can authorise the adolescents’ admission to hospital and treatment for mental disorder.

Thirdly, to identify any shortfall between them, the human rights lens is used to compare the situations in which national law permits non-consensual adolescent psychiatric care with relevant human rights standards.

Accordingly, this thesis explores whether analysing the legal framework for adolescent psychiatric through such a human rights lens can help to clarify how this area of law should operate, elucidate any areas of potential uncertainty or other areas of concern and identify how such concerns might be addressed.

This thesis is premised on three linked assertions, which are explained below.

(1) The ‘climate of uncertainty’ in this area of law persists.

The legal framework for adolescent psychiatric care is renowned for being complex¹⁰ and confusing.¹¹ Sandland describes this area of law as ‘a complex weave of ideas, principles, and frameworks, articulated through a variety of primary and secondary legislation, guidance, codes of practice and case law’.¹² The development of law since the Richardson report in 1999 has added further layers of complexity, as illustrated by the 2015 *Mental Health Act 1983: Code of Practice* (the MHA Code 2015).¹³ This advises practitioners responsible for the care of children and young people in hospital that, in addition to the Mental Health Act (MHA) 1983, they should be familiar with the Children Acts of 1989 and 2004, the Mental Capacity Act (MCA) 2005 and the Human Rights Act (HRA) 1998, as well as relevant case-law.¹⁴

⁹ G Landsdown on behalf of the UNICEF Innocenti Research Centre, *The Evolving Capacities of the Child* (Save the Children and UNICEF 2005) 4.

¹⁰ That this legal framework ‘is complex’ is noted at *The Mental Health Act 1983 – Code of Practice* (1999) Department of Health and Welsh Office, para 29.3.

¹¹ J Fortin, *Children’s Rights and the Developing Law* (3rd edn, Cambridge University Press 2009) 170.

¹² Sandland (n 4) para 18.01.

¹³ Department of Health *Mental Health Act 1983: Code of Practice* (2015). This Code applies to England and came into force in April 2015.

¹⁴ MHA Code 2015 (n 13) para 19.4.

As Bainham notes, the situation for 16 and 17 year olds is further complicated given that they occupy what he describes as ‘a legal “Twilight Zone” between minority and adulthood’.¹⁵ However, whether the adolescent is a young person aged 16 or 17, or a child aged under 16, complex legal issues can arise when that adolescent’s wishes are perceived by others (adults) to be in conflict with his or her welfare. Hence the term ‘adolescent(s)’ is used to avoid the need to set an arbitrary lower age limit for children who may be able to make decisions for themselves (thereby falling within the scope of this thesis), while distinguishing between such children and the specific issues concerning parental decision-making in relation to very young children (which fall outside the scope of this thesis).¹⁶

Although recent developments in law and policy have clarified aspects of the legal framework for adolescent psychiatric care, uncertainties remain.

(2) The underlying cause of the uncertainty is that three ‘drivers for protection’ converge in this area of law.

Adolescents in need of psychiatric care potentially belong to three groups of people for whom the law permits non-consensual interventions where such interventions are considered necessary for their protection. Thus, even if an adolescent presents no risk of causing harm to others, action can be taken without the adolescent’s consent to protect his or her welfare.

First, an adolescent’s status as a minor (in other words the adolescent is a ‘child’ for the purpose of the Children Act (CA) 1989¹⁷) means that in certain circumstances either the adolescent’s parents, or the courts, can make decisions on the adolescent’s behalf, in the adolescent’s best interests.

Secondly, if the adolescent lacks capacity as defined under MCA 2005 (and is aged 16 or 17), decisions may be made on the adolescent’s behalf in his or her best interests in accordance with that Act.

¹⁵ A Bainham, *Children Parents and the State* (Modern Legal Studies), (Sweet and Maxwell, 1988), 63.

¹⁶ In relation to younger children see J Bridgeman, *Parental Responsibility, Young Children and Healthcare Law*, (Cambridge University Press 2007).

¹⁷ Children Act (CA) 1989 s 105.

Thirdly, if the adolescent has a mental disorder, the criteria for detention in hospital and compulsory treatment under the MHA 1983 may apply. Adolescents may be subject to such compulsory powers in the interests of their own health, or safety, or for the protection of others.

These three 'drivers for protection' (minority, mental incapacity and mental disorder) underpin the legal authority for the admission to hospital and treatment for mental disorder of adolescents without their consent. They provide the key to understanding how this area of law operates. That there are three possible grounds upon which the law permits the non-consensual psychiatric care explains why there are various potential legal routes by which an adolescent's psychiatric care can be authorised and hence why this area of law is regarded as being complex and confusing.¹⁸ However, closer analysis, reveals that the legal routes flowing from the drivers of protection are separate and distinct, while the extent to which they overlap is minimal and likely to have little practical impact. This is due to two crucial points.

- a) The drivers for protection are merely the precursor for taking action without the adolescent's consent. Neither the presence of a mental disorder, an assessment of a lack of mental capacity, nor the minority status of an adolescent are in themselves sufficient to authorise non-consensual adolescent psychiatric care. The circumstances in which the law permits non-consensual adolescent psychiatric care on the basis of the adolescent's minority differs from the circumstances in which it would be authorised on the basis of the adolescent's mental disorder, which again differs from the circumstances authorising an intervention on the basis of an adolescent's mental capacity. Which legal route is applicable will depend on the circumstances relevant to the particular adolescent.
- b) There is a process for determining the appropriate legal route. By virtue of section 131 of the MHA 1983, individuals can be admitted to hospital 'informally', without the use of that Act's compulsory admission procedures. Moreover, an important

¹⁸ That there is an inter-relationship between these differing legal routes which creates 'what may be regarded as the conflicts between the current law, current clinical practice and the child's human rights' was noted by A Harbour, S Bailey and W Bingley 'Children's consent to medical treatment' (2000) *The Psychiatrist* 24(5) 196.

principle of the MHA 1983 is that its powers of compulsory admission and treatment are measures of 'last resort'.¹⁹

Thus, the first consideration should be whether the adolescent can be admitted to hospital and treated informally without recourse to the compulsory powers under the MHA 1983 (commonly referred to as being 'sectioned').²⁰ This might be because, where willing and able to do so, the adolescent has consented to the proposed admission to hospital and treatment for mental disorder. Alternatively, in some cases it might be possible for such interventions to be authorised by parental consent, or undertaken in accordance with the MCA 2005.

Only if informal admission and treatment is not appropriate will it be necessary to consider whether the criteria for detention under the MHA 1983 are met. An application to the court (whether to the High Court, which has powers in relation to under 18s, or the Court of Protection which can make orders in accordance with the MCA 2005) will only be necessary if the MHA 1983 is not applicable.

To identify which of the potential legal routes provides the requisite authority for an adolescent's admission to hospital and treatment for mental disorder therefore requires an understanding of the limits inherent in the laws that permit non-consensual interventions on the basis of an adolescent's minority, mental incapacity or mental disorder. This leads to the third premise.

(3) The uncertainty is compounded by a lack of clarity on the meaning and application of concepts key to determining the legal authority for adolescent psychiatric care.

Where such confusion arises, the legal authority for the proposed intervention (the adolescent's admission to hospital or treatment for mental disorder) is unclear.²¹

¹⁹ *R v Bournemouth Community and Mental Health NHS Trust, Ex p. L* (Secretary of State for Health and others intervening) [1999] AC 458; [1998] 3 All ER 289.

²⁰ MHA Code 2015 (n 13) sets out the framework for informal admission of under 18s – see Chapter 19. The provisions of MHA 1983 s131 are discussed in more detail in chapters 2 and 6.

²¹ The lack of clarity on concepts that are central to the law on consent to treatment for adolescents generally is highlighted by practitioners and academics; see for example J Tan and D Jones 'Children's consent' in (2001) *Curr Opin Psychiatry* 14: 303 who note (at 303) that there is 'considerable confusion in the current definitions and the issues involved in the area of children's consent' and S Gilmore and J Herring "'No" is the hardest word: consent and children's autonomy' [2011] *CFLQ* 3: 'One recurring theme in this article is the use of terminology and legal categories: consent; refusal of treatment; capacity, lack of capacity:

Such uncertainty risks infringing adolescents' human rights, in particular, those concerned with the protection of liberty²² and respect for personal autonomy and physical integrity.²³

The most marked area of uncertainty relates to the circumstances in which parental consent can be relied upon to authorise their child's admission to hospital and psychiatric treatment. The decision in *Trust A v X (A Child)*²⁴ suggests that parents can consent to extensive restrictions placed on adolescents aged under 16 who are unable to make such decisions for themselves. As a result, whereas the non-consensual in-patient psychiatric care of adolescents aged 16 and 17 is likely to be governed by the MHA 1983, adolescents aged under 16 who are unable to make decisions about such care for themselves can be admitted to hospital and treated for mental disorder on the basis of parental consent and therefore without the safeguards that would be available to them if they had been 'sectioned' under the MHA 1983.

Accordingly, there is a significant gap in the protections available to adolescents aged under 16 who are in need of in-patient psychiatric care. For the reasons explored in this thesis, this gap has arisen due to the lack of clarity on the meaning of 'the scope of parental responsibility' and 'deprivation of liberty' and how these concepts relate to each other. Moreover, the thesis identifies uncertainties arising from the law's approach to assessing adolescents' ability to make decisions for themselves. Given that the concept of 'decisional capacity' is a key factor in determining whether an adolescent can be admitted on the basis of parental consent, this is also a significant concern.

To analyse the legal framework for adolescent psychiatric care through a human rights lens, this thesis:

- (1) Charts the various potential legal routes for adolescents' admission to hospital and treatment for mental disorder. This is to identify the circumstances in which national law permits such interventions with, and without, the adolescent's

autonomy. The use of such tools is common in legal analysis. However, they carry dangers and require careful use (as many tools do)'.
²² International Covenant on Civil and Political Rights (ICCPR) art. 9 and European Convention on Human Rights (ECHR) art. 5.

²³ *YF v Turkey* 39 EHRR 34, para 33: 'a person's body concerns the most intimate aspects of private life'.

²⁴ *Trust A v X (A Child)* [2015] EWHC 922 (Fam), [2016] 3 WLR 1401.

consent and the concepts that are key to determining which legal route is applicable.

- (2) Explores the legal basis on which adolescents can consent to their admission to hospital and treatment for mental disorder and the circumstances in which their refusal of such psychiatric care can be overridden. This entails consideration of what is meant by 'adolescent autonomy' and the legal tests for assessing whether adolescents are able to make decisions for themselves.
- (3) Considers three scenarios of non-consensual adolescent psychiatric care, namely:
 - a) the powers of the High Court to override an adolescent's refusal of life-saving treatment;
 - b) the compulsory powers under the Mental Health Act (MHA) 1983 to admit and treat individuals for their mental disorder;
 - c) the circumstances in which adolescents who are assessed as being unable to make decisions for themselves can be admitted to hospital for psychiatric care without their consent.

For each of these scenarios the following 'human rights decision-making questions' are considered:

- i. the basis on which non-consensual adolescent psychiatric care is justified under national law ('the justification question');
 - ii. the extent to which this takes into account the wishes of the adolescent ('the wishes versus welfare question'); and
 - iii. how this compares to human rights standards ('the human rights comparison question').
- (4) Highlights, in the light of the above, the following:
 - a) areas that might give rise to uncertainty about how the law operates, such as: key concepts that are unclear, misunderstood and/or misapplied; where the legal routes for adolescent psychiatric care overlap; and any gaps in the law;
 - b) the human rights implications of the concerns raised.

- (5) Makes recommendations to address the concerns identified and areas in which further research is required.

This thesis is concerned with the basis on which adolescents can be lawfully admitted to hospital and treated for mental disorder rather than seeking to provide a comprehensive analysis of all issues affecting adolescents who are subject to compulsory care. For the same reason, the potential means of challenging the use of compulsory powers, which might include age and/or disability discrimination²⁵ fall outside the scope of the analysis. Furthermore, while there are circumstances in which domestic law permits non-consensual interventions to prevent individuals from causing harm to others, this thesis focuses on the circumstances in which psychiatric interventions are deemed necessary to protect the adolescent's welfare.

Given that there are now significant differences between the laws of England and the laws of Wales, including the legal framework for adolescent psychiatric care,²⁶ this thesis focuses on law and policy relating to England (albeit, where helpful to do so, references to other jurisdictions are made by way of comparison).

The rest of this chapter is set out in three parts. Part 1 provides an overview of the legal framework for adolescent psychiatric care. Part 2 explains why and how the legal framework will be considered from a human rights perspective. Part 3 sets out the structure of the thesis.

PART 1: ADOLESCENT PSYCHIATRIC CARE: OVERVIEW OF THE LEGAL LANDSCAPE

The MHA 1983, together with the MHA Code 2015 set out the circumstances in which individuals of any age, with a 'mental disorder', can be compulsorily admitted to hospital, detained there, and treated without their consent. The MHA Code 2015 is significant in this regard in that it provides 'statutory guidance' to mental health professionals 'on how they should proceed when undertaking duties under the Act'.²⁷ Its importance was emphasised by the House of Lords in *R (Munjaz) v Mersey Care National Health Service*

²⁵ European Convention on Human Rights (ECHR) art. 14.

²⁶ For example, Wales has a separate Code of Practice to the Mental Health Act 1983.

²⁷ MHA Code 2015 (n 13), 12.

Trust, which noted that although the MHA Code is only guidance, it should be given great weight and should only be departed from if there are ‘cogent reasons for doing so’.²⁸ Since then, the MHA 1983 has been amended so that those working under this Act ‘shall have regard to the code’.²⁹

The first edition of the Code of Practice to the MHA 1983 was published in 1990, the MHA Code 2015 being the fourth revision since then. Given its significance, the MHA Code 2015, and where relevant earlier versions of the Code will be referred to throughout this thesis. However, it should be noted that while the MHA Code 2015 is intended to provide guidance on the implementation of the MHA 1983, concerns have been raised about the scope of such guidance, such as that it further complicates matters by introducing supplementary legal standards to that of the Act, thereby creating ambiguities over which standards to be applied³⁰ and that it provides ‘support for coercive interventions which find no mention in the [MHA 1983]’.³¹

A summary of the differing legal routes to hospital admission and treatment for mental disorder is set out below. This is followed by consideration of the concepts that are identified as being key to determining the basis on which an adolescent can be admitted to hospital and treated for mental disorder.

1.1 Mapping the legal framework for adolescent psychiatric care

While they are separate decisions, and the rules for authorising adolescents’ admission to hospital differ to some degree from those authorising medical treatment, the underlying basis on which they can be admitted to hospital and/or treated on an informal basis are the same. It adopts the approach taken by the MHA Code 2015, the summary refers to adolescents aged under 16 as ‘children’ and those aged 16 and 17 years as ‘young people’. This is because whereas the CA 1989 defines a ‘child’ as under 18,³² the

²⁸ *R (Munjaz) v Mersey Care National Health Service Trust* [2005] UKHL 58; [2006] AC 148; [21].

²⁹ Mental Health Act (MHA) 1983 s 118(2D). The MHA Code 2015 (n 13) has also been issued under the Local Authorities and Social Services Act 1970 s7 which relates to the exercise of social services functions. See L Clements, *Community Care and the Law* (Legal Action Group 6th ed 2017) paras 1.44-1.50, for the status of guidance issued under this provision.

³⁰ P Bartlett and R Sandland *Mental Health Law Policy and Practice* (3rd ed OUP 2007) 30.

³¹ P Fennell, ‘Mental Health Law: History, Policy and Regulation’ in Gostin (2010) (n 4) paras 1.158 and, 1.164. See also discussion in R Jones *Mental Health Act Manual* (Sweet and Maxwell 19th ed 2016) 523 – 525.

³² Children Act (CA) 1989 s 105.

rules relating to the admission to hospital and treatment for 'mental disorder' of these two age groups differ significantly.³³

- a. *Consent*: adolescents may be able to consent to their admission to hospital and/or treatment for mental disorder.

Young people: Section 131(3) of the MHA 1983 provides that 16 and 17 year olds with capacity can decide for themselves whether they wish to agree to their admission to hospital. Section 8(1) of the Family Law Reform Act (FLRA) 1969 provides that adolescents can consent to their own medical treatment. The MCA 2005 applies to young people aged 16 and 17 so that, like adults, they are presumed to have the capacity to make such decisions,³⁴ unless established otherwise.³⁵

Children: In contrast, the starting point for children under the age of 16 is that they are not able to make decisions for themselves.³⁶ However, the MHA Code 2015 states that children who are 'Gillick competent'³⁷ and who consent to their admission and/or treatment can consent to their admission to hospital and/or medical treatment.³⁸ The MHA Code 2015 explains that a child who is 'Gillick competent' has been assessed as having 'sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention' is regarded as being competent to make that decision.³⁹

Thus, crucial to the question whether an adolescent can consent to the proposed admission to hospital and/or treatment, is whether that adolescent has the 'decisional capacity' to do so. (The term 'decisional capacity' is used

³³ National Institute for Mental Health in England *The Legal Aspects of Children with Mental Disorder: A Guide for Professionals* 2009, para 2.8.

³⁴ MHA 1983 s. 131(4) provides that 'the reference to a patient who has capacity is to be read in accordance with the Mental Capacity Act (MCA)2005'.

³⁵ If there are concerns that a young person lacks capacity, this should be assessed in accordance with the MCA 2005 (ss 2 and 3). The MCA 2005 is considered in Chapter 3.

³⁶ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 [1985] 3 WLR 830 HL.

³⁷ The term was coined during the legal arguments before the Court of Appeal in *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11, [1991] All ER 177, CA, 23.

³⁸ MHA Code 2015 (n 13), para 19.65.

³⁹ MHA Code 2015 (n 13), para 19.34.

to cover the legal tests of *Gillick* competence (for adolescents aged under 16) and mental capacity under the MCA 2005 (for adolescents aged 16 or 17).)

- b. *Parental consent*: parents may consent to such interventions on behalf of their child.⁴⁰ However, this is subject to two provisos.

The first is that the decision must fall within the 'scope of parental responsibility'. Guidance on this concept is provided in the MHA Code 2015.⁴¹

The second is that parental consent is not to be relied upon in cases where the adolescent has decisional capacity and refuses the admission and/or treatment. In relation to the admission to hospital of adolescents aged 16 or 17, section 131(4) of the MHA 1983, provides that parents cannot override the decision of an adolescent who has the mental capacity to make that decision. The MHA Code 2015 advises against relying on parental consent to override such an adolescent's refusal of treatment.⁴² In relation to under 16s who are *Gillick* competent, the MHA Code states that 'it is not advisable to rely on the consent of a parent with parental responsibility to admit or treat a child who is competent to make the decision and does not consent to it'.⁴³

Thus, when considering whether parental consent can be relied upon to authorise the intervention without the adolescent's consent, the two key considerations are a) whether the adolescent has 'decisional capacity', and b) whether the decision falls within 'the scope of parental responsibility'.

- c. *Mental Capacity Act (MCA) 2005*: the admission to hospital and/or medical treatment may be authorised in accordance with the MCA 2005, in relation to adolescents who are aged 16 or 17 and lack capacity as defined under this Act; provided that the intervention does not amount to a 'deprivation of liberty'.

⁴⁰ See for example *Gillick* (n 36). The term 'parent' is used to refer to those individuals with 'parental responsibility' (defined in the Children Act (CA) 1989, s 3) which will usually, but not always be the parents of the adolescent – this is explained in the MHA Code 2015 (n 13) para 19.7). For a discussion on the qualifications on parental rights see N Lowe *Parental Responsibilities – England and Wales National Report*, Center for International Family Law Studies < <http://ceflonline.net/wp-content/uploads/England-Parental-Responsibilities.pdf> > accessed 30 October 2017, 11.

⁴¹ MHA Code 2015 (n 13) paras 19.38-19.42.

⁴² MHA Code 2015 (n 13), para 19.59.

⁴³ MHA Code 2015 (n 13), para 19.39

Thus, the key considerations when seeking to rely on the MCA 2005 to authorise in-patient psychiatric care without an adolescent's consent are: a) to establish that the adolescent lacks the mental capacity to make the decision in question (as defined in sections 2 and 3); b) that the proposed intervention is in the adolescents best interests (determined in accordance with section 4); and c) that the proposed intervention falls within the scope of the 'acts in connection with the care and treatment' of the adolescent (these are set out in sections 5 and 6 and are referred to as 'the general provisions of the MCA 2005'). Crucially, this third point means that if the intervention amounts to a deprivation of liberty it would not be possible to admit and/or treat the adolescent on an informal basis. Whereas the MCA 2005 includes provisions that permit the deprivation of liberty of individuals (known as Deprivation of Liberty Safeguards DoLS) these do not apply to under 18s.⁴⁴ Accordingly, it will not be possible to rely on the MCA 2015 where the psychiatric care of an adolescent gives rise to a deprivation of liberty unless it is authorised by the Court of Protection.⁴⁵

- d. *Mental Health Act (MHA) 1983*: this Act, which applies to individuals of any age, may authorise such interventions where adolescents have a mental disorder (as defined in section 1) and other relevant criteria are met. In relation to admission to hospital, the relevant criteria for admission under Part II of the Act must be met. Although the criteria differ between the two main provisions for detention under the Act (sections 2 and 3), in essence, they require that the person has a mental disorder of a nature or degree that warrants his or her detention and that detention in hospital is necessary in the interests of the person's health or safety, or the protection of others. Individuals detained under the Act can be treated for mental disorder without their consent if this is authorised under Part IV of the Act.
- e. *Court order*: the MHA Code 2015 advises that if the adolescent cannot be admitted to hospital and/or treated on an informal basis and the criteria for detention under the MHA 1983 are not met 'legal advice should be obtained on whether to seek the assistance of the High Court' while also noting that

⁴⁴ Mental Capacity Act (MCA) 2005 4A(5); Schedule A1, para 13.

⁴⁵ MHA Code 2015 (n 13), para 19.52.

‘the Court of Protection can make a deprivation of liberty order in respect of young people aged 16 and 17’.⁴⁶

It is evident from the above summary of the legal framework for adolescent care that the concept of decisional capacity (this term embracing the concept of *Gillick* competence and ‘mental capacity’ as defined in the MCA 2005) is pivotal to ascertaining the appropriate legal route for an adolescent’s admission to hospital and medical treatment.

Significantly, given section 131 of the MHA 1983 and the guidance in the MHA Code 2015, it will not be possible to admit or treat an adolescent informally if the adolescent has decisional capacity and is refusing the proposed intervention. In such cases, consideration would need to be given as to whether the criteria under the Act are met. However, the MHA Code 2015 advises that treatment can be given to an adolescent who is refusing medical treatment if ‘the failure to treat the child or young person would be likely to lead to their death or to severe permanent injury’ and there is no time to detain and treat under the MHA 1983 or seek a court declaration.⁴⁷

1.2 The Legal Framework for Adolescent Psychiatric Care: Key Concepts

The above summary of the potential legal routes for adolescent psychiatric care illustrates the complexity of this area of law. It also identifies that the following concepts are central to determining the legal basis for adolescent psychiatric care:

- i. an adolescent’s *consent* can provide sufficient authority for the admission to hospital and/or treatment for mental disorder;
- ii. the adolescent must have the *decisional capacity* to give such consent;
- iii. parental consent can only be relied upon if the adolescent lacks decisional capacity and the decision (to admit to hospital or to treat for mental disorder) falls within the *scope of parental responsibility*;

⁴⁶ MHA Code 2015 (n 13), para 19.52.

⁴⁷ MHA Code 2015 (n 13), para. 19.71, which makes clear (at para 19.72) that the action taken is to address the emergency situation so that ‘[o]nce the child or young person’s condition is stabilised, legal authority for on-going treatment must be established’. Fennell, *Mental Health Law and Practice* (n 4) notes (para 11.39) that ‘the circumstances where emergency treatment without recourse to the Mental Health Act of the courts would be justified will surely be extremely exceptional’.

- iv. the general provisions of the MCA 2005 cannot be relied upon if the admission to hospital or the treatment for mental disorder gives rise to a *deprivation of liberty*;
- v. the compulsory powers under the MHA 1983 can only be engaged if the adolescent has a *mental disorder* and the relevant criteria for detention and treatment without consent are met; and
- vi. the court must determine whether the proposed admission to hospital and/or treatment is in the adolescent's *best interests*.

These concepts are considered in the following chapters, when examining the differing legal routes for adolescent psychiatric care. As noted above, the confusion over the meaning and application of 'decisional capacity', 'deprivation of liberty' and 'the scope of parental responsibility' is of particular concern.

One possible cause for confusion over concepts might be because terms used in relation to adults with apparent clarity and consensus on their meaning, such as 'capacity' and 'deprivation of liberty', do not apply in the same way to adolescents. Another cause for confusion might be that relevant concepts fall outside the decision-maker's professional lexicon. For example, Approved Mental Health Professionals (AMHPs) who have a crucial role in determining whether individuals should be detained in hospital under the MHA 1983, may not be familiar with concepts that apply to adolescents, such as 'the scope of parental responsibility'.⁴⁸ In a similar vein, the terminology used might differ between the professionals involved in the adolescent's care. For example, a common (misplaced) view is that when referring to a child's ability to decide about matters relating to their health care, the term '*Fraser's guidelines*' should be used and that it is incorrect to refer to '*Gillick competence*'.⁴⁹ While the use of differing terminology is not in itself a problem, it will be if it creates confusion as to what criteria should be applied when assessing an adolescent's decisional capacity,⁵⁰ or causes conflict between the professionals involved thereby affecting the process for determining the appropriate legal route to authorise the adolescent's psychiatric care.

Identifying the legal authority for an adolescent's psychiatric care may be further complicated by the cognitive dissonance⁵¹ engendered by the potential application of the

⁴⁸ CA 1989 s 3.

⁴⁹ R Wheeler, 'Gillick or Fraser? A plea for consistency' BMJ 2006;332:807.

⁵⁰ The concept of *Gillick competence* is discussed in Chapter 3.

⁵¹ Defined in Collins Dictionary of the English Language 1986 (2nd ed.) as 'an uncomfortable mental state resulting from conflicting cognitions'. The theory of cognitive dissonance, developed by Leon Festinger in 1957, is outlined by E Harmon-Jones and J Mills 'An

MHA 1983. For example, even though incorrect, a concern often cited as a reason for not applying the MHA 1983 in relation to under 18s, is that anyone who has been detained this Act will be prohibited from visiting the United States of America.⁵² Moreover, in the past, there has been a reluctance to use the MHA 1983 in relation to children and young people, on the basis that this would stigmatise them⁵³ That there is a stigma to 'being sectioned' remains a matter of concern for some practitioners⁵⁴ and is also expressed from time to time by both the courts⁵⁵ and the Government.⁵⁶ However, while its stigmatising effect is regarded as a significant reason for not using the MHA 1983 for adolescents, as a 2003 study published by the Royal College of Psychiatrists observed '[h]ow this stigma is manifest and what its effects are unclear'.⁵⁷

The extent to which confusion over key concepts and other matters such as attitudes towards using the MHA 1983 in respect of under 18s, hinders the process for determining the appropriate legal authority for an adolescent's psychiatric care requires further investigation through empirical research of which there has been little to date. In a rare example of such work, the Royal College of Psychiatrists' study, which undertook a survey of psychiatrists on the use of the use of legislation to detain adolescents with mental health problems, noted that this is an under-researched area.⁵⁸ Whereas its recommendation that further research is undertaken in this area was not followed up,

Introduction to Cognitive Dissonance Theory and an Overview of Current Perspectives on the Theory' in *Cognitive dissonance: progress on a pivotal theory in social psychology* (American Psychological Association 1999).

⁵² See: R Hurrell, B Di Mambo & G Doody 'Impact of compulsory detention under the Mental Health Act 1983 on future visa and insurance applications' (2011) *The Psychiatrist* 35, 5.

⁵³ See Joint Committee on the Draft Mental Health Bill *Draft Mental Health Bill* (2004-5 HL Paper 79-1, HC 95-1) para 212, that if the relevant provisions of the draft Bill applied to 16 and 17 year olds 'there is no way they can avoid the process and stigma of compulsory treatment'.

⁵⁴ M Bowers and B Dubicka 'Legal dilemmas for clinicians involved in the care and treatment of children and young people with mental disorder' (2009) in *Child Care, Health and Development*, 36(4) 595. See also F Akerele *Adolescent decision-making and the zone of parental control: a missed opportunity for legislative change* (2014) *Advances in Psychiatric Treatment* 20:144, 148 and N Evans 'Child Psychiatry, mental disorder and the law: is a more specific statutory framework necessary?' (2004) *BJP* 184(1), 1.

⁵⁵ *AM v South London and Maudsley NHS Foundation Trust* [2013] UKUT 365 (AAC) paras 65 & 66.

⁵⁶ *AM v SLAM* (note 55) and *HL v the United Kingdom* (2005) 40 EHRR, para 80.

⁵⁷ Royal College of Psychiatrists 'An evaluation of the use of the Children Act 1989 and the Mental Health Act 1983 in Children and Adolescents in Psychiatric Settings (CAMHA-CAPS)' 2003 < www.rcpsych.ac.uk/pdf/CAMHA-CAPS%20report%20for%20NIMHE.pdf > accessed 30 October 2017, 10. See also J Tan and D Jones, (n 22) 306 who note that 'a review of the literature shows a dearth of articles and empirical work in the area of children's consent and mental illness'. For a discussion on the attitudes of professionals on how to approach the refusal of medical treatment by adolescents, see C Johnston, 'Overriding competent medical treatment refusal by adolescents: when "no" means "no"', (2009) *Arch Dis Child* 94(5) 487.

⁵⁸ Royal College of Psychiatrists (n 57) 19.

observations made by legal commentators,⁵⁹ practitioners⁶⁰ and policy-makers⁶¹ suggest that in the past the preferred legal route for an adolescent's in-patient psychiatric (albeit less so for 16 and 17 year olds⁶²), was to rely on parental consent, with judicial rulings supporting such an approach.⁶³ In this regard, the Royal College of Psychiatrists' study noted that notwithstanding the anxiety expressed by professionals about the stigma that might be caused in doing so, the MHA 1983 was routinely used, whereas the more contentious question was under what circumstances the MHA 1983 should be used and when to rely upon parental consent.⁶⁴

PART 2: THE LEGAL FRAMEWORK FOR ADOLESCENT PSYCHIATRIC CARE THROUGH A HUMAN RIGHTS LENS

Set out below is an overview of the reasons for analysing the legal framework for adolescent psychiatric care through a human rights lens. This is followed by an explanation of the issues falling within the three 'human rights decision-making questions' that are applied in the subsequent chapters when examining the circumstances in which the law permits non-consensual adolescent psychiatric care.

2.1 The ECHR and the wider human rights landscape

Analysing the legal framework for adolescent care from a human rights perspective is merited on two counts. First, notwithstanding the uncertainty about its future,⁶⁵ the HRA

⁵⁹ See for example, Fortin (n 4), 172.

⁶⁰ See for example, S Wolley, 'The limits of parental responsibility regarding medical treatment decisions (2009) Arch Dis Child, 96(11) 1060; Bowers and Dubicka (n 54); F Akerle, 'Adolescent decision-making and the zone of parental control: a missed opportunity for legislative change' (2014) APT 20, 144.

⁶¹ Joint Committee on the Draft Mental Health Bill *Draft Mental Health Bill* (2004-05 HL 79-1, HC 95-1) para 206.

⁶² T Ford and A Kessel, 'Feeling the way: childhood mental illness and consent to admission and treatment' (2001) BJP 179(5) 384 state that reflecting current clinical practice and human rights theory 'few child psychiatrists would be willing to use parental authority alone to override the wishes of a competent 16 year old'. See also Akerle (n 60). As discussed below, this is now reflected in the MHA 1983 and MHA Code 2015 (n 13).

⁶³ See for example, *Re K, W and H* [1993] 1 FLR 854.

⁶⁴ Royal College of Psychiatrists (n 57) 73.

⁶⁵ The Conservative manifesto stated that it would 'scrap the Human Rights Act and introduce a British Bill of Rights' (The Conservative Party, *Strong Leadership, a clear economic plan, a brighter, more secure future: The Conservative Party Manifesto 2015*, 60 <www.conservatives.com/manifesto> accessed 6th July 2016. However, it is not clear when

1998 remains in force so that public authorities (a term that includes local authorities and NHS bodies and the courts) are under a duty to act compatibly with the ECHR unless prevented from doing so by primary legislation.⁶⁶ Given that the ECHR applies to individuals of all ages, those public agencies involved in decisions about an adolescent's psychiatric care must comply with the ECHR.

Furthermore, in the past decisions emanating from the European Court of Human Rights (ECtHR) and the (now defunct) European Commission on Human Rights⁶⁷ (referred to collectively as 'the Strasbourg bodies') have had a huge influence on legal and policy reform,⁶⁸ especially mental health law.⁶⁹ As will be evident in subsequent chapters, such influence has increased considerably in the post-HRA era.

Secondly, international and European human rights standards are of significant to mental health law, policy and practice.⁷⁰ Both the ECtHR and national courts can, and increasingly do, look beyond the ECHR and refer to various human rights treaties and non-binding human rights standards (often referred to as 'soft law'⁷¹) of the Council of

and how it proposes to do so. While this may change under Theresa May's watch as Prime Minister, based upon the government proposals presented to it in early 2016, a parliamentary inquiry noted that 'all the rights contained within the ECHR are likely to be affirmed in any British Bill of Rights' (European Union Committee *The UK, the EU and a British Bill of Rights* (2015-16 HL 139) para 46.

⁶⁶ Human Rights Act (HRA) 1998 s 6.

⁶⁷ J Wadham and others (*Blackstone's Guide to The Human Rights Act 1998* (4th ed OUP 2007), 20) note that this body ceased to exist as from November 1998.

⁶⁸ Fortin *Children's Rights and the Developing Law* (n 11), 56 notes: 'long before it had become part of English law in 2000, the Convention's contents had considerable influence on the development of law here'. JG Merrills, *The development of international law by the European Court of Human Rights* (2nd edn, Manchester University Press, 1993), 12, notes that the ECHR '...the only international Treaty in the history of humankind that guarantees the right of an individual to make a complaint that is capable of resulting in a binding judgment enforceable against a member state'.

⁶⁹ O Thorold, 'The Implications of the European Convention on Human Rights for United Kingdom Mental Health Legislation', [1996] EHRLR Issue 6, 619 at 622.

⁷⁰ Gostin argues that: 'There exist three relationships between mental health and human rights: mental health policy affects human rights, human rights violations affect mental health, and positive promotion of mental health and human rights are mutually reinforcing.' (L O Gostin, (2001) 10 Cambridge Quarterly of Healthcare Ethics, 264, 265.)

⁷¹ Although not legally binding, these instruments provide a guide to States on what action they need to take to comply with their treaty obligations. See M O'Flaherty, *Human Rights and the UN: Practice Before the Treaty Bodies* (2nd edn., Kluwer Law International 2002) 7. E Rosenthal and C Sundram state that the general comments of the UN treaty committees 'represent the official view as to the proper interpretation of the convention' (*International Human Rights and Mental Health Legislation*, (2001-2002) 21 NYLSchL Int'l & Comp L, 469, 482).

Europe (CoE)⁷² and the United Nations (UN)⁷³ to assist in the interpretation of the ECHR.⁷⁴ In *Nada v Switzerland* (2012) the ECtHR ‘reiterates that the Convention cannot be interpreted in a vacuum but must be interpreted in harmony with the general principles of international law’,⁷⁵ a point endorsed by the UK Supreme Court.⁷⁶ Furthermore, the MHA Code 2015 emphasises the importance of commissioners and providers protecting and promoting human rights and ‘putting human rights principles and standards into practice’.⁷⁷ Its list of relevant international conventions, includes the UNCRC and the UNCRPD. Thus, notwithstanding the importance of the ECHR, there is a wider human rights landscape to consider⁷⁸ and for the reasons outlined below these two UN human rights treaties are of particular importance.

The UNCRC is referred to by the ECtHR to assist in its interpretation of the ECHR.⁷⁹ While although not part of English law,⁸⁰ its principles ‘guide domestic law and practice, and are often referred to by the courts when interpreting obligations imposed by human

⁷² Council of Europe, *Report by the Secretary General on the Review of the Council of Europe Conventions*, 16 May 2012, SG/Inf(2012)12 notes (para 7) that since its inception in 1949, the Council of Europe has drawn up over 200 conventions in the three areas of human rights, rule of law and judicial co-operation and democracy. In addition to the European Convention on Human Rights (ECHR) (1950), these include the European Social Charter (1961, revised 1996) (ESC) and the European Convention for the Prevention of Torture or Inhuman or Degrading Treatment or Punishment of 1987 (CPT).

⁷³ The nine core UN human rights treaties are summarised in UN Human Rights Office of the High Commissioner *The United Nations Human Rights Treaty System* Fact Sheet No 30/Rev 1, 2012 < www.ohchr.org/Documents/Publications/FactSheet30Rev1.pdf > accessed 22 April 2017.

⁷⁴ *Demir v Turkey* (2009) 48 EHRR 54 paras 65 – 86; cited in *R (SG) v Secretary of State for Work and Pensions* [2015] UKSC 16; 1 WLR 1449, (2015) [83] (Lord Reed), [116]–[117], [130] (Lord Carnwath), [142] Lord Hughes, [259] Lord Kerr.

⁷⁵ (2013) 56 EHRR 18 GC, para 167.

⁷⁶ The notion of seeking harmony between international human rights instruments was quoted with approval in *ZH (Tanzania) v Secretary of State for the Home Department* [2011] UKSC 4, [2011] 2 AC 166, [21] (Lady Hale) and also in *Mathieson v Secretary of State for Work and Pensions* [2015] UKSC 47, [2015] 1 WLR 3250 [42]–[44] (Lord Wilson, with Lady Hale, Lord Clarke and Lord Reed concurring).

⁷⁷ The MHA Code 2015 (n 13) includes a new chapter (Chapter 3) which emphasises the importance of commissioners and providers protecting and promoting human rights and ‘putting human rights principles into practice’ (para. 3.3).

⁷⁸ L Clements and J Read, *Disabled People and European Human Rights: A review of the implications of the 1998 Human Rights Act for disabled children and adults in the UK* (The Policy Press, 2003), 17, note that the ‘principle source of inspiration’ of our contemporary understanding of human rights is United Nations Universal Declaration of Human Rights of 1948, which sets out a range of civil, cultural, economic, political and social rights that belong to everyone.

⁷⁹ In *Demir* (n. 74) the ECtHR explained that the obligations imposed under the ECHR ‘may be interpreted, firstly, in the light of relevant international treaties that are applicable in the particular sphere’, giving as an example ECHR art 8 as being interpreted in the light of the United Nations Convention on the Rights of the Child (UNCRC).

⁸⁰ In contrast to Wales, see Rights of Children and Young Persons (Wales) Measure 2011.

rights and other legislation'.⁸¹ That the UNCRC has a significant role in national law was emphasised in the Supreme Court's 2015 decision, *R (SG) v Secretary of State for Work and Pensions (R(SG))* with all the judges adopting a similar view to that expressed by Lord Reed when he stated that 'the UNCRC can be relevant to questions concerning the rights of children under the ECHR'.⁸²

Although, only adopted in 2008, the UNCRPD has already attained an influential role in the development of law and policy relevant to people with disabilities⁸³ at a European and national level. For example, the ECtHR regards the UNCRPD as evidence of the 'European and worldwide consensus on the need to protect people with disabilities from discriminatory treatment'.⁸⁴ At a national level the UNCRPD's potential to assist in the interpretation of Article 14 (prohibition of discrimination) of the ECHR has been raised by both the Court of Appeal⁸⁵ and the Supreme Court.⁸⁶

Although comparisons between the ECHR and other international and European human rights standards highlight the limitations of human rights law, for example that there are gaps in the areas covered and inconsistencies across the treaties of the UN and CoE (discussed below), such analysis identifies that a common theme across these standards is the emphasis on seeking the person's views in the process for determining whether such non-consensual interventions are necessary.

2.2 Justification for non-consensual psychiatric care (Question 1)

The premise that there must be a lawful basis for the proposed intervention is the cornerstone of national law relating to consent to treatment generally⁸⁷ and is applicable

⁸¹ Human Rights Joint Committee *The UK's compliance with the UN Convention on the Rights of the Child* (2014-2015 HL 144 HC 1016) 7.

⁸² *R (SG)* (n 62), (Lord Reed), [86]. See also [100]-[101] (Lord Carnwath), [137] (Lord Hughes), [217] (Lady Hale) and [256] (Lord Kerr).

⁸³ This is the term used under the UN Convention of the Rights of Persons with Disabilities (UNCRPD), whereas in the United Kingdom the term 'disabled people' is more usually adopted.

⁸⁴ *Glor v Switzerland* (App 1330444/04) 30 April 2009, ECHR 2009 para 53. It has also referred to the views expressed by the CRPD Committee in its concluding observations – see *MS v Croatia No 2*. (App 75450/12) 19 February 2015, [2015] MHLR 226 para 47 – 53.

⁸⁵ *Burnip v Birmingham City Council* [2012] EWCA Civ 629.

⁸⁶ *R(SG)* (n 62) [119] and [130] (Lord Carnwath), [212] – [218] (Lady Hale), [259] (Lord Kerr).

⁸⁷ See for example, *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 [2014] AC 591, [2013] WLR 1299, [19] (Lady Hale) stated 'any treatment that the doctors do decide to give must be lawful', citing *Airedale NHS Trust v Bland* [1993] AC 789 [1993], 1 All ER 821 HL in support. Given that the MHA 1983 s131 makes specific provision for the informal admission of patients, questions in relation to admission to hospital turn upon the circumstances in which those who lack decisional capacity can be admitted informally. This is discussed in Chapter 6.

to individuals of all ages.⁸⁸ However, in addition to considering the legal authority for adolescent psychiatric care (the adolescent's consent, parental consent, the MCA 2005 or the MHA 1983, or a court order) the intervention must also be compatible with the ECHR. Whereas in certain circumstances restrictions of individual's rights are permitted under the ECHR,⁸⁹ the following three points are relevant.

First, the ECHR requires that any restriction must accord with both the 'principle of legality', which requires there to be a clear legal basis for the restriction under national law and the 'law must be sufficiently precise to allow the citizen – if need be, with appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action may entail'.⁹⁰ Its purpose 'is to ensure that there is one rule for all, that power is not exercised arbitrarily or for an improper purpose, and that minimum safeguards exist against an abuse of power'.⁹¹

Secondly, the 'principle of proportionality', considered to be 'the defining characteristic of the Strasbourg approach to the protection of human rights',⁹² reflects the view of the ECtHR that 'inherent in the whole of the Convention is a search for a fair balance between the demands of the general interest of the community and the requirements of the protection of the individual's fundamental rights'.⁹³ In essence this means that '...even where it is clear that there is a legitimate purpose for restricting a Convention right, the authorities must still show that the actual restriction employed does not go beyond what is strictly necessary to achieve that purpose'.⁹⁴ This principle is also

⁸⁸ In *Re R* (n 37), which concerned a fifteen year old girl, Lord Donaldson (p. 22) stated 'It is trite law that in general a doctor is not entitled to treat a patient without the consent of someone who is authorised to give that consent. If he does so, he will be liable in damages for trespass to the person and may be guilty of criminal assault', albeit adding that 'in cases of emergency a doctor may treat the patient notwithstanding the absence of consent'. See also *Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, [2000] 4 All ER 961 CA; having found that parents (with parental responsibility) can give proxy consent for young children, Ward LJ (at p 179) cited Lord Donaldson's above comments in *Re R*, stating that treating a child without parental consent would be 'an unlawful assault on the child'.

⁸⁹ For example, ECHR art 5(1) sets out six prescribed situations in which individuals can be deprived of their liberty.

⁹⁰ *HL v the United Kingdom* (2005) 40 EHRR 32 [114].

⁹¹ H Mountfield, 'The Concept of Lawful Interference with Fundamental Rights' in Jowell and J Cooper (eds) *Understanding human rights principles* (Hart Publishing 2001) 17.

⁹² K Starmer, *European Human Rights Law* (Legal Action Group 1999) para. 4.37 (Starmer 1999). M Fordham and T de la Mare argue that '[t]he principle of proportionality is at the heart of the European legal order and increasingly recognised as a key component in the rule of law' (see 'Identifying the principles of proportionality' in Jowell and Cooper (eds) *Understanding Rights Principles* (n 79) 27).

⁹³ *Soering v the United Kingdom* (1989) 11 EHRR 439 para 89.

⁹⁴ Starmer *European Human Rights Law* (n 92) para 4.38.

relevant in determining whether a positive obligation has been met and whether the prohibition of discrimination (Article 14) has been infringed.⁹⁵

Thirdly, although the ECtHR case-law concerning mental health deals with human rights that are 'essentially 'negative' in character, placing limits on government interference with rights and freedoms',⁹⁶ there is a growing jurisprudence on 'positive' rights, in other words 'obligations on state authorities to take positive steps or measures to protect the Convention rights of individuals'.⁹⁷ When discussing the development of the ECtHR jurisprudence in relation to positive obligations in 2001, Keir Starmer stated that the primary purpose of the ECHR is 'to safeguard human dignity' (a point recently emphasised by the ECtHR, when stating 'respect for human dignity forms part of the very essence of the Convention'⁹⁸) and its emphasis is 'on the "effective" protection of human rights, not the entrenchment of "theoretical" or "illusory" rights'.⁹⁹ Since then there has been an extensive development of this area of law, so much so that while 'positive obligations were once thought to be the exception rather than the rule, there are now hardly any provisions of the Convention under which positive obligations have not been recognised'.¹⁰⁰ However, a remaining concern is the difficulty in determining the limits of these obligations.¹⁰¹

In this regard, much of the discussions in relation to adolescent psychiatric care are focused on 'negative' rights when analysing the circumstance in which non-consensual interventions are permitted under national law. Nonetheless, the ECtHR's jurisprudence on positive obligations is relevant in some areas, such as the High Court's duty to act to protect the life of an adolescent who is refusing life-saving treatment, which is considered in Chapter 4.

⁹⁵ See Harris, O'Boyle & Warbrick *Law of the European Convention on Human Rights* (2nd ed OUP), 10 – 11.

⁹⁶ L O Gostin 'Human Rights of Persons with Mental Disabilities' in Gostin (2010) (n 4) para 3.61

⁹⁷ K Starmer, 'Positive Obligations under the Convention', J Jowell and J Cooper (eds) *Understanding Rights Principles* (Hart Publishing 2001) 139.

⁹⁸ *Bouyid v Belgium* (2015) 62 EHRR 32 GC [89] and [101].

⁹⁹ Starmer 'Positive Obligations under the Convention' (n 97), 144-145. See also A Mowbray, *The Development of Positive Obligations under the European Convention on Human Rights by the European Court of Human Rights* (Hart Publishing 2004).

¹⁰⁰ B Rainey, E Wicks and C Ovey, Jacobs, White & Ovey, *The European Convention on Human Rights* (6th ed OUP 2014) 102.

¹⁰¹ Rainey and others (n 100) 103.

2.3 The 'wishes versus welfare dynamic' (Question 2)

The notion of the 'wishes versus welfare dynamic' described in the introduction to this chapter is relevant to all three of the scenarios of non-consensual adolescent psychiatric care considered in this thesis. It is perhaps at its most extreme when the High Court is asked to determine whether an adolescent's refusal of life-saving medical treatment should be overridden (considered in Chapter 4). It will also be engaged when the use of the MHA 1983 is considered (Chapter 5), for example, when adolescents do not wish to accept the in-patient psychiatric care that is being proposed as a means of addressing serious concerns about their mental health and wellbeing, such as self-harm, anxiety and/or depression. It is also relevant to cases such as those considered in Chapter 6, where the adolescent concerned lacks decisional capacity. In that context focusing on the wishes versus welfare dynamic highlights the importance of encouraging and supporting adolescents, who may otherwise have difficulties in communicating their wishes, to express their views.

The wishes versus welfare dynamic engages two linked, but separate aspects of decision-making. The first is the role of the concept of 'autonomy' and second is the nature of 'children's rights' (a term which includes all under 18s, not just children aged under 16). As Feldman notes, there is:

...a tension, in relation to children's rights, between the desire to protect them against harm and exercise control in order to make possible a more perfect autonomy in their adulthood, and the need to respect them as people in their own right, with their own claims to dignity and self-respect.¹⁰²

The tension described by Feldman has engaged a range of concerns, such as the debates between the 'child liberationists' and the child protectors in the 1970s,¹⁰³ and the on-going exchange amongst legal academics and others on the question of the right of 'mature minors' to refuse medical treatment.¹⁰⁴ Thus, the notion of the 'wishes versus welfare dynamic' is not new. Nor is it unique to under 18s given that in certain circumstances national law also permits non-consensual interventions in relation to people with 'mental disorder' and 'mental incapacity'. Furthermore, as discussed

¹⁰² D Feldman, *Civil Liberties and Human Rights in England and Wales* (2nd ed OUP 2002) 266.

¹⁰³ See D Archard, *Children – Rights and Childhood* (2nd ed Routledge 2004) ch 5 and Fortin *Children's Rights and the Developing Law* (n 4) ch 1.

¹⁰⁴ See for example, Gilmore and Herring (n 18) E Cave and J Wallbank, 'Minors Capacity to Refuse Treatment: A Reply to Gilmore and Herring' (2012) *MedLR* 20(3), 1.

throughout this thesis, human rights standards, permit non-consensual interventions in relation to all three groups on varying grounds, albeit the UNCRPD challenges such actions in relation to people with disabilities (which includes those who are deemed to have a mental disorder or to lack the mental capacity to make decisions for themselves). These points are considered further below.

First, in relation to autonomy, it is argued that notwithstanding its importance in relation to health care decisions (and therefore the legal framework for adolescent care), the interconnection between autonomy and the concept of liberty is crucial, given the symbiotic relationship in the context of medical law. Understanding this autonomy-liberty dyad is crucial to identifying the basis on which an adolescent's psychiatric care can be given lawfully.

Secondly, Fortin's comment that how 'best interests test interacts with the concept of human rights remains the elephant in the room'¹⁰⁵ is spot on, given that (perhaps controversially) it is argued that the concept of the 'best interests of the child' applies to all under 18s, whether or not they have decisional capacity. Another important feature of children's rights that differentiates them from that of adults, is the acknowledgement that parents are the primary decision-makers in relation to the care and upbringing of their child.

2.3.1 *The 'autonomy-liberty dyad'*

The relevance of the notions of autonomy and liberty to the legal framework for adolescent psychiatric care is that, together, they determine the agency of the adolescent, in other words, whether the adolescent is acknowledged as having the authority to make health care decisions for him or herself. While there are many and varied conceptions of both autonomy and liberty, some of which suggest that they are synonymous,¹⁰⁶ Griffin identifies a significant distinction between them. He regards autonomy as being the value of being able to make decisions for ourselves whereas liberty is the value of being able to carry out those decisions.¹⁰⁷

The ideological roots of the autonomy-liberty dyad are outlined first, followed by consideration of its relevance, first to the law on consent, and second, to human rights.

¹⁰⁵ J Fortin, 'Children's rights – flattering to deceive? (2014), CFLQ 26(1) 63.

¹⁰⁶ See discussion in Chapter 2 on the different meanings of autonomy.

¹⁰⁷ J Griffin, *On Human Rights*, (OUP 2008) 150 - 151.

2.3.1.1 *Autonomy and liberty: ideological roots*

Autonomy and liberty's connection with the law on consent stems from traditional liberal political theory.¹⁰⁸ As Archard observes, this theory holds 'that all adult human beings are capable of making rational, autonomous decisions. In view of this they should be left to lead their own lives as they see fit. The one constraint on this freedom is that its exercise should not interfere with a similar freedom for others'.¹⁰⁹ Thus liberty, which in 'its simplest and most general sense...entails non-interference by others with one's freedom of choice and action',¹¹⁰ has tended to be linked to a concept of autonomy that is personified as the independent, rational (and typically male) individual who does not need, nor want, others to intervene in the way he chooses to live his life. This understanding of autonomy has been the subject of severe criticism¹¹¹ and its meaning continues to be a vexed question.¹¹² Nonetheless autonomy plays a crucial role in health care decisions.

2.3.1.2 *Autonomy and liberty: relevance to the law on consent to treatment*

In the medical law context, autonomy is regarded as being intimately connected with the administration of medical treatment (as similar principles apply it is argued that this is also the case for decisions about admission to hospital). Consent to (and refusal of) medical treatment is considered to be the 'principle legal mechanism through which the right to autonomy has been delivered'.¹¹³ This is played out in two key ways.

¹⁰⁸ See for example, J Christman and J Anderson (eds) *Autonomy and the Challenges to Liberalism New Essays*, (Cambridge University Press, 2005).

¹⁰⁹ Archard (n 103) 77. In a similar vein, Christman and Anderson refer to 'exercising autonomy – and demanding the respect for individual autonomy [as being] central to liberalism' (Christman and Anderson (n 96) 12).

¹¹⁰ Feldman (n 102) 4.

¹¹¹ See for example, C Mackenzie and N Stoljar, *Relational Autonomy: Feminist Perspectives, Agency and the Social Self* (OUP 2000).

¹¹² Dworkin describes personal autonomy as a 'term of art' used by theorists 'in an attempt to make sense of a tangled net of intuitions, conceptual and empirical issues, and normative claims' (G Dworkin *Theory and Practice of Autonomy*, (Cambridge University Press 1988), 7). See also A. Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge*, 10; O O'Neill, *Autonomy and Trust in Bioethics*, 2002, 21 – 23, and S Conly, *Against Autonomy - Justifying Coercive Paternalism* (Cambridge University Press) 2013.

¹¹³ This point is made by M Donnelly *Healthcare Decision-Making and the Law, Autonomy, Capacity and the Limits of Liberalism* (Cambridge University Press 2010) 52. See also, T Beauchamp and J Childress *Principles of Biomedical Ethics* (7th ed OUP 2013) 110, who likewise note that consent to treatment (and refusal) is the 'basic paradigm of the exercise of autonomy', albeit pointing out that consent is not always 'necessary or sufficient for certain interventions to be justified'.

First, is the link between autonomy and the concept of 'informed consent' in the area of medical negligence and concerns the level and quality of information given to patients.¹¹⁴ As such, this aspect of the relationship between autonomy and consent falls outside the scope of this thesis, although as noted in Chapter 2, human rights standards and the MHA Code 2015 emphasise the importance of ensuring that individuals are given sufficient information when making health care decisions.

Secondly, autonomy is relevant to medical law in that in legal terms the status of being autonomous, is equated with an adult's mental capacity to decide about the proposed intervention. As noted in Part 1 above, the legal test to determine an adolescent's ability to decide depends on his or her age ('*Gillick* competence' if under 16 years and 'mental capacity' under the MCA 2005 if 16 or 17 years). However, even if adolescents have decisional capacity and might therefore be regarded as 'autonomous', this is no guarantee that their decisions will be respected given that (like adults) they can be subject to compulsory psychiatric care under the MHA 1983, or (unlike adults) on the basis of a court order. In this regard, Coggon and Miola's distinction between liberty (legal capacity) and autonomy (mental capacity) is apposite. Drawing from Griffin's distinction between autonomy and liberty noted above, Coggon and Miola warn against conflating 'autonomy', which is concerned with 'the essence of a decision and how the decision is reached' (and therefore equated with 'mental capacity') and 'liberty', which focuses on the right to make that decision (and is therefore equated with 'legal capacity').¹¹⁵

2.3.1.3 Autonomy and liberty: connection with human rights

In the past, the autonomy-liberty dyad was relevant to the question as to who could be 'rights-holders',¹¹⁶ the focus of the debate being whether such entitlements depended on the person having the requisite autonomy to exercise these rights.¹¹⁷ This is reflected in the conflicts between the 'will and interest theories' which, as Freeman noted in 1992, 'has been regarded as of crucial importance in arguments over the rights of children'.¹¹⁸

¹¹⁴ See *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] 2 WLR 768. For a discussion on this aspect of autonomy and consent, see S McLean *Autonomy Consent and the Law* (Taylor & Francis 2009).

¹¹⁵ J Coggon and J Miola, 'Autonomy, liberty and medical decision-making', (2011) *Cambridge Law Journal* 70(3) 523, 526.

¹¹⁶ Freeman noted in 1992 that children's rights 'have been argued about for well over a century' Freeman 'Rights Ideology and Children' in M Freeman and P Veerman (eds) *The Ideologies of Children's Rights* (Martinus Nijhoff Publishers 1992), 3.

¹¹⁷ This is still an issue for moral philosophers see for example Griffin (n 107).

¹¹⁸ Freeman and Veerman (n 116).

The issue revolves around the function of rights: whether rights are to 'enable the right-holder to enforce (or waive) the exercise of her or his will' (the will theory) or if they are 'to protect the interests of the rights holder' (the interest theory).¹¹⁹

The interest theory is able to accommodate those too young or otherwise unable to claim rights for themselves given that the person's lack of requisite decision-making abilities is irrelevant; what matters is whether the person has 'interests which it may be appropriate to protect in the form of rights'.¹²⁰ In contrast, the 'will theory' holds that a 'person cannot be described as a rights-holder unless he or she is able to exercise choice over the exercise of that right' - children have no rights until they acquire the capacity to make rational choices.¹²¹ Writing in the early 1990s, Campbell condemned this 'exclusive stress on self-sufficiency and autonomy' as a 'woefully partial expression of why people count and why we matter to each other',¹²² pointing out that such an approach has a wider reach than children given that it also excludes individuals, 'who, for one reason or another have not developed [the relevant capacities] or, having developed them, have lost them'.¹²³ This means 'that severely mentally handicapped people and persons whose thought disorders destroy their capacity for autonomy cannot in terms of the theory, have any rights'.¹²⁴

Such an approach is an anathema to the UNCRPD. Weller describes how the CRPD challenges the 'western political order' within which recognition as being the bearer of rights depends upon being an 'autonomous, fully rational self-determining person' and those who lack rationality are subject to 'welfare principles and best interests determinations', which 'renders their views, wishes and preferences wholly irrelevant to the decision-making process'.¹²⁵ Crucially though, as noted below, the UNCRPD incorporates the UNCRC's principle of the best interests of the child.¹²⁶

¹¹⁹ P Alston, S Parker and J Seymour (eds), *Children, Rights and the Law* (Clarendon Press 1992) note that the will/interest debate has surfaced over many years, viii.

¹²⁰ Alston and others (n 119) ix.

¹²¹ Fortin, *Children's Rights and the Developing Law* (n 4) 12-13.

¹²² T Campbell 'The Rights of the Minor' in Alston and others (n 119), 3.

¹²³ T Campbell (n 122) 18.

¹²⁴ T Campbell and C Heginbotham *Mental Illness, Prejudice Discrimination and the Law* (Dartmouth Publishing Company Ltd, 1991) 65.

¹²⁵ P Weller 'Lost in Translation: Human Rights and Mental Health Law', in B McSherry and P Weller (eds) *Rethinking Rights-based Mental Health Laws*, (Hart Publishing 2010) 71-72.

¹²⁶ UNCRPD art. 7(2).

Today, the near global recognition of the UNCRC¹²⁷, alongside the widespread ratification of the UNCRPD¹²⁸ and the predominance of the ECHR across the 47 members of the Council of Europe,¹²⁹ lends support to MacDonald's assertion that the 'long debate about whether children have rights must surely be settled'.¹³⁰ Nonetheless, there remains the question of *how* human rights apply to children and young people. The view that the debate about human rights has to a large extent merely shifted from whether such rights exist (and who can claim to hold such rights) to how they are interpreted and applied¹³¹ is particularly true for under 18s. In the post-HRA era the question is not so much whether they have rights, the problem, as Fortin notes is that the HRA 1998:

...produces a number of dilemmas, the most important being whether children can claim Convention rights in precisely the same way as adults, or whether such rights can be interpreted paternalistically...a growing emphasis on adults' right to autonomy under the ECHR are inevitably influencing ideas about adolescents' decision-making rights.¹³²

Fortin was writing in 2009; since then the ECtHR's decision in *M and M v Croatia* (2015)¹³³ provides a partial answer to her question. The ECtHR described the 'right to personal autonomy', as 'the right to make choices as to how to lead one's own life, provided that this does not unjustifiably interfere with the rights and freedoms of others' (thus, more akin to Griffin's notion of liberty). However, this right 'has a different scope in

¹²⁷ 196 States have ratified the United Nations Convention on the Rights of the Child (UNCRC). See UN Treaty Collection:

<https://treaties.un.org/pages/Treaties.aspx?id=4&subid=A&clang=_en> accessed 2 February 2017. S Broach, L Clements and J Read, *Disabled Children: A Legal Handbook* (Legal Action Group, 2016) para 2.23, note that the UNCRC is 'as close as possible to a universally agreed international human rights treaty'.

¹²⁸ 172 States have ratified the UNCRPD. (see UN Treaty Collection <<https://treaties.un.org/pages/Treaties.aspx?id=4&subid=A&clang=en>> accessed 2 February 2017.

¹²⁹ See <www.coe.int/en/web/portal/47-members-states> accessed 1st February 2017.

¹³⁰ A MacDonald, *The Rights of the Child Law and Practice*, (Jordon Publishing Ltd 2011) para 1.36. For a detailed analysis of the development of the concept of children's rights see Fortin *Children's Rights and the Developing Law* (n 4) ch 1 and MDA Freeman, *The Rights and Wrongs of Children*, (Frances Pinter 1983) chs 1 and 2.

¹³¹ C Harvey, 'Talking about human rights' (2004) EHRLR 500, states (at 501): 'The interesting arguments today, and the real struggles, are over the scope of human rights, their contested meaning, the relationship with other values, and their institutional promotion, protection and effective implementation'.

¹³² Fortin, *Children's Rights and the Developing Law* (n 4) 22.

¹³³ *M and M v Croatia* (App 10161/13) 3 September 2015 ECHR 2015 (extracts) [2016] 2 FLR 18.

the case of children'.¹³⁴ The ECtHR referred to children's 'circumscribed autonomy', explaining that this 'gradually increases with their evolving maturity' and 'is exercised through their right to be consulted and heard' in accordance with Article 12 of the UNCRC (discussed further below).¹³⁵ The ECtHR noted that in addition to having the right to express his or her views, the child has the 'right to have due weight given to those views in accordance with his or her age and maturity',¹³⁶ while also recalling 'the best interests of the child' as being 'a primary consideration'.¹³⁷ Further consideration as to how under 18s' rights differ from that of adults is considered next.

2.3.2 *The nature of children's rights*

Of the two features of 'children's rights', namely the concept of the 'best interests of the child' and the role of parents, the former provides an overarching principle in that parents are expected to act in the best interests of their child.¹³⁸ Accordingly, this is considered first.

2.3.2.1 *Best interests of the child*

That the best interests of the child shall be 'a primary consideration' in all actions concerning children is 'one of the fundamental values of the [UNCRC]'.¹³⁹ It forms one of four general principles 'for interpreting and implementing all the rights of the child'; the others being 'the right of all children to be heard and taken seriously', the right to non-discrimination and the right to life and development.¹⁴⁰ Article 3(1) of the UNCRC states:

In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

The reach of this principle is very wide, applying to all actions undertaken by a range of public or private bodies (which would therefore include decisions about adolescent's psychiatric and general medical care) while parents are also expected to act in the best interests of their child.¹⁴¹ In comparison, the 'welfare principle' under section 1(1) CA

¹³⁴ *M and M v Croatia* (n 133) [171].

¹³⁵ *M and M v Croatia* (n 133) [171].

¹³⁶ *M and M v Croatia* (n 133) [171].

¹³⁷ *M and M v Croatia* (n 133) [172].

¹³⁸ UNCRC art 18(1).

¹³⁹ 'General comment 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para 1)' (CRC General Comment 14). CRC/C/GC/14 para 1.

¹⁴⁰ CRC General Comment 14 (n 139).

¹⁴¹ UNCRC art 18(1).

1989 applies only to certain court decisions,¹⁴² providing that ‘the child’s welfare shall be the court’s paramount consideration’.¹⁴³

Furthermore, as the UNCRC applies to individuals up until the age of 18, unless the age of majority is achieved earlier under national law¹⁴⁴ (which is not the case in the UK¹⁴⁵) its best interests principle under Article 3(1) is relevant to adolescents until they reach adulthood. Accordingly, the phrase ‘best interests of the child’ refers to young people aged 16 and 17 as well as children aged under 16 years.

The Committee on the Rights of the Child (‘the CRC’), the UN body responsible for overseeing States’ compliance with the UNCRC, has issued ‘*General comment 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para 1)*’ (‘General Comment 14’). While not attempting to ‘prescribe what is best for the child in any given situation at any point in time’, it ‘seeks to ensure the application of and respect for the best interests of the child’¹⁴⁶ and ‘provides a framework for assessing and determining the child’s best interests’.¹⁴⁷ Its conception of best interests provides a framework for decision-making, giving greater attention to adolescent’s views than the more traditional understanding of this principle. This interpretation, is significant to decision-making in relation to adolescents on a number of counts.

First, the purpose of the best interests principle ‘should be to ensure the full and effective enjoyment of the rights recognized in the [UNCRC] and the holistic development of the child’¹⁴⁸ and that ‘an adult’s judgment of a child’s best interests cannot override the obligation to respect all the child’s rights under the [UNCRC]’.¹⁴⁹

Secondly, the views of the child are considered to be integral to a best interests determination. General Comment 14 states that an assessment of the best interests of the child ‘must include respect for the child’s right to express his or her views freely and due weight given to said views in all matter affecting the child’.¹⁵⁰ This approach is based on Article 12 of the UNCRC which provides that those under 18s, who are ‘capable of

¹⁴² CA 1989 s1(4).

¹⁴³ CA 1989 s1(1).

¹⁴⁴ UNCRC art. 1. UNICEF (n 9) 36 states: ‘the underlying principle of the best interests of children governs all matters affecting children until they are 18’.

¹⁴⁵ Family Law Reform Act (FLRA)1969 s 1.

¹⁴⁶ CRC General Comment 14 (n 139) para 10.

¹⁴⁷ CRC General Comment 14 (n 139) para 11.

¹⁴⁸ CRC General Comment 14 (n 139) para 4.

¹⁴⁹ CRC General Comment 14 (n 139) para 4.

¹⁵⁰ CRC General Comment 14 (n 139) para 43.

forming his or her own views' have 'the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child'. Like the concept of best interests, the right of the child to be heard and taken seriously is one of the fundamental principles of the UNCRC. The CRC regards Article 12 of the UNCRC as a 'unique provision in a human rights treaty' in that it 'addresses the legal and social status of children, who, on the one hand lack the full autonomy of adults, but on the other are subjects of rights'.¹⁵¹ There is no age limit to the child being able to express his or her views and States should start from the presumption that the child is capable of expressing them and enabling the child to express his or her views 'requires that the child be informed about the matters, options and possible decisions to be taken and their consequences'.¹⁵²

Thirdly, the notion of the 'evolving capacities of the child' is a major consideration. This seeks to provide a means by which the exercise of under 18s rights are transferred from parents (who are acting on behalf of their child), to the adolescents themselves. As Geraldine Van Buren notes, the presupposition by many of the human rights instruments that individuals are autonomous 'is problematic when applied to children who achieve autonomy at different stages in their lives and whose relationship with the state is both direct and through their parents'.¹⁵³ The concept of the evolving capacities 'reflects children's different rates of development' and takes into account that '[a]t different stages in their lives children require different degrees of protection, provision, prevention and participation'.¹⁵⁴ This fulfils two significant roles. It bridges the perceived gap between the dependency of children on others and the agency considered necessary for individuals to be true holders of rights – 'the realisation of children's rights is not contingent on the ability to exercise agency, or on the acquisition of a given age'.¹⁵⁵ It also establishes that under 18s have rights, irrespective of their ability to exercise them, with parents and others with responsibilities for them children exercising those rights on behalf of their child until the child is capable of doing so for herself.¹⁵⁶

The CRC describes the concept of the 'evolving capacities of the child' as 'processes of maturation and learning whereby children progressively acquire knowledge

¹⁵¹ General comment no. 12 *The right of the child to be heard* (CRC/C/GC/12) (CRC General Comment 12) para 91.

¹⁵² CRC General Comment 12 (n 151) paras 20 – 25.

¹⁵³ G Van Bueren, *The international law on the rights of the child* (Springer 1995) 3.

¹⁵⁴ Van Bueren (n 153) 50.

¹⁵⁵ UNICEF (n 9) 5. UNICEF states: 'the issue in question is to what extent children themselves exercise those rights, and what responsibilities are undertaken on their behalf by parents or other caregivers, and how the process of transition takes effect'.

¹⁵⁶ UNICEF (n 9) 3.

competencies and understandings, including acquiring understanding about their rights and about how they can best be realized'.¹⁵⁷ Although the term is not found in Article 12, the principle that decisions about children and young people must take into account their 'evolving capacities' is replicated in Article 12's reference to 'the views of the child being given due weight in accordance with the age and maturity of the child'.¹⁵⁸ The CRC highlights the link between the evolving capacities of the child and Article of the 12 in the context of the best interests of the child when stating that the evolving capacities of the child 'must be taken into consideration when the child's best interests and the right to be heard are at stake'.¹⁵⁹ Using language reminiscent of that of Lord Denning in *Hewer v Bryant*¹⁶⁰ the CRC emphasises that:

...the more the child knows, has experienced and understands, the more the parent, legal guardian or other persons legally responsible for him or her have to transform direction and guidance into reminders and advice, and later to an exchange on an equal footing. Similarly, as the child matures, his or her views shall have increasing weight in the assessment of his or her best interests. ¹⁶¹

Accordingly, while the CRC best interests model applies irrespective of the adolescent's decisional capacity, in the light of Article 12 UNCRC's emphasis on giving weight in accordance with the age and maturity of the adolescent and the concept of the 'evolving capacities of the child', the views of an adolescent with decisional capacity should be regarded as being a major factor when determining what is in that adolescent's best interests.

General Comment 14 makes clear that the 'evolving capacities of the child', together with the requirement to respect the views of the child under Article 12 of the UNCRC, are two significant factors to be taken into account when determining the child's best interests. Thus, rather than pitting the wishes of the child against the traditional welfare-orientated

¹⁵⁷ General Comment no. 7 (2005) *Implementing child rights in early childhood* (CRC/C/GC/7/Rev.1) para 17.

¹⁵⁸ MacDonald (n 130) notes (at para. 6.26) 'Both the "age" and "maturity" criteria are of equal value as children vary developmentally within defined ages. They are closely linked with the concept of evolving capacity'. See also Van Bueren (n 153) 219.

¹⁵⁹ CRC General Comment 14 (n 127) para. 44.

¹⁶⁰ (1970) 1 QB 357, at 369, Lord Denning referred to the 'dwindling right' of parents which 'the courts will hesitate to enforce against the wishes of the child, the older he is. It starts with a right of control and ends with little more than advice'.

¹⁶¹ CRC General Comment 14 (n 139) para 44.

concept of best interests, the CRC emphasises that the child's views form an essential element of assessing his or her best interests.¹⁶²

Moreover, recognition of the significance of the principle of the best interests of the child extends beyond the UNCRC, being relevant to other UN treaties, the jurisprudence of the ECtHR and national law.¹⁶³ Whereas the CRPD Committee objects to the application of 'the "best interests" principle' to adults,¹⁶⁴ in relation to under 18s, Article 7(2) (Children with disabilities) of the UNCRPD states that '[i]n all actions concerning children with disabilities, the best interests of the child shall be a primary consideration'. Despite the absence of such a provision in the ECHR, the ECtHR considers that there is 'a broad consensus - including in international law - in support of the idea that in all decisions concerning children, their best interests must be paramount importance'.¹⁶⁵ In support of this approach, the ECtHR refers to the requirement under Article 3(1) of the UNCRC that 'the best interests of the child shall be a primary consideration in all actions taken by public authorities concerning children'.¹⁶⁶ Furthermore, the Supreme Court of the United Kingdom (the 'Supreme Court') has emphasised the importance of the UNCRC's principle of the best interests of the child. It has recognised that '[t]he spirit, if not the precise language',¹⁶⁷ of this principle has been translated into national law, through for example, the CA 2004, 11(2) which 'places a duty on a wide range of bodies providing public services to carry out their functions "having regard to the need to safeguard and promote the welfare of children"'.¹⁶⁸ It also considers General Comment 14 to be authoritative guidance on Article 3(1).¹⁶⁹

¹⁶² CRC General Comment 14 (n 139), paras 53 – 54.

¹⁶³ As noted by Lady Hale in *ZH(Tanzania)* (n 76) [22], the ECtHR 'collected references in support of this proposition from several international human rights instruments' in *Neulinger and Shuruk v Switzerland* (2012) 52 EHRR 11 paras 49 -56, for example arts. 5(b) and 16(d) of the Convention on the Elimination of All Forms of Discrimination against Women 1979 and the Charter of Fundamental Rights of the European Union, art. 24.

¹⁶⁴ Committee on the Rights of Persons with Disabilities General Comment No. 1 (2014) *Article 12: Equal Recognition before the law CRPD/C/CG/1* (CRPD General Comment 1) para 21.

¹⁶⁵ *Neulinger and Shuruk v Switzerland* (n 163) para 135.

¹⁶⁶ *Neulinger and Shuruk v Switzerland* (n 163) para 135. See also *X v Latvia* (2014) 59 EHRR 3 para 96 and *Sarközi and Mahran v Austria* (App 27945/10), 2 April 2015. In *R (SG)* (n 74) [125], Lady Hale referred to her comments in *ZH (Tanzania)* (n 76) in which she noted (at [25]) that the language adopted by the ECtHR varies in that it also refers to the best interests of the child as being 'the primary consideration' or 'the primary consideration' but then observed that the obligation under international law is for the best interests of the child to be 'a primary consideration' (the term used in the UNCRC art. 3).

¹⁶⁷ *R(SG)* (n 74) [82] (Lord Reed), citing *ZH (Tanzania)* (n 76) [23].

¹⁶⁸ *R(SG)* (n 74) [215] (Lady Hale).

¹⁶⁹ *Mathieson* (n 76) [39] (Lord Wilson, with Lady Hale, Lord Clarke and Lord Reed concurring) noted that Lord Carnwath 'described the [CRC] committee's analysis as authoritative guidance' in *R(SG)* (n 64) [105]-[106]. In *R(SG)* (n 74), (Lord Carnwath) [105] referred to the CRC General Comment as being 'the most authoritative guidance' on Article 3(1).

2.3.2.2 Parents' role in decision-making

Article 18 of the UNCRC provides that parents have 'primary responsibility for the upbringing and development of the child' (and that they should be supported in doing so¹⁷⁰), this is subject to two important caveats.

First, the 'best interests of the child will be their basic concern'.¹⁷¹ Challenging an historical 'assumption that parental rights over children could be exercised for the benefit of the parents alone', the UNCRC 'requires that current legal principles of parental rights be translated into principles of parental responsibilities – the legal responsibilities of parents to act in the best interests of their child'.¹⁷² The rights and responsibilities of parents to provide direction and guidance to children are, therefore, not in consequence of their 'ownership' of the child, but rather, a function of parenthood, until the child is capable of exercising those rights on his or her own behalf.¹⁷³

Secondly, parents' rights and responsibilities must be read in conjunction with Article 5 of the UNCRC, which recognises the role of parents in giving guidance and direction to their children but provides that this should be 'in a manner consistent with the evolving capacities of the child'.¹⁷⁴ Thus, CRC emphasises that the role of parents is 'to enable the child to exercise his or her rights'.¹⁷⁵ The UNICEF Innocenti Research Centre observes that parents and other caregivers cannot decide to do whatever they think is suitable, rather their guidance and direction 'must be directed towards promoting respect for the rights of child and parents must respect the extent to which the child is capable of exercising those rights on his or her behalf'.¹⁷⁶ Both the ECtHR¹⁷⁷ and national courts¹⁷⁸ have acknowledged that there are limits to the powers of parents to make decisions in relation to their children and that parents are expected to act in their child's best interests. However, no precise parameters have been developed.

In relation to adolescent psychiatric care, while the decision-making role of parents might be described in terms of 'parental rights', the reality will often be that parents are asked to consent to their child's admission to hospital or medical treatment, when such

¹⁷⁰ UNCRC art. 18(2) requires that 'States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities'.

¹⁷¹ UNCRC art.18(1). See also CRC General Comment 14 (n 139), para 25.

¹⁷² R Hodgkin and P Newell *Implementation Handbook for the Convention on the Rights of the Child* ('the CRC Handbook') (3rd ed UNICEF 2007), 232.

¹⁷³ UNICEF (n 9) 6.

¹⁷⁴ UNCRC art 5.

¹⁷⁵ CRC General Comment 12 (n 151) 91.

¹⁷⁶ UNICEF (n 9) 6.

¹⁷⁷ *Nielsen v Denmark* (1989) 11 EHRR 175 para. 72

¹⁷⁸ See for example *Hewer v Bryant* [1970] 1 QB 357, CA 369.

interventions have been assessed by health care professionals as being necessary.¹⁷⁹ If the parents are not able, or willing, to authorise the proposed intervention it will be necessary to ascertain what alternative legal route is available, such as, detention under the MHA 1983, if the criteria are met.

2.4 Relevant Human Rights Standards (Question 3)

For the reasons noted above, the human rights analysis of this thesis extends beyond the ECHR. In addition to considering other human rights treaties, in particular the UNCRC and UNCRPD, reference is made to general comments of UN treaty bodies, as well as reports and recommendations of UN and Council of Europe (CoE) bodies. This not only reflects ECtHR's practice of referring to 'relevant international material' but highlights areas of consistency as well as discord across the spectrum of international and European human rights. Furthermore, UN treaty bodies' general comments are considered to 'constitute authoritative interpretations of the provisions'.¹⁸⁰

Key aspects of the UNCRC and the importance of the CRC's General Comment 14 were outlined above when considering the nature of children's rights. The core ECHR rights that will be discussed in subsequent chapters are outlined below. This is followed by an overview of the challenge to national law, specifically the MHA 1983 and the MCA 2005 that is presented by the UNCRPD.

2.4.1 Adolescent Psychiatric Care: Core ECHR Rights

Just as with adults, where it is proposed to either admit to hospital or treat an adolescent without that adolescent's consent, a range of ECHR rights are likely to be engaged, the main ones being as follows.

First, if the intervention gives rise to a deprivation of liberty, Article 5 will be engaged. Article 5 provides that everyone (including minors¹⁸¹) 'has the right to liberty and security of person'.¹⁸² The compatibility of the MHA 1983 with Article 5(1)(e), which makes explicit provision for the detention of individuals on grounds of their 'unsound mind', is

¹⁷⁹ This is not to exclude the possibility that parents may seek the admission of their child to a psychiatric facility but even then, presumably the admission would not proceed unless the medical opinion was that this was necessary.

¹⁸⁰ O'Flaherty (n 71) 7.

¹⁸¹ *Nielsen* (n 177) para 58.

¹⁸² In the limited occasions they have considered this point, the Strasbourg bodies regard 'security' to be concerned with protecting individuals from arbitrary interference with their liberty'. See *Bozano v France* (1987) 9 EHHR 297, para 54, *East African Asians v the United Kingdom* (App 4626/70), European Commission decision, 6 March 1978, paras 6 – 8.

considered in Chapter 5. The circumstances in which an adolescent's deprivation of liberty may arise are considered in Chapter 6.

Secondly, an adolescent's admission to hospital and treatment for mental disorder may engage Article 8 ('right to respect for private and family life, his home and his correspondence) in which case it must be justified under Article 8(2). This sets out a broad range of circumstances in which an interference with Article 8 rights is justified, which requires that it is 'in accordance with the law', pursues a 'legitimate aim' (such as the protection of health...or the protection of the rights and freedoms of others') and is a proportionate response to that legitimate aim.

To date, where the applicant's placement gives rise to a deprivation of liberty, the ECtHR has declined to consider the Article 8 implications of the compulsory admission to hospital.¹⁸³ However, in recent cases it has acknowledged that detention may well lead to the person being subjected to compulsory treatment, thereby giving rise to an interference with Article 8.¹⁸⁴ Article 8 will be engaged by 'imposing a medical intervention in defiance of the subject's will'¹⁸⁵ (or in the case of a child lacking decisional capacity, in defiance of the parent's objections¹⁸⁶), 'even if it is of minor importance'.¹⁸⁷ Accordingly, 'forced administration of medication represents a serious interference with a person's physical integrity'¹⁸⁸ and therefore falls within the scope of this right. The relevance of Article 8 to treatment without consent is considered in Chapter 5 in relation to the compulsory treatment provisions of Part IV of the MHA 1983 and in Chapter 4 in relation to the High Court's powers to override an adolescent's refusal of life-saving treatment.

Thirdly, where the High Court is asked to determine whether to authorise medical treatment without the adolescent's consent will engage ECHR rights. Where the adolescent is refusing life-saving this will require a balancing of the adolescent's ECHR

¹⁸³ *Storck v Germany* (2006) 43 EHRR 6, para 141.

¹⁸³ *Fyodorov and Fyodorova v Ukraine* (App 39229/03) 7 July 2011, para 82.

¹⁸⁴ *Zagidulina v Russia* (App 11737/06) 2 May 2013 [2015] MHLR 246, para 53: 'hospitalisation in a specialised medical institution frequently results in interference with an individual's private life and physical integrity through medical interventions against the individual's will'.

¹⁸⁵ *Pretty v. the United Kingdom*, (2002) 35 EHRR 1.

¹⁸⁶ *Glass v. the United Kingdom* (2004) 39 EHRR 341, para 70. See also *MAK v UK* (2010) 51 EHRR 14 paras 75 – 77 (the ECtHR noted that the child was 9 years old and there was no suggestion that she had capacity to consent to the intervention).

¹⁸⁷ *YF v Turkey* (n 23) para 33 (referring to two long established Commission decisions: *X v Austria* (App 8278/78) 12 December 1979, which concerned compulsory blood tests to establish paternity and *Acmanne and Others v Belgium* (App 10438/83) 10 December 1984, which concerned compulsory screening for tuberculosis).

¹⁸⁸ *X v Finland* (App 34806/04) 3 July 2012, ECHR 2012 (extracts) [2012] MHLR 318, para 220.

rights. The court will need to consider its positive duties to protect the adolescent's life (engaged by the adolescent's right to life under Article 2 and Article 8) and on the other, to respect the adolescent's decision to refuse medical treatment (protected by Article 8, which covers individual's personal autonomy and physical integrity¹⁸⁹). This is considered in Chapter 4.

Fourthly, Article 3, considered by the ECtHR to enshrine 'one of the most fundamental values of a democratic societies',¹⁹⁰ 'prohibits in absolute terms torture or inhuman or degrading treatment or punishment, irrespective of the circumstances and the victim's behaviour'.¹⁹¹ For ill-treatment to fall within the scope of Article 3, it must 'attain a minimum level of severity', the assessment of which 'is a relative one, depending on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim'.¹⁹² This right is considered when reviewing the compulsory treatment provisions of the MHA 1983 in Chapter 5.

In addition, where the above ECHR rights are engaged, compliance with Article 14 requires that such rights 'shall be secured without discrimination on any grounds such as sex, race colour, language, religion, political or other opinion national or social origin, association with a national minority, property, birth or other status'. The ECtHR considers the list set out in Article 14 to be 'illustrative and not exhaustive'.¹⁹³ Its inclusive approach to who might fall within the catch all phrase 'other status', due to their personal characteristics,¹⁹⁴ such as 'disability'¹⁹⁵ is reflected in the national courts' view that a 'a generous meaning should be given to the words 'or other status'''.¹⁹⁶

¹⁸⁹ *Pretty v United Kingdom* (n 185).

¹⁹⁰ *Labita v Italy* (2008) 46 EHRR 50 para 119.

¹⁹¹ *Nevmerzhitsky v Ukraine* (2006) 43 EHRR 32 para 79.

¹⁹² *M.S. v the United Kingdom* (2012) 55 EHRR 23 para 38.

¹⁹³ *Carson and Others v the United Kingdom* (2010) 51 EHRR 11 GC para 70. *Stummer v Austria* (2012) 54 EHRR 11 para 90 held that 'being a prisoner was an aspect of personal status for the purposes of Article 14'.

¹⁹⁴ *Kjeldsen, Busk Madsen and Pederson v Denmark* (1979-80) 1 EHRR 711 para 56.

¹⁹⁵ *Glor v Switzerland* (n 84) para 80.

¹⁹⁶ *R (RJM) v Secretary of State for Work and Pensions* - [2008] UKHL 63, [2009] 1 AC 311, [42] (Lord Neuberger), citing *R (Clift) v Secretary of State for the Home Department* [2006] UKHL 54 [2007] 1 AC 484, [48] (Lord Hope).

2.4.2 The UNCRPD: 'shaking us out of our complacency'¹⁹⁷

The UN Committee on the Rights of Persons with Disabilities (the 'CRPD Committee') which monitors the implementation of the UNCRPD by those States that have ratified it, argues that restrictions based on a person's purported mental disorder or mental incapacity discriminate against disabled people and are therefore contrary to the UNCRPD. Accordingly, the Committee rejects laws that a) permit detention on grounds of disability (which includes individuals with a 'mental disorder'); b)) deny legal capacity (the ability to hold, as well as exercise, rights and duties) on the basis of an assessment of 'impaired decision-making skills, often because of a cognitive or psychosocial disability' (mental incapacity) and/or c) authorise treatment without consent on the basis of a mental disorder or mental incapacity.¹⁹⁸

From a national perspective, therefore, the CRPD Committee requires a level of legal reform that strikes at the heart of both the MHA 1983 because it provides for the compulsory care and treatment on grounds of mental disorder and the MCA 2005 because it provides for decisions to be made on behalf of individuals who lack the capacity to make such decisions for themselves. The CRPD Committee's interpretation of the obligations under the UNCRPD also establishes an insurmountable conflict with the ECHR, given that the ECHR makes specific provision for the detention and compulsory treatment on grounds of mental disorder.

This thesis does not purport to provide a detailed analysis of the UNCRPD's implications for mental health law (a topic that has already generated a wealth of scholarly commentary¹⁹⁹), nor to reconcile the conflict between the UNCRPD and the ECHR. However, whatever the outcome of such divisions, the UNCRPD requires a reconsideration of the basis on which individuals are subject to compulsion and this question is as important for adolescents as it is for adults. The UNCRPD is therefore referred to where relevant to adolescent psychiatric care, in particular Chapter 5 which considers admission and treatment for mental disorder under the MHA 1983. As

¹⁹⁷ Phrase used by Cathy Asante, Legal Officer, Scottish Human Rights Commission in her presentation at the Inaugural UK Mental Disability Conference, Nottingham University, June 2016.

¹⁹⁸ CRPD General Comment 1 (n 164) para 15.

¹⁹⁹ See for example P Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75 (5) MLR 752-778; G Szmukler, R Daw and F Callar 'Mental health and the UN Convention on the rights of persons with disabilities' (2014) International Journal of Law and Psychiatry 37(3) 245; B McSherry and P Weller (eds) *Rethinking Rights Based Mental Health Laws* (Hart Publishing 2010); P Fennell and U Khaliq, 'Conflicting or complementary obligations? The UN Disability Rights Convention on Human Rights and English Law', EHRLR [2011] (6) 662.

discussed in that chapter the CRPD Committee's interpretation of the UNCRPD's prohibition of compulsory care on grounds of a mental disorder has recently been endorsed by the UN High Commission on Human Rights' report to the UN General Assembly.²⁰⁰

PART 3: STRUCTURE OF THESIS

Part I (Chapters 2 – 3): Foundations of the Legal Framework for Adolescent Psychiatric Care

Chapter 2 is concerned with the circumstances in which adolescents can consent to their admission to hospital and treatment for mental disorder. This is the first legal route identified in the summary of adolescent psychiatric care set out in Part 1 above. By exploring the meanings of the concepts of competence, capacity and consent and how they relate to each other also provides the conceptual framework for the analysis of the circumstances in which non-consensual adolescent psychiatric care is permitted under national law, which is considered in Part II of this thesis.

These points are explored through the prism of autonomy, focusing on the four meanings of autonomy described by the philosopher Joel Feinberg.²⁰¹ It does so because although the principle of respect for autonomy is a common mantra within medical law, and the term 'adolescent autonomy' has entered into the legal lexicon, the meaning and scope of autonomy is unclear. Generally, it receives little analysis from the courts. This chapter identifies 'Gillick competence' as playing a similar role to that of mental capacity, by acting as a gatekeeper to autonomy, but highlights that autonomy should not be equated with the right of self-determination. Thus, the autonomy-liberty dyad noted in Part 2 above is relevant, in that there is a distinction between adolescents having the right (liberty) to make decisions and their ability (autonomy) to do so. This highlights the differences between legal capacity and mental capacity, a distinction that has been blurred with the advent of the MCA 2005, but is fundamental to understanding the legal framework for adolescent psychiatric care.

²⁰⁰ Human Rights Council, Annual Report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary General *Mental health and human rights Report of the United Nations High Commissioner for Human Rights A/HRC/34/32*, 2017.

²⁰¹ J Feinberg 'Autonomy', in J Christman (ed) *The Inner Citadel Essays on Individual Autonomy*, Echo Point Books & Media 2014), (Feinberg) 28. This chapter was originally published as chapter 18 of *Harm to Self*, by J Feinberg 1986 OUP (Feinberg).

Chapter 3 is concerned with the basis on which the law recognises adolescents as having the decisional capacity to make decisions about their psychiatric care, which as noted in Part 1 above is a crucial factor in determining which legal route to adolescent psychiatric care applies in any given case. It examines the two relevant legal tests, the concept of ‘*Gillick* competence’ and the assessment of a lack of capacity under the MCA 2005, by exploring the development of the law in this area, starting with the House of Lords decision in *Gillick v West Norfolk and Wisbech Area Health Authority (Gillick)*,²⁰² which culminated in the introduction of the MCA 2005.

The chapter argues that no clear criteria for assessing *Gillick* competence were established by either the House of Lords in *Gillick*, or the Court of Appeal in the subsequent cases concerning adolescents’ refusal of treatment. As a result, inconsistent interpretations of this concept have been applied by the courts. This may be addressed by the MHA Code 2015’s guidance which suggests a test of *Gillick* competence that is based on the criteria for ‘ability to decide’ under the MCA 2005. The chapter considers the MCA 2005 and its application to young people. This is not straightforward given that some provisions of the MCA 2005 do not apply to young people. There is also an overlap between the MCA 2005 and the laws that govern under 18s. Despite such complexity, in comparison to the wealth of legal commentary in relation to adults, the MCA 2005’s application to young people has received little attention.

Part II (Chapters 4 – 6): Analysing Adolescent Non-consensual Psychiatric Care Through a Human Rights Lens

Part II focuses on three scenarios in which non-consensual adolescent psychiatric care is permitted under national law, namely the High Court’s powers to override an adolescent’s refusal of treatment; adolescents’ admission and treatment under the MHA 1983 and the powers of parents to authorise the informal admission of their child. In each of these chapters the three ‘human rights decision-making questions’ discussed in Part 2 above are considered and areas of confusion or uncertainty identified.

Chapter 4 is concerned with the powers of the High Court to override an adolescent’s refusal of life-saving treatment irrespective of the adolescents’ decisional capacity. An application to the court is the necessary legal route where the adolescent cannot be

²⁰² *Gillick* (n 36) For a detailed account of the historical background to this case see J Fortin ‘The *Gillick* Decision – Not Just a High-water Mark’ in S Gilmore, J Herring and R Probert (eds) *Landmark cases in family law* (Hart Publishing 2011).

admitted and treated on an informal basis but, for some reason, detention under the MHA is not possible. The justification for the non-consensual intervention, and therefore the key issue for the court to determine, is whether it is in the ‘best interests’ of the adolescent to override the adolescent’s refusal.

The chapter first analyses the decision of the Supreme Court of Canada in *AC and Others v Manitoba (Director of Child and Family Services) (Manitoba)*.²⁰³ This judgment illustrates the complexities of such cases and the varying approaches the courts take to justify overriding the wishes of an adolescent when the consequence of not doing so may be fatal. The chapter goes on to consider the decision in *An NHS Foundation Trust v P (P 2014)*,²⁰⁴ in which the court authorised the treatment of an adolescent who was refusing life-saving treatment following an overdose. It argues that while such cases are likely to engage a positive duty on the High Court to protect the adolescent’s life under Article 2 of the ECHR, this does not abrogate the court’s responsibility to consider the adolescent’s rights under Article 8 to her bodily integrity (such as to be free from non-consensual medical treatment). Although neither address such cases specifically, both ECHR jurisprudence and the CRC in its General Comment 14 require greater consideration of the adolescent’s wishes than is given by the national courts. The national courts should explain how the adolescent’s wishes not to receive the medical treatment have been balanced against the (understandable and pressing) concerns to act against those wishes in the interests of the adolescent’s welfare.

Chapter 5 considers the powers under the MHA 1983 to detain individuals with a mental disorder in hospital and treat them without consent. Such powers, which can be applied to individuals of any age and irrespective of the person’s decisional capacity, are likely to be considered if it is not possible to provide the adolescent with psychiatric care on an informal basis. By examining the basis on which the MHA 1983 authorises compulsory care on the grounds of ‘mental disorder’ through the human rights lens outlined in Part 2 above, this chapter highlights significant cracks in the façade of the MHA 1983’s compatibility with the ECHR, in particular the Act’s the extensive compulsory treatment powers. The chapter also highlights specific concerns in relation to the admission of adolescents to adult psychiatric wards or their placement in child and adolescent psychiatric units that are situated many miles from their homes.

²⁰³ (2009) SCC 30 [2009] 2 SCR 181.

²⁰⁴ [2014] EWHC 1650 (Fam), [2014] Fam Law 1249.

Chapter 6 examines the circumstances in which parents can authorise their child's admission to hospital for psychiatric care so that the adolescent can be admitted informally. This question arises when the adolescent lacks decisional capacity in relation to the proposed admission to hospital for psychiatric care and engages two key concepts, namely the 'scope of parental responsibility' and 'deprivation of liberty'. As noted in Part 1 above, an adolescent who lacks decisional capacity can be admitted on the basis of parental consent, if this falls within the 'scope of parental responsibility'. If the adolescent is aged 16 or 17 and lacks capacity under the MCA 2005, the adolescent can be admitted in accordance with the MCA 2005 provided that this does not give rise to a deprivation of liberty. The chapter explains the relevance of the concepts of the scope of parental responsibility and deprivation of liberty to these two legal routes.

The chapter argues that considerable confusion has arisen in this area of law due to a misunderstanding and/or misapplication of these two key concepts and how they relate to each other. The chapter covers three main areas. First, it explores what is meant by the scope of parental responsibility and deprivation of liberty in national law and why they are relevant to determining whether adolescents who lack decisional capacity can be admitted to hospital informally. Secondly, it considers the development of the ECtHR's jurisprudence in establishing when a deprivation of liberty has arisen and in the light of such case law, revisits *Nielsen v Denmark* (1988)²⁰⁵ which remains the leading case on the deprivation of liberty of adolescents in need of psychiatric care. Thirdly, it analyses two recent cases emanating from the national courts concerning the deprivation of liberty and adolescents, namely *Trust A v X (A Child)*²⁰⁶ and *Birmingham City Council v D (A Child)*.²⁰⁷ It argues that the court's expansive interpretation of the scope of parental responsibility in *Trust A v X* neither accords with the guidance on the scope of parental responsibility, nor reflects ECtHR jurisprudence. It also highlights the inconsistencies between the approach adopted in *Trust A v X* in relation to under 16s and that of *Birmingham CC v D* in relation to 16 and 17 year olds.

Part III (Chapter 7): Conclusion

Chapter 7 concludes the thesis as follows. First, it revisits how the legal framework for adolescent psychiatric care should operate. Secondly, it identifies areas of uncertainty in

²⁰⁵ *Nielsen v Denmark* (1989) 11 EHRR 175 para. 72.

²⁰⁶ *Trust A v X* (n 24).

²⁰⁷ *Birmingham City Council v D (A Child)* [2016] EWCOP 8, [2016] COPLR 198.

matters relating to decisional capacity, the determination of best interests, the application of the MHA 1983, deprivation of liberty, the scope of parental responsibility and the role of parental consent. Thirdly, the chapter considers the human rights implications of the legal framework for adolescent psychiatric care, focusing on three points. The first is that more needs to be done to ensure that the views of the adolescent are taken into account when making decisions about their non-consensual psychiatric care. The chapter explains why the CRC's General Comment 14 provides a model of best practice in this regard. The second point highlights concerns about the compatibility of the MHA 1983 with the ECHR, in particular in relation to the compulsory treatment provisions under part IV of this Act. Thirdly, it reiterates the serious concern that whereas, in the wake of *Trust A v X*,²⁰⁸ parents appear to have extensive powers regarding the psychiatric care of adolescents who lack *Gillick* competence, such an approach does not accord with relevant ECHR jurisprudence.

The summary provided in Part 4 of the chapter concludes that the law relating to adolescent psychiatric care is uncertain and that an underlying cause of such uncertainty is the presence of the three 'drivers for protection' (mental disorder, mental incapacity and minority). Although recent changes in law and policy have helped to clarify how the law should operate, uncertainties remain, the most significant uncertainties being due to a lack of clarity on the meaning and application of key concepts, namely decisional capacity, deprivation of liberty and the scope of parental responsibility.

Secondly, the chapter makes a series of recommendations which are divided into three categories. The first, relating to enhancing best practice, proposes that guidance based on the CRC's General Comment 14 should be developed as a tool to assist in decision making in relation to adolescent psychiatric care; and that a survey is undertaken of professionals working in Child and Adolescent Mental Health Services (CAMHS) and other professionals to ascertain what training and further guidance they require. The second category identifies areas for further research (to better understand how the law is operated in practice, to undertake a human rights evaluation of adolescent psychiatric care and to further investigate the concerns raised about the stigma and discrimination arising from being detained under the MHA 1983). The third category concerns legal reform, proposing that it is essential that a comprehensive review of the law concerning the provision of care and support to under 18s is undertaken. Furthermore, two areas of law specific to adolescent psychiatric care are proposed. The first is that the compulsory treatment provisions of the MHA 1983 must be amended to address their incompatibility

²⁰⁸ (n 25).

with the ECHR. The second is that safeguards should be introduced for all under 18s admitted to hospital for psychiatric care as informal patients, whether or not they are considered to be deprived of their liberty.

CHAPTER 2: AUTONOMY, COMPETENCE, CAPACITY AND CONSENT: KEY CONCEPTS FOR ADOLESCENTS' PSYCHIATRIC CARE

INTRODUCTION

Just like adults, adolescents can consent to their admission to hospital and treatment for mental disorder, if they are willing and able to do so. Unlike adults, not all adolescents are assumed to have the legal authority to do so.

The *Mental Health 1983 Code of Practice* (MHA Code 2015),¹ which is statutory guidance (so practitioners undertaking functions under the MHA 1983 must have regard to it and give reasons for any departure from it²) identifies three key elements of consent. First, there must be 'the voluntary and continuing permission of a patient' in relation to a particular treatment.³ Secondly, this must be 'based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it'.⁴ Thirdly, '[b]y definition, a person who lacks capacity is unable to consent or refuse treatment, even if they co-operate with the treatment or actively seek it'.⁵ Failure to meet any one of these requirements for 'capacity, voluntariness and adequate information' will mean that the person's consent is not valid. To put it another way, this would 'render a decision non-autonomous'.⁶ However, there is a fourth requirement, namely that the person has the authority (legal capacity) to decide about the proposed health care intervention. Although adolescents can be admitted to hospital and treated for their mental disorder informally, on the basis of their consent, if they have the decisional capacity to give consent and do so, the source of their legal authority to give consent differs from that of adults.

The purpose of this chapter is twofold. The first is to examine the legal basis on which adolescents can consent to their psychiatric care and the principles that underpin the law. This entails consideration of the concepts of 'competence' and 'capacity', what they

¹ Department of Health *Mental Health Act 1983: Code of Practice* (TSO 2015), (the MHA Code 2015).

² MHA 1983 s118. See also discussion in Chapter 1 on the importance of the MHA Code 2015.

³ MHA Code 2015 (n 1) para 24.34.

⁴ MHA Code 2015 (n 1) para 24.34.

⁵ MHA Code 2015 (n 1) para 24.35.

⁶ M Donnelly, 'The right of autonomy in Irish law', (2008) MLJI 14(2) 36.

mean and how they relate to consent and to each other, and where the law differs in this regard between adults and adolescents. Identifying such anomalies is fundamental to understanding some of the complexities in the legal framework for adolescent psychiatric care. This links to the second purpose, which is to provide the conceptual framework for the discussions in subsequent chapters by highlighting areas requiring further analysis.

Analysis and structure of this chapter

The analysis is undertaken through the prism of 'autonomy'. The reason for doing so is twofold. First, this provides a means for exploring the four elements of consent noted above and how this relates to the autonomy-liberty dyad highlighted in Chapter 1 as being an important feature of adolescent psychiatric care. Secondly, within the medical law context (within which the law relating to adolescent psychiatric care sits), 'autonomy' is a term that is often used, but rarely explained. Its ubiquitous use belies its complexity. Given that since the introduction of the Human Rights Act (HRA) 1998, the concept of 'adolescent autonomy' has also become a common mantra, it is necessary to consider what autonomy means and how it relates to the legal framework for adolescent psychiatric care.

Part 1 explains the basis on which adolescents can consent to their admission to hospital and treatment for mental disorder and the changes in law and policy which have limited the circumstances in which parental consent can authorise such psychiatric interventions to cases where the adolescent lacks decisional capacity.

Part 2 examines the concept of autonomy and how it relates to the concepts of competence, capacity and consent to explore how these concepts are relevant to the legal framework for adolescent psychiatric care. It does so by considering how these elements connect with the four descriptions of autonomy described by Joel Feinberg in his 1986 essay, 'Autonomy'.⁷

The chapter concludes by summarising the issues that require further consideration and which of the subsequent chapters will address them.

⁷ J Feinberg 'Autonomy', in J Christman (ed) *The Inner Citadel Essays on Individual Autonomy*, Echo Point Books & Media 2014), 28. This chapter was originally published as chapter 18 of *Harm to Self*, by J Feinberg (OUP 1986).

PART 1: ADOLESCENTS' CONSENT TO ADMISSION TO HOSPITAL AND TREATMENT

A significant difference in the law of consent between adults and adolescents was illustrated by the findings of the Latey Committee (commissioned to consider whether the age of majority (then 21 years) should be lowered) which reported in 1967 that there was 'no rule of English law which renders a minor incapable of giving his consent to an operation but there seems to be no direct judicial authority establishing that the consent of such a person is valid'.⁸ As a result of this Committee's recommendation that the position be clarified in relation to young people aged 16 and over,⁹ legislation (section 8 of the Family Law Reform Act (FLRA) 1969) makes provision for this group of adolescents, but not for those aged under 16.

Similarly, section 131 of the Mental Health Act (MHA) 1983 makes specific provision for young people aged 16 and 17 to make decisions about their admission to hospital, but is silent with regard to under 16s. However, under common law under 16s are able to consent to their admission to hospital and medical treatment if they are *Gillick* competent.

The basis on which adolescents of both age groups can be admitted to hospital and treated for their mental disorder on the basis of their consent is discussed below. This is followed by consideration of the legal routes available where the adolescent does not consent to the proposed admission to hospital or treatment for mental disorder.

1.1 Legal Capacity to Consent to Medical Treatment: Adolescents Aged 16 and 17

The legal authority for young people to consent to their own medical treatment is set out in section 8(1) of the FLRA 1969, which states:

The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of

⁸ *Report of the Committee on the Age of Majority* (1967) (Cmnd. 3342) (Latey Commission) 117, para 479.

⁹ Latey Commission (n 8), 118, para 483 '...without prejudice to any consent that may otherwise be lawful, the consent of young people aged 16 and over to medical or dental treatment shall be as valid as the consent of a person of full age'.

this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

Section 8 establishes that just as adults do, young people can authorise their own medical treatment. It 'presumes that young people have the legal capacity to agree to surgical, medical or dental treatment'.¹⁰ Thus, the consent of an adolescent aged 16 and 17 provides the requisite authority for that treatment to be given so there is no need to obtain parental consent.

1.2 Legal Capacity to Consent to Medical Treatment: Adolescents Aged Under 16

In relation to adolescents aged under 16 years, case-law, not legislation, established their right to consent to treatment. As Lord Donaldson noted in *Re W*, the 1985 decision of the House of Lords in *Gillick v West Norfolk & Wisbeck Area Health Authority* ('*Gillick*')¹¹ established that 'at common law a child of sufficient intelligence and understanding (the "*Gillick* competent" child) could consent to treatment, notwithstanding the absence of the parents' consent and even an express prohibition by the parents'.¹²

Prior to this ruling, it was not clear whether children could consent to their own treatment. Such a question was of major significance given that otherwise any doctor who provided medical treatment to a person aged less than 16 years without parental consent would be liable for trespass or assault.¹³ In his pre-*Gillick* publication, *Law, Ethics and Medicine*, Skegg took a similar line to that adopted by the House of Lords in *Gillick*. He regarded the argument that minors were incapable of consenting to medical procedures as being due to a 'misconception' of the law. He explained that if children could not consent to this form of 'touching', they would not be able to consent to others, such as having a haircut and there would have been no need for the introduction of the Tattooing of Minors Act 1969 'for a tattooist who tattooed a minor with only that minor's consent would commit a battery'.¹⁴ He considered that the 'common law does not fix any age below which minors

¹⁰ Department of Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice*, (the MCA Code) para 12.11. See also: P Skegg *Law, Ethics, and Medicine: Studies in Medical Law*, (Clarendon Press Oxford 1984), 'the minor has attained the age of sixteen years there can be no doubt as to his capacity to consent to medical 'treatment'', 50.

¹¹ [1986] AC 112, [1985] 3 All ER 205.

¹² *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, [1992] 4 All ER 627, CA 75 (Lord Donaldson).

¹³ Technically this would only be the case if the doctor had to examine, or otherwise touch the patient. However, *Gillick* (n 11) raised the question of the 'legal capacity of a girl under 16 to consent to contraceptive advice, examination and treatment', 166 (Lord Fraser).

¹⁴ Skegg (n 10) 52. Tattooing of Minors Act 1969 s1 states: 'It shall be an offence to tattoo a person under the age of eighteen except where the tattoo is performed for medical reasons by a duly qualified medical practitioner or by a person under his direction, but it shall be a defence for

are automatically incapable of consenting to medical procedures' and the question would be 'whether the minor can understand what is involved in the procedure in question'.¹⁵

In any event *Gillick* confirmed that subject to being assessed as being competent, adolescents will have the legal capacity to consent. How *Gillick* competence is determined is discussed in Chapter 3.

1.3 Legal Capacity of Adolescents to Consent to Admission to Hospital

Individuals can be admitted to hospital without use of the compulsory admission procedures under the MHA 1983. Section 131 (1) states:

Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or [registered establishment] in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act, or from remaining in any hospital or [registered establishment] in pursuance of such arrangements after he has ceased to be so liable to be detained.¹⁶

This means that adolescents can be admitted to hospital informally, in other words without being detained in hospital under the MHA 1983. Adolescents aged under 16 who are *Gillick* competent can consent to their admission to hospital.¹⁷ Specific provision is made for adolescents aged 16 or 17 years in that section 131 (3) of the MHA 1983 provides that if they have capacity (as defined under the MCA 2005¹⁸) 16 and 17 year olds can decide whether they wish to agree to, or refuse, their admission to hospital¹⁹ and their decision cannot be overridden by parental consent.²⁰ Like adults, 16 and 17

a person charged to show that at the time the tattoo was performed he had reasonable cause to believe that the person tattooed was of or over the age of eighteen and did in fact so believe'. J Montgomery ('Children as Property' (1988) 51 MLR 323, 340) states that this legislation was introduced 'to turn the moral principle that minors are insufficiently mature to understand the wider significance of tattooing into legal reality'.

¹⁵ Skegg (n 10) 53.

¹⁶ MHA 1983 s131. Chapter 19 of the MHA Code 2015 (n 1) provides guidance on issues relevant to children and young people's admission to hospital and treatment for mental disorder.

¹⁷ MHA Code 2015 (n 1) para 19.65.

¹⁸ MHA 1983 s131(5)(a).

¹⁹ MHA 1983 s 131 applies to informal admission for patients requiring 'treatment for mental disorder'. In *R v Kirklees Metropolitan Borough Council ex p C* (a minor) [1992] 2 FCR 321; [1992] 2 FLR 117; [1993] Fam Law 455 (CA), the Court of Appeal considered that although this provision does not cover admission for assessment of mental disorder, this could be arranged under common law.

²⁰ MHA 1983 s131(4).

year olds are presumed to have the capacity to decide about their admission to hospital,²¹ unless established otherwise.²²

1.4 Admission to Hospital and Medical Treatment: Adolescent's Refusal

Chapter 1 noted the shift in law and policy in relation to the circumstances in which adolescents' refusal of admission and treatment can be overridden by their parents. Whereas in the past it was possible to rely on parental consent where the adolescent did not agree to the admission to hospital or treatment, reliance on parental consent to authorise an adolescent's informal admission to hospital and/or treatment for mental disorder is limited to where the adolescent lacks decisional capacity. The MHA Code 2015, summarises the position in its statement that: '[p]arental consent should not be relied upon when the child is competent or the young person has capacity to make the particular decision'.²³

In relation to young people's admission to hospital, section 131(4) of the MHA 1983 makes explicit that parental consent cannot be relied upon to override the adolescent's refusal.²⁴ Although the Act makes no such provision in relation to the refusal of adolescents aged under 16 years who are *Gillick* competent, the MHA Code 2015 advises against relying on parental consent in such circumstances. The Code also advises against relying on parental consent where an adolescent (of any age) with decisional capacity is refusing treatment.²⁵

When explaining such changes, the MHA Code 2008 stated that there is no post-Human Rights Act decision' in relation to parents overriding the adolescent's refusal in such

²¹ MHA 1983 s131(5) provides that 'the reference to a patient who has capacity is to be read in accordance with the Mental Capacity Act 2005'. See chapter 3 for further discussion on the Mental Capacity Act 2005 (MCA 2005).

²² If there are concerns that a young person lacks capacity, this should be assessed in accordance with the MCA 2005 s 2 and s 3.

²³ MHA Code 2015 (n 1), paras 19.39 and 19.66 (in relation to under 16s) and 19.59 (in relation to 16 and 17 year olds).

²⁴ The statutory recognition of a young person's refusal was introduced as part of the reforms under the Mental Health Act (MHA) 2007. See C Parker 'Children and Young People and the Mental Health Act 2007' (Nov 2007) 16 JMHL 174 who notes (176-177) that initially this provision was not included in the Bill laid before Parliament, even though the Draft Mental Health Bill 2004 (clause 20) had included a similar provision, reflecting the observation in the White Paper, *Reforming the Mental Health Act, Part 1: The new legal framework*, (December 2000) CM5016-I (paras 3.70-3.72) that 'complex ethical problems' arose from the then legal position that a young person's refusal could be overridden by parental consent. However, the Government agreed to introduce such an amendment in response to concerns raised during the parliamentary debates.

²⁵ MHA Code 2015 (n 1) para 19.39.

circumstances and that the 'trend in recent cases is to reflect greater autonomy for competent under 18s'.²⁶ The previous Code of Practice to the MHA 1983 of 1999 had considered that the parents of under 16 year olds could override their child's refusal of admission to hospital or treatment for mental disorder.²⁷ In relation to 16 and 17 year olds, it advised that if the young person was unwilling to be admitted consideration should be given to using the MHA 1983 but in relation to medical treatment, stated that parental consent could override the young person's refusal (albeit suggesting again that consideration should be given to whether the use of the MHA 1983 would be appropriate).²⁸

The 1999 MHA Code's advice was based on the Court of Appeal's decisions in the 'treatment refusal cases'²⁹ of *Re R (A Minor) (Wardship: Consent to Treatment) (Re R)*³⁰ and *Re W (A Minor) (Medical Treatment: Court's Jurisdiction) (Re W)*,³¹ which countered the widespread interpretation of the decision of the House of Lords in *Gillick* as establishing that if 'Gillick competent', adolescents could make decisions for themselves, irrespective of the outcome. The Court of Appeal held, first in *Re R* (in relation to a 15 year old) and then in *Re W* (in relation to a 16 year old) that notwithstanding their right to consent to medical treatment, adolescents' refusal of such treatment can be overridden by the High Court acting under its inherent jurisdiction if this is in the adolescent's best interests. Although not relevant to the issue before the court in either case (the court's comments therefore being *obiter*), in *Re W*, Lord Donaldson MR repeated the view (supported by both Balcombe LJ and Nolan LJ) he had expressed in *Re R*³² that parental consent could override the wishes of minors. These decisions,

²⁶ Department of Health *Mental Health Act 1983: Code of Practice* (TSO 2008) (MHA Code 2008) para 36.43; see also para 36.33. The MHA Code 2015 (n 1) (para 19.39) refers to the courts giving 'greater weight to their [adolescent's] views'.

²⁷ Department of Health *Mental Health Act 1983: Code of Practice* (1999) (MHA Code 1999) paras 31.6 and 31.12.

²⁸ MHA Code 1999 (n 27) 31.9 and 31.

²⁹ A term used by some commentators for the series of cases, starting with *Re E (A Minor) (Wardship: Medical Treatment)* [1992] 2 FCR 219; [1993] 1 FLR 386; [1993] Fam Law 116; in which the courts were asked to consider whether treatment should be given to children despite their refusal (the case was decided in September 1990).

³⁰ [1992] Fam 11; [1991] 4 All ER 177.

³¹ *Re W* (n 12).

³² *Re R* (n 30). This point was not considered by the other judges in *Re R*. Lord Staughton [29] indicated that he did not agree with this interpretation but did not think it necessary to decide upon this issue because in his view a wardship judge has powers to consent to treatment 'when the ward has not been asked or has declined'.

'perceived as signalling the retreat from *Gillick*',³³ have generated widespread criticism,³⁴ and their ramifications continue to be the subject of debate.³⁵

Although stating only that it is 'not advisable' to rely on parental consent in such circumstances,³⁶ practitioners are expected to comply with the guidance in the MHA Code 2015 unless there is a good reason not to do so. Adherence to the Code should mean that adolescents who have decisional capacity and are not willing to agree to their admission to hospital or treatment for their mental disorder are no longer admitted or treated informally by relying on parental consent.

As a consequence of this change in law and policy the number of under 18s who are admitted under the MHA 1983 is likely to rise. This is because, like adults, even though they have decisional capacity, adolescents who are not willing to consent to the proposed admission to hospital and treatment for mental disorder can be detained and treated without their consent under the MHA 1983,³⁷ if the criteria are met. If it is not possible to admit under the MHA 1983, a court order would need to be sought,³⁸ save where a life-threatening emergency required immediate action to prevent death or severe permanent injury.³⁹

1.5 Summary of Part 1

Part 1 has identified the basis on which the law permits adolescents to consent to their admission to hospital and treatment. It has also highlighted the change in law and policy which limits the circumstances in which parental consent can be relied upon to authorise adolescents' admission to hospital and treatment therein to cases in which the adolescent lacks decisional capacity. However, adolescents can be admitted to hospital

³³ M Brazier and C Bridge, 'Coercion or Caring: Analysing Adolescent Autonomy' (1996) 16 *Legal Studies* 84, referring to the term used, reflecting the commentary on *Re R* by Douglas (G Douglas 'The Retreat from *Gillick*', (1992) 55 *MLR* 569).

³⁴ See for example Douglas (n 33) 575, A Bainham 'The Judge and the Competent Minor' (1992) 108 *LQR* 194. For a contrary view, see N Lowe and S Juss, 'Medical Treatment Pragmatism and the Search for Principle' (1993) 56 *MLR* 865, LF Ross 'Against the Tide: Arguments against Respecting a Minor's Refusal of Efficacious Life-Saving Treatment', (2009) *Camb Q Health Ethics* 18, 302.

³⁵ S Gilmore and J Herring ' "No" is the hardest word: consent and children's autonomy' (2011) *CFLQ* 23(1), 3 and Cave E and Wallbank J, 'Minors Capacity to Refuse Treatment: A Reply to Gilmore and Herring' (2012) *MedLRev* 20 (3), 423.

³⁶ MHA Code 2015 (n 1) para 19.39.

³⁷ Discussed in Chapter 5.

³⁸ MHA Code 2015 (n 1) para 19.39. Similar advice is given in Department of Health *Reference Guide to Consent for Examination of Treatment* (2nd ed., DH 2009) 34 and 35.

³⁹ MHA Code 2015 (n 1) paras 19.71 – 19.72.

and treated for mental disorder without their consent under the MHA 1983 (if the criteria for detention are met), failing which an application could be made to the court for authorisation of such non-consensual treatment.

PART 2: AUTONOMY COMPETENCE, CAPACITY AND CONSENT

Feinberg's meanings of autonomy (which are not mutually exclusive) illustrate that this concept 'has a variety of different connotations and can be understood and appreciated and applied in importantly distinct ways'.⁴⁰ Autonomy:

...can refer either to the *capacity* to govern oneself, which of course is a matter of degree; or to the *actual condition* of self-government and its associated virtues; or to an *ideal of character* derived from that conception; or (on analogy to the political state) to the *sovereign authority* to govern oneself, which is absolute within one's own moral boundaries (one's own "territory", "realm", "sphere" or "domain").⁴¹

The first of Feinberg's categories, the 'capacity to govern oneself', is the 'minimum relevant capability' of individuals for 'the "task" of living their own lives according to their own values as they choose'. This reflects the generally accepted view, that self-government is central to autonomy.⁴²

Having such 'basic autonomy'⁴³ is crucial to Feinberg's '*actual condition* of self-government' (which focuses on whether the individual can self-govern at the relevant time) and '*sovereign authority*' (in other words, right) to govern oneself.⁴⁴ He observes that it could be possible to 'possess both the capacity and the condition without the right of self-government' adding that '[i]t is clearly possible to possess the right and the

⁴⁰ V Ashley, 'Philosophical Models of Personal Autonomy', *Essex Autonomy Project Green Paper Report* (University of Essex: Essex Autonomy Project, 2012) (the EAP report).

⁴¹ Feinberg (n 7), 28.

⁴² J Christman and J Anderson *Autonomy and the Challenges of Liberalism* (Cambridge University Press, 2005), 3, consider that the core meaning of autonomy rests 'in the idea of being one's own person, directed by considerations, desires, conditions and characteristics that are not simply imposed externally on one, but are part of what can somehow be called one's authentic self', so that the focus is on 'the person's competent self-direction free of manipulation and "external" forces - in a word "self-government"'.⁴³

⁴³ The term used by the EAP report ((n 40) 5) for this understanding of autonomy: 'minimal capacity...which signifies the ability to act independently, authoritatively and responsibly'.

⁴⁴ Feinberg (n 7), 29, further notes that although some 'competent persons' have more capabilities, such as intelligence and judgment, than others, 'above the appropriate threshold they are deemed no more competent (qualified) than the others at the "task" of living their own lives according to their own values as they choose'.

capacity while falling short of the condition'.⁴⁵ However, 'it does not seem possible to either achieve the condition or possess the right while lacking (totally lacking) the capacity'. Feinberg's meaning of autonomy as 'an ideal of character' ('ideal autonomy'), highlights that there are negative, as well as positive, aspects of autonomy.

Part 2, explores the key aspects of consent, namely 'competence' and 'capacity' and how they apply to adolescent psychiatric care, within these four meanings of autonomy.

First, the notion of autonomy and the law of consent is outlined, focusing on three areas of concern that have been raised by commentators in relation to adults, and which are also relevant to adolescent psychiatric care. These are that autonomy does not equate with the right of self-determination, the gatekeeping role of decisional capacity for autonomy, and the sharp divide between those who are autonomous and those who are not.

Secondly, adolescents' legal capacity to make decisions about their psychiatric care is considered in the context of Feinberg's meanings of autonomy as the 'capacity to govern oneself' and the right to self-govern.

Thirdly, Feinberg's meaning of autonomy as the '*actual condition* of self-government' and its connection to the three elements of consent identified by the MHA Code 2015 (decisional capacity, voluntariness and sufficient information) is considered, including a discussion on the function of 'competence', as compared to 'capacity'.

Fourthly, Feinberg's observations on autonomy as 'an *ideal of character*' which question whether autonomy is credible, achievable, or even desirable are also explored. Such questions form part of contemporary philosophical critiques of autonomy. Moreover, they link to the shift that can be observed in legal and human rights principles, which in some areas have started to move away from regarding autonomy as being the arbiter on whether individuals wishes are respected, towards a focus on enabling individuals to participate in the decision-making process, regardless of their decisional-capacity.

2.1 Autonomy and the Law on Consent to Treatment

In the medico-legal context, the 'classic expression'⁴⁶ of the principle of autonomy, often cited by the judiciary, is that articulated by Cardozo J. in *Schloendorff v. Society of New*

⁴⁵ Feinberg (n 7) 28.

⁴⁶ A Maclean, 'Now You See It, Now You Don't: Consent and the Legal protection of Autonomy', (2000) *Journal of Applied Philosophy*, 17(3) 277.

York Hospitals,⁴⁷ in which he stated that ‘every human being of adult years and sound mind has a right to determine what shall be done with his own body’⁴⁸ (albeit today the terms ‘capacity’ or ‘mental capacity’ are substituted for the out-dated term ‘sound mind’). While the principle appears to be clear, the reality is somewhat different. Paradoxically, as Coggon and Miola note, while autonomy ‘has become deceptively familiar’ and ‘has, in many respects, attained a supreme status’ within medical ethics and health care law, there is a ‘considerable variation in *how* the concept is understood’.⁴⁹ Differing judicial accounts of autonomy include: an entitlement ‘to be eccentric ...unorthodox...obstinate...irrational’;⁵⁰ entailing ‘the freedom and the capacity to make a choice’;⁵¹ making a decision which may be unwise or with which others might disagree⁵² and freedom from external control or influence’.⁵³

Donnelly observes that although ‘respect for autonomy now provides the philosophical underpinning for much of bioethics and law, this concept ‘is more dynamic and complex than is sometimes appreciated in legal discussions on its role in healthcare decision-making’.⁵⁴ Foster notes that despite the ‘vast and nuanced literature’ on autonomy, ‘by and large, practising lawyers either ignore, or are unaware of the philosopher’s efforts’ and although some legal academics have engaged with the philosophical theories ‘their work has either not been quoted in courtroom argument, or has not been thought to be sufficiently material to be grafted into the judgments’.⁵⁵ In a similar vein, Veitch argues

⁴⁷ (1914) 211 N.Y. 125; 105 N.E. 92, 95.

⁴⁸ *Schloendorff* (n 47) 95. C Foster describes this statement as ‘Mill, without the harm principle’ in ‘Autonomy in the Medico-Legal Courtroom: A Principle Fit for Purpose?’ (2014) *MedLRev* 22(1): 48, 52.

⁴⁹ J Coggon & J Miola ‘Autonomy, liberty and decision-making’ (2011) *Cambridge Law Journal* 70(3) 523, 524 [emphasis in the original].

⁵⁰ *DL v Local Authority* [2012] EWCA Civ 253, [2012] Fam 1, [2012] 3 All ER 1064 [76] (Davis LJ).

⁵¹ *R v C (Respondent) (On Appeal from the Court of Appeal (Criminal Division))* [2009] UKHL 42, [2009] 1WLR 1786 [27] (Lady Hale).

⁵² *Re SB (A Patient) (Capacity to Consent to Termination)* [2013] EWHC 1417 (COP), [2013] 3 FCR 384, [10].

⁵³ *XXC v AA and Others* [2012] EWHC 2183 (CoP) [59]. An interesting international comparison is the New Zealand case, *Seales v Attorney General* [2015] NZHC 1239, in which Collins J noted that this concept of “is multi-faceted and subject to much debate”. The Judge adopted Beauchamp and Childress’s description of individual autonomy as “... self-rule that is free from both controlling interference by others and limitations that prevent [the individual from making] meaningful choice[s] [about his or her body]” (citing *Principles of Biomedical Ethics* (7th edn) at 101)).

⁵⁴ M Donnelly *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism: Autonomy, capacity and liberalism* (Cambridge University Press 2010), 10.

⁵⁵ Foster (n 48) 49. Donnelly (n 54) makes a similar comment, noting that an article by K Atkins (‘Autonomy and the Subjective Character of Experience’, (2000) 17 *Journal of Applied Philosophy* 71) ‘is one of the rare philosophical pieces relied upon by the courts, having been quoted by Dame Butler-Sloss in *Re B (An Adult: Medical Treatment)* [2002] 2 All ER 449, 469-70’ In that case, the article was referred to by the Official Solicitor’s medical (psychiatric) expert, whom Dame Butler-Sloss regarded as ‘a most impressive witness’.

that the 'importance of autonomy in medical law has been accompanied by the unimportance of the need for detailed reflection on its meaning'.⁵⁶ Likewise, Coggon notes that although the courts refer to academic literature on autonomy from time to time, '[i]t is rare for a judge to provide an explicit, philosophical investigation of autonomy'.⁵⁷

The following three points are of key relevance when considering the relationship between autonomy and the law of consent.

First, while autonomy is regarded as significant in health care decisions, it is not synonymous with the right of self-determination, even for adults. Although 'adolescent autonomy' has been enhanced to the extent that the powers of parents to override the wishes of adolescents has diminished, the courts can and do override adolescents' wishes where this is considered necessary for their welfare.

Secondly, for both adults and adolescents, the test for decisional capacity has a 'gatekeeping role' for autonomy.⁵⁸ However, in relation to adults, commentators have raised concerns that the test for decisional capacity is used to override the wishes of the person concerned while purporting to uphold the principle of respect for autonomy. Thus, Foster describes the courts paying 'lip service to autonomy', arguing that while the courts purport 'to rely only or mainly on autonomy they generally use (often covertly), other principles too', such as beneficence.⁵⁹ He criticises the courts for delegating 'the real decision-making to the notion of capacity'.⁶⁰ Donnelly observes that 'the right to refuse treatment has been moderated in practice through the enthusiastic application of the capacity requirement'.⁶¹ That the courts have applied an outcome orientated test is also a criticism raised by commentators in relation to adolescents' decisional capacity.⁶²

⁵⁶ K Veitch *The Jurisdiction of Medical Law* (Ashgate 2007) 55.

⁵⁷ J Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) *Health Care Anal* 15, 235, 236.

⁵⁸ Donnelly (n 54) 272. See also T Beauchamp and J Childress *Principles of Biomedical Ethics* (7th ed OUP 2013) 114.

⁵⁹ Foster (n 48), 49. Foster's comments echo a debate within medical ethics over the status of autonomy, which is only one of the 'four clusters of moral principles' proposed by Beauchamp and Childress (n 58), the others generally considered to be nonmaleficence (obligation to abstain from harming others), beneficence (contributing to others welfare), and justice (fair, equitable and appropriate treatment. Professor Carl Schneider refers to the 'suffocating hegemony of the autonomy principle' ('Beyond Autonomy' (2006) 41 *Wake Forest L. Rev.* 411, 413). McCall Smith raises concerns about the extent to which 'autonomy has crowded out other values and how uncritically it is used', commenting that 'the governing concept of autonomy is frankly overworked' ('Beyond Autonomy', (1997-1998) 14 *J. Contemp. HealthL. Pol'y* 23, 27 and 30). See also, M Brazier 'Do no harm - do patients have responsibilities too?' (2006) *CLJ* 65, 397.

⁶⁰ Foster (n 48) 49 – 58.

⁶¹ Donnelly (n 54) 71.

⁶² Brazier and Bridge (n 33).

Thirdly, there is ‘a dramatic and draconian apartheid between the capacitous and the incapacitous’.⁶³ Donnelly illustrates this when she notes that the smallest pin-prick, given without consent, can constitute a battery, whereas for a person who lacks mental capacity, even extreme physical invasions are considered to be unproblematic ‘provided that the basis for the invasion met an often amorphous best interest standard’.⁶⁴ This is also a concern for adolescents who lack decisional capacity.

These points are returned to in the analysis below which considers how Feinberg’s meanings of autonomy provide further insights into the legal framework for adolescent psychiatric care.

2.2 Autonomy as the Right to Self-Govern: Adolescents’ Legal Capacity

The following four areas relating to adolescent’s legal capacity to consent to their psychiatric care are considered: a) basic autonomy, minority and legal capacity; b) the limitations of autonomy as a right to self-govern; c) the myth of adolescent autonomy; and d) the distinction between legal capacity and mental capacity.

2.2.1 Basic Autonomy: Minority and Legal Incapacity

Whereas, the Court of Appeal held in *Re T (adult: refusal of treatment)*⁶⁵ that adults ‘have the right and capacity’ to decide whether or not to receive medical treatment (albeit the presumption of (mental) capacity is rebuttable) this is not the case for under 18s.⁶⁶ Adolescents’ legal capacity is derived either from legislation or case law that specially provides the extent to which they have authority to make decisions for themselves. In a rare judicial explanation for the distinction between adults and minors, Sir Thomas Bingham MR stated in *Re S (Hospital Patient: Court’s Jurisdiction)* that the ‘simple rule’ of respecting ‘the right of adults of sound mind to physical autonomy’ did not apply to ‘minors and those subject to serious mental illness because they...may be unable to form or express any, or reliable, judgment of where their best interests lie’.⁶⁷ This is similar to Feinberg’s requirement that individuals have the capacity to self-govern, thus ‘basic autonomy – which signifies the ability to act independently, authoritatively and responsibly’.⁶⁸ It also resonates with John Stuart Mill’s doctrine of liberty, which is

⁶³ Foster (n 48) 58.

⁶⁴ Donnelley (n 54) 71.

⁶⁵ [1993] Fam 95, [1992] 4 All ER 649.

⁶⁶ Whereas in *Re T* (n 65) Lord Donaldson stated (at 654) that adults have the ‘absolute right’ to make decisions about their treatment, he made clear that this excluded minors.

⁶⁷ [1995] 1 FLR 1075, CA, 1087.

⁶⁸ The EAP report (n 40) 5.

regarded as being a significant influence on the understanding of autonomy within the law of consent.⁶⁹ Famously, it excluded minors.⁷⁰ Arnott explains that this was due to the ‘widespread belief that children were immature and incapable of looking after themselves physically, mentally and emotionally’ they were ‘viewed as being unable to consent’ and ‘were perceived as lacking the ability to form their own judgments’.⁷¹

Noting that the views of John Locke and John Stuart Mill are regarded as being influential in this area, Arnott cites Locke’s view that ‘parents had a duty to take care of their offspring “during the imperfect state of childhood...[and to] govern the actions of their yet ignorant nonage”’ and that ‘Mill excluded children from his principle of liberty because they were not ‘in the maturity of their faculties [and] must be protected against their own actions as well as against external injury’.⁷² The minors depicted by Locke and Mill would not meet Feinberg’s threshold for basic autonomy and as such could not be regarded as having the right to self-govern, in other words, they would lack legal capacity.

Nonetheless, as discussed in Part 1 above, adolescents can acquire the legal capacity to make health care decisions in certain circumstances.

2.2.2 Limitations of autonomy as a right to self-govern

The courts use a variety of phrases such as the ‘principle of self-determination’⁷³ and the ‘right to decide one’s own fate’⁷⁴ (‘which may be seen as a basic human right protected by the common law’⁷⁵), as if they equate with, or at least go hand in hand with, the principle of respect for autonomy.⁷⁶ Thus in *R (Burke) v General Medical Council*

⁶⁹ Donnelly (n 54) 17 – 19. Donnelly concludes that Mill’s libertarian approach is the most likely influence on the law’s approach to autonomy (commentators also cite the philosophical writings of Immanuel Kant as another possible source of inspiration). Having concluded that the ‘Kantian conception of autonomy’ is ‘not about free choice but about the drive to appropriate or moral action’, Donnelly sides with O’Neill in questioning how this links to personal autonomy. O’Neill is not convinced that either Mill or Kant is the true protagonist. O’Neill considers that within medical ethics, autonomy is generally seen as ‘a capacity for independent decisions and action’ and that such a view of autonomy as independence is likely to owe ‘as much or more to twentieth-century conceptions of character and individual psychology and to studies of moral development than they do to older traditions of moral philosophy’ (O’Neill, *Autonomy and Trust in Bioethics* (Cambridge University Press 2002) 23).

⁷⁰ *On Liberty* (1859) in J S Mill, *Utilitarianism* (Fontana Press 1962) 135.

⁷¹ S Arnott ‘Autonomy, Standing and Children’s Rights’ (2006-2007) 33 Wm. Mitchell L. Rev. 807, 812.

⁷² Arnott (n 70) 812.

⁷³ See for example, *Airedale National Health Service Trust v Bland* [1993] AC 789 HL, 864 (Lord Goff).

⁷⁴ *Re T* (n 65) 112 (Lord Donaldson).

⁷⁵ *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, 882 (Lord Scarman).

⁷⁶ *Coggon* (n 57) 237, notes ‘On the whole, judges talk of autonomy as being equivalent to self-determination’. See for example, *St George’s Healthcare NHS Trust* [1999] Fam 26, 43 (Judge

(*Burke*) Munby J (as he then was) emphasised the ‘absolute nature’ of the principle of autonomy⁷⁷ when citing the ‘well established rule’ articulated by Butler-Sloss LJ in *Re MB* that ‘[a] mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death’.⁷⁸ The reality, however, is that autonomy does not confer on individuals such an ‘absolute right’ on whether to give or withhold consent to medical treatment as the following points illustrate.

First, while this view of autonomy is considered to be influenced by John Stuart Mill’s philosophy of libertarianism,⁷⁹ it is only a partial understanding of Mill’s doctrine. Foster notes that it focuses on the sovereignty element (‘Over himself, over his body and mind, the individual is sovereign’) at the expense of ‘his “harm principle” - the notion that individual liberties can legitimately be truncated in order to avoid harms to third parties’.⁸⁰ Donnelly is concerned that it does not truly reflect the philosophy propounded by Mill, which was a more sophisticated theory than the ‘simple view of autonomy as non-interference’.⁸¹

The importance of this caveat is highlighted by O’Neill who explains that Mill’s harm principle is reflected in medicine and contemporary ethics in that the ‘general requirement of consent to medical treatment is always hedged with provisos permitting treatment without consent when refraining from treating would harm others’.⁸²

Secondly, “[a]utonomy and the right of self-determination do not entitle the patient to insist on receiving a particular treatment regardless of the nature of the treatment’⁸³ – in other words, consent to treatment is limited to what is proposed by the health professionals.

Thirdly, even if a person consents to the treatment offered, this may not be sufficient. For example, the MHA 1983 provides that some treatments, such as psycho-surgery⁸⁴ and

LJ): ‘Even when his or her own life depends on receiving treatment, an adult of sound mind is entitled to refuse it. This reflects the autonomy of each individual and the right of self-determination.’

⁷⁷ [2004] EWHC 1879 (Admin), [2005] QB 424, 2 WLR 431, Munby J noted that the ‘source of this aphorism’ is from Lord Templeman’s judgment in *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 904.

⁷⁸ *Burke* [2005] EWCA Civ 1003; [2006] QB 273, (Lord Phillips MR giving the judgment of the court).

⁷⁹ Donnelly (n 54) Foster (n 48).

⁸⁰ Foster (n 48) 50.

⁸¹ Donnelly (n 54) 23.

⁸² O’Neill (n 68).

⁸³ *Burke* CA (n 77).

⁸⁴ MHA 1983 s 57.

electro-convulsive therapy for under 18s,⁸⁵ require (save in emergencies) specific safeguards to be followed before the treatment can be given, irrespective of the person's consent.

Such points highlight the autonomy-liberty dyad referred to in Chapter 1. In this regard, Coggon and Miola describe 'autonomy' as relating to free will, 'so an "autonomous agent" is someone with free will', while liberty 'relates to freedom to act without the interference of a third party'.⁸⁶ They explain that 'a person has the mental capacity to evaluate a situation and come to some decision of what is right does not automatically entail that she should be at liberty (have the legal capacity) then to act on her decision'.⁸⁷ To illustrate the difference between autonomy (mental capacity) and liberty (legal capacity), Coggon and Miola refer to the case of Diane Pretty,⁸⁸ who had a progressive neuro-degenerative disease and was unsuccessful in her legal battle to gain a declaration that her husband could assist her to die at a time of her choosing. They point out that Ms Pretty 'had the mental competence to make a decision that she should die but lacked the legal capacity to permit her husband to end her life'.⁸⁹

The autonomy-liberty dyad is relevant to the compulsory treatment powers under the Mental Health Act (MHA) 1983. Individuals may have the decisional capacity (autonomy) to make decisions about their admission to hospital and medical treatment therein, but if the criteria for detention are met, they can be detained in hospital and treated for mental disorder without their consent under the MHA 1983 regardless of their decisional capacity. Thus, they do not have the right (liberty) to refuse their admission to hospital, or treatment for mental disorder. The compulsory powers of the MHA 1983 are discussed in Chapter 5.

The relationship between autonomy and liberty is also relevant to where adolescents refuse health care (including psychiatric care) given that such refusals can be overridden by the courts if the intervention is in the adolescent's best interests. This is explored further below.

⁸⁵ MHA 1983 s 58A.

⁸⁶ Coggon and Miola (n 49). Noting that philosophical debates often consider autonomy from the perspective of Millian or Kantian theories, they question whether 'ideas based on Kantian autonomy...can be straightforwardly juxtaposed with Millian liberty'.

⁸⁷ Coggon and Miola (n 49) 532. Brazier ((n 59) 400) considers that while respect for autonomy is a key principle of medical ethics, 'this means more than simply "I must be given what I want"'.
⁸⁸ *Pretty v United Kingdom* (2002) 35 EHRR 1.

⁸⁹ Coggon and Miola (n 49) 532.

2.2.3 *The Myth of Adolescent Autonomy?*

As noted in Part 1 above, the explanation given in the MHA Code 2008 for advising against relying on parental consent to override the refusal of psychiatric care by adolescents with decisional capacity was that the 'trend in recent cases is to reflect greater autonomy for competent under 18s'.⁹⁰ While decisions of the courts might give this impression for the reasons set out below, if not a legal fiction, 'adolescent autonomy' has a limited currency.

First, while the post-HRA cases seem to promote 'adolescent autonomy', the judiciary's notion of this concept is less progressive than it first appears. In *Mabon v Mabon*,⁹¹ Thorpe LJ referred to a 'keener appreciation of the autonomy of the child and the child's consequential right to participate in decision making processes that fundamentally affect his family life'.⁹² The Judge placed great emphasis on Article 12 (the right of children to be heard) of the UN Convention on the Rights of the Child (UNCRC), when upholding the right of adolescents to be separately represented in proceedings between their parents that would determine which of the parents the adolescents would live. However, the right of participation is not the same as the right to be the arbiter of the decision. Fortin is concerned that Thorpe LJ 'comes dangerously close to eliding two very different principles',⁹³ while Bainham describes this decision as reflecting 'a weak form of autonomy', amounting 'to something less than a right of participation and certainly not a right to take decisions'.⁹⁴

Two other decisions are notable for their emphasis on adolescent autonomy. One is that of Munby J (as he then was) in *Re Roddy (a child) (identification: restriction on publication)* (Roddy),⁹⁵ which concerned a young person's wish to speak to the media. The other is the decision of Silber J in *R (Axon) v Secretary of State for Health and the Family Planning Association (Axon)*,⁹⁶ which concerned young people's right to have information concerning their sexual health kept confidential from their parents. The judges in both cases considered that adolescents who were 'Gillick competent' have a

⁹⁰ MHA Code 2008, para 36.43; see also para 36.33. Similar advice (albeit no reference is made to autonomy) Department of Health *Reference Guide to Consent for Examination of Treatment* (n 38) 15, para 34. The MHA Code 2015 (para 19.39) refers to the courts giving 'greater weight to their [adolescent's] views'.

⁹¹ [2005] EWCA Civ 634; [2005] Fam 366; [2005] 2 FLR 1011.

⁹² *Mabon v Mabon* (n 89) [26].

⁹³ J Fortin, 'The Gillick decision - not just a high water mark' in S Gilmore, J Herring and R Probert (eds), *Landmark cases in family law* (Hart Publications 2011) 217.

⁹⁴ A Bainham, 'Liberal paternalism in the courts' (2006) CLJ 65, 285, 288.

⁹⁵ [2003] EWHC 2917 (Fam); [2004] 2 FLR 949.

⁹⁶ [2006] EWHC 37 (Admin); [2006] QB 539, 2 WLR 1130.

right to respect for their autonomy under Article 8 (the right to private and family life) of the ECHR. However, Article 8 is a qualified right meaning that there may be circumstances in which an interference with the right may be justified, such as where there are concerns about the adolescent's welfare.⁹⁷ As Fortin notes, in *Roddy* the question was whether the young person could tell her story to the media, 'the outcome of which would not endanger her life'.⁹⁸ Silber J's (*obiter*) view that parents' right to family life under Article 8 (and with it the right to be involved in health care decisions about their child) falls away once their child attains *Gillick* competence⁹⁹ is more to the point. *Axon* may also be the source of the Department of Health's advice against relying on parental consent in such circumstances, with some commentators suggesting that 'the parental power to veto a competent child's consent may be subjected to legal challenge'¹⁰⁰ However, commentators question whether Silber J's interpretation of Article 8 is supported by ECtHR jurisprudence.¹⁰¹

Secondly, irrespective of the views expressed by the judiciary in relation to 'adolescent autonomy', it was not raised in either of the two post-HRA cases concerning adolescents' refusal of life-saving medical treatment. The outcome of both cases was that the court authorised the medical treatment. In the first case, which related to a 16 year old Jehovah's Witness who refused blood treatments, neither the HRA 1998, nor the adolescent's autonomy was mentioned.¹⁰² In the second case, *An NHS Foundation Trust Hospital v P (P 2014)*,¹⁰³ (explored in more detail in Chapter 4), although the HRA 1998 was referred to by the court, the outcome was that the adolescent's refusal could

⁹⁷ The list of circumstances in which an interference with the right to private and family life might be justified under Article 8 (2) includes 'the protection of health'.

⁹⁸ Fortin 'The *Gillick* decision' (n 91).

⁹⁹ *Axon* (n 94) [131].

¹⁰⁰ E Cave and Z Stavrinides in *Medical Practitioners, Adolescents and Informed Consent* School of Law, University of Leeds April 2013, 22 suggest that in the light of *Axon* (n 94) 'the parental power to veto a competent child's consent may be subjected to legal challenge'. Cave explores this further in E Cave 'Competence and authority: adolescent treatment refusals for physical and mental health conditions' (2013) *Contemporary Social Science* 8(2), 92. The General Medical Council states in *0 – 18 years: guidance for all doctors* (General Medical Council 2007) '...the law on parents overriding young people's competent refusal is complex', and advises that legal advice is sought on whether to apply to the court (see paras 31 – 32).

¹⁰¹ See R Taylor, 'Reversing the retreat from *Gillick*? R (*Axon*) v Secretary of State for Health' (2007) *CFLQ* 19(1) 81, 94; albeit Taylor considers (at 92) that 'the proposition that Article 8 rights to parental authority dwindle with the maturity of the child is an attractive one', being 'able to accommodate the growing respect for the autonomy of children'. Fortin, is less convinced, commenting that Silber J's general comments in this area 'had little real substance' (Fortin 'The *Gillick* decision' (n 91) 219 – 220).

¹⁰² *Re P (Medical Treatment: Best Interests)* [2003] EWHC 2327 (Fam); [2004] 2 FLR 1117.

¹⁰³ [2014] EWHC 1650 (Fam); [2014] Fam Law 1249.

be overridden, notwithstanding the Judge's conclusion that on the limited evidence available to him he was not satisfied that the adolescent lacked capacity.¹⁰⁴

Thus, the courts have maintained their pre-HRA 1998 stance in holding that 'it is the duty to the court to ensure so far it can' that adolescents reach adulthood.¹⁰⁵ In this regard, the view expressed by Taylor in 2007 on the position of adolescents following the treatment refusal cases of the Court of Appeal remains pertinent (albeit in relation to adolescent psychiatric care, her concerns in relation to parents have been alleviated somewhat by the legal and policy changes noted in Part 1 of this chapter).¹⁰⁶ Having noted that while the House of Lords decision in *Gillick* 'appeared to give a "*Gillick* competent" child the autonomy to control important aspects of her life', Taylor identifies two developments that have limited this interpretation as 'granting autonomy to mature minors'. The first is that 'the courts have been unwilling to find that a child is competent if her decision conflicts with the court's view of her welfare, even where the child's decision is based on long-held beliefs'.¹⁰⁷ The second is that in cases concerning refusal of treatment, '*Gillick* has been interpreted as granting children the capacity to consent to treatment but not as removing parental rights of consent [which] means that a *Gillick* competent child's decision to refuse can be overridden by the consent of her parents or the court'.¹⁰⁸

Similarly, Freeman refers to the 'pretence that is competence', suggesting that the courts and probably doctors are 'reluctant to find a child competent to the point of imposing more stringent requirements than are imposed on adults' and that 'it is clear that competence is irrelevant where the really important questions are addressed'.¹⁰⁹ Brazier and Cave observe that while '*Gillick* appeared to establish a right to adolescent autonomy. It proved an odd sort of 'right', a right to say yes but not to say no'.¹¹⁰ In their view '[a]dolescent autonomy is little more than myth'.¹¹¹

¹⁰⁴ *P* (2014) (n 101).

¹⁰⁵ Johnson J in *Re P* 2003 (n 100) [9] citing Nolan LJ in *Re W* (n 12). Baker J referred to the 'heavy duty of the court' to do so in *P* (2014) (n 101) [16].

¹⁰⁶ Taylor (n 99) 82.

¹⁰⁷ Taylor (n 99) 82.

¹⁰⁸ Taylor (n 99) 82.

¹⁰⁹ M Freeman 'Rethinking *Gillick*' (2005) 13 *Int'l J Chil. Rts* 201, 4. See also C Bridge 'Religious Beliefs and Teenage Refusal of Medical Treatment' (1999) 62 *MLR* 585, 594.

¹¹⁰ M Brazier and E Cave, *Medicine, Patients and the Law* (6th ed, Manchester University Press 2016) para 14.1. See also Cave 'Competence and authority' (n 98).

¹¹¹ Brazier and Cave (n 108) para 14.21.

2.2.4 The Distinction Between Legal Capacity and Mental Capacity

Two of Feinberg's meanings of autonomy, the actual condition of autonomy and the right of self-government,¹¹² illustrate the important distinction between 'legal capacity' and 'mental capacity' and thus the relevance of the autonomy-liberty dyad described in Chapter 1.

In the aftermath of the MCA 2005, discussions on decision-making have tended to focus on mental capacity and to the extent that legal capacity is considered relevant, it appears to have been conflated with mental capacity. However, that there is a distinction, and an important one, is demonstrated by the above discussion on the limitations autonomy as a right to self-govern. It is also relevant to 'adolescent autonomy'. The reason for questioning whether this is a myth is because whereas adolescents might have the decisional capacity to refuse medical treatment they do not have the legal capacity to do so given that the courts can override their refusal. The following points expand upon this distinction between legal capacity and mental capacity and its relevance to adolescent psychiatric care.

First, legal capacity provides the authority (in other words, power, or right) of individuals (agents) to perform a particular function with legally binding consequences, such as making a will, entering into a contract or giving consent to treatment. If the law does not recognise a person as having the authority to act, that person lacks the necessary 'legal capacity', irrespective of his or her abilities to make the particular decision or take the relevant action. It is '...in its essential form the exercise of a legally recognised power, bestowed in English law through statute or the common law' including the 'a legal power vested in an individual by law to make decisions affecting herself in respect of a specific activity'.¹¹³

On the other hand, 'mental capacity' is concerned with an individual's ability to make the decision. Crucially, the test under the MCA 2005 to establish whether a person lacks capacity entails a 'functional' test combined with a 'diagnostic' test in that to lack mental capacity under this Act the person must be unable to decide 'because of an impairment

¹¹² Feinberg (n 7) discusses 'Autonomy as Right' at 46 - 49.

¹¹³ P Bielby *'The conflation of competence and capacity in English medical law: A philosophical critique'*, (2005) *Medicine, Health Care and Philosophy* 8:357, 359. Bielby argues that there are two senses of legal capacity; the first being the one noted in the text. The second is where 'a surrogate decision-maker exercising legal capacity on behalf of a mentally incompetent person'. Bielby gives the powers of the Lasting Power of Attorney under the MCA 2005 as example of this second meaning. As such powers are not relevant to adolescents (they apply only to those over 18), the discussion in the text focuses on Bielby's first sense of legal capacity.

of, or a disturbance in the functioning of, the mind or brain' (the 'diagnostic element').¹¹⁴ The relevance of a finding that the person lacks capacity under the MCA 2005 is that decisions can be made on the person's behalf, in accordance with the MCA 2005, which requires that any action taken is made in the person's 'best interests'.¹¹⁵ The test for capacity under the MCA 2005 is discussed in more detail in Chapter 3.

Secondly, the distinction between legal capacity and mental capacity has perhaps been lost because, by virtue of having reached 'the age of majority' (eighteen years),¹¹⁶ individuals gain the legal capacity to undertake a range of decisions, including decisions about their health care and are presumed to have the decisional capability to make decisions for themselves.¹¹⁷ The MCA 2005 provides that '[a] person must be assumed to have capacity unless it is established that he lacks capacity'.¹¹⁸

Adults generally only lose their legal capacity if they are held to lack mental capacity in accordance with the MCA 2005. Thus, for adults, as Richardson explains, there is a direct correlation between legal capacity and mental capacity:

For the law, mental capacity is an essential ingredient of individual autonomy and is employed to define the line between legally effective and legally ineffective decisions. Those with *mental* capacity will have the *legal* capacity to act; their decisions or choices will be respected. In contrast, those who lack mental capacity will also lack legal capacity; their decisions and choices will not be respected and decisions will be made by others on their behalf.¹¹⁹

Hence, for adults, having the right to make decisions (Feinberg's autonomy as 'the right to self-govern', Coggon and Miola's 'liberty') is within the health care context determined by whether they have the 'mental capacity' to do so (unless they are detained under the MHA 1983).

Such a link is not as straightforward for adolescents as it is for adults. As Hollingsworth notes, in many areas adolescents may lack the legal capacity (which she described as

¹¹⁴ MCA 2005 s 2.

¹¹⁵ MCA Code (n 10) para 1.3, MCA 2005 sections 4 and 5.

¹¹⁶ Family Law Reform Act (FLRA) 1969 s1.

¹¹⁷ See Bielby (n 111) 357 'Historically, competence to consent to treatment and research has been accorded on the presumption of being a cognitively functional adult'.

¹¹⁸ MCA 2005 s1(2).

¹¹⁹ G Richardson 'Mental Capacity in the Shadow of Suicide' (2013) *International Journal of Law in Context* 9(1) 87, 89. *Masterman-Lister v Brutton & Co* [2002] EWCA Civ 1889, [2003] 3 All ER 162 [57] (Lord Justice Chadwick).

'de jure autonomy') - because they are not legally entitled to perform the relevant task, or make the particular decision - even if they are competent to perform the particular task (and therefore have 'de facto autonomy').¹²⁰

Thirdly, that legal incapacity is not just a consequence of 'mental incapacity' was emphasised by the Law Commission in its 1991 consultation paper *Mentally Incapacitated Adults and Decision-Making: An Overview*. It explained that it 'can arise from a variety of conditions', whenever the law provides that a particular person 'is incapable of taking a particular decision, undertaking a particular juristic act, or engaging in a particular activity'.¹²¹ It is therefore not just a consequence of 'mental incapacity', with the Law Commission referring to 'being under the age of majority' as an example of a legal incapacity that is not concerned with 'mental incapacity'.¹²²

Fourthly, recognition of the importance of maintaining a distinction between these two concepts has been revived by the UN Convention on the Rights of Persons with Disabilities (UNCRPD), with the Committee for this treaty (CRPD Committee) holding that 'mental capacity must not be used as a justification for denying legal capacity'. It refers to legal capacity as 'the ability to hold rights and duties (legal standing) and to exercise these rights and duties (legal agency), while mental capacity 'refers to the decision-making skills of a person'.¹²³

2.3 Consent and Autonomy as the Actual Condition of Self-government

While Feinberg's exploration of what might be required to meet 'the actual condition of self-government'¹²⁴ (which he considers to encompass 'a remarkably miscellaneous' set of virtues¹²⁵) delves into yet more profound notions such as self-possession and authenticity, his initial observations resonate with the three core elements of consent (decisional capacity, voluntary and sufficient information). He notes that irrespective of a person's 'capacity for, and right to, self-government', for a range of differing reasons, situations arise in which the person 'does not actually govern himself, whatever his rights and capacities'; thus:

¹²⁰ K Hollingsworth, 'Theorising Children's Rights in Youth Justice: The Significance of Autonomy and Foundational Rights', (2013) 76(6) MLR 1046-1069, 1058.

¹²¹ Law Commission, Consultation Paper No. 119 (Law Com No 119, 1991).

¹²² Law Com No 119 (n 119) para 2.10.

¹²³ Committee on the Rights of Persons with Disabilities General Comment No. 1 (2014) *Article 12: Equal Recognition before the law* (CRPD/C/GC/1) para. 12.

¹²⁴ Feinberg (n 7) 3.

¹²⁵ The EAP report (n 40), 11, notes that 'the conditions for autonomy' is 'a site of much debate and disagreement'.

I do not govern myself if you overpower me by brute force and wrongfully impose your will on mine, or if illness throws me into a febrile stupor, delirium or coma, or poverty reduces me to abject dependence on the assistance of others.¹²⁶

The connections between this conception of autonomy, which emphasises that a wide range of factors can enhance or hinder the attainment of autonomy at any one time¹²⁷ and the core elements of consent are explored by considering the following areas.

First, Bielby's detailed examination of the meaning of competence is considered, which he distinguishes from 'capacity'. Although it is common for the concepts of 'competence' and 'capacity' to be used interchangeably in English law, Bielby argues that they are 'two of the least understood and most poorly employed'.¹²⁸

Secondly, the factors that might inhibit a person acting autonomously and how this might be evaluated are considered. This section draws from the analysis of the report of the Essex Autonomy Project, *Philosophical Models of Autonomy* (the EAP report)¹²⁹ which examines the various ways in which autonomy theorists have sought to explain what it means to be autonomous.

Thirdly, two models of autonomy identified by the EAP report ('weakly substantive' and 'strongly substantive') are contrasted with the powers of the High Court to authorise non-consensual interventions in the best interests of the adolescent and irrespective of their decisional capacity.

2.3.1 Competence: ability to perform the task

The importance of the link between the ability to decide is expressed by Grisso and Appelbaum in *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals*, as '...the enjoyment of one of the most fundamental rights of a free society – the right to determine what shall be done to one's own body –

¹²⁶ Feinberg (n 7) 31.

¹²⁷ Feinberg (n 7) devotes most of his article on this meaning of autonomy (30 – 45). He also points out that 'de facto self-government presupposes *luck* [emphasis in original]', 31.

¹²⁸ Bielby (n 111) 357. Although Beauchamp and Childress ((n 58) 114) argue that the distinction 'breaks down in practice' the distinction they have identified differs from the one considered here – they refer to clinicians assessing capacity and incapacity 'whereas courts determine competence and incompetence', but as argued in this chapter the distinction needs to be made to show how the different legal concepts of 'competence', 'mental capacity' and 'legal capacity' operate within English law.

¹²⁹ The EAP report (n 40).

turns on the possession of those characteristics that we view as constituting decision-making competence'.¹³⁰

Bielby identifies two functions of competence (it should be noted that he is not using this term in the legal 'Gillick competence' sense, rather to explore what the notion of 'competence' entails). The first is 'agency competence', which is the ability, or potential ability, 'to act voluntarily for freely chosen purposes or at least the potentiality to do so'.¹³¹ The second function of competence, referred to by Bielby as 'task specific competence' 'describes the ability of an individual to perform or participate in a specialised activity successfully', such as cooking or playing the cello.¹³² These two functions of competence and how they are determined are explained below.

2.3.1.1 Competence to Decide

Bielby's 'agency competence', like Feinberg's 'basic autonomy' has a low threshold and 'will be met by most persons', including adolescents.¹³³ In contrast, the threshold for task specific competence will depend on the task. The very nature of task specific competency (involving 'specialised abilities such as abstract reasoning, creative talent or physical strength') means that individuals will achieve a different set of task competencies because each person will 'possess a different range of task specific competencies and to different degrees of proficiency'.¹³⁴ This is similar to the views expressed by the medical ethicists, Beauchamp and Childress, who emphasise that the criteria for particular competencies will vary, depending on the task being considered so that the test for 'someone's competence to stand trial, to raise dachshunds, to answer physician's questions, and to lecture to medical students are radically different'.¹³⁵

¹³⁰ T Grisso and P Appelbaum *Assessing Consent to Treatment A Guide for Physicians and other Health Professionals* (OUP) 1998, 1.

¹³¹ Bielby (n 111) 358.

¹³² Although Feinberg's description of competence does not include the concept of 'agency competency' and 'task competency' he refers to individuals having 'natural competence – minimal relevant capability for a task – that is used in stipulations of necessary and sufficient conditions for the sovereign right of self-government ascribed to individuals', having previously noted that different individuals will have the legal competence to perform different task (the priest can conduct a wedding but not legislate, the legislator can make laws but 'lacks the power to make people married' (Feinberg (n 7) 28-29).

¹³³. This is clear from Bielby's subsequent discussions in relation to the circumstances in which children and young people can make decisions about their health care. While noting that there is a question as to whether 'agency competency can be had by neonates, severely mentally ill persons or those in a persistent vegetative state', Bielby (n 311) considers this to be a separate point and therefore does not seek to address this (see footnote 79) 358.

¹³⁴ Bielby (n 111) 358.

¹³⁵ Beauchamp and Childress (n 58) 115.

Bielby's two-part notion of competence is relevant to decisions about admission to hospital and treatment for mental disorder, in that it identifies that individuals may be capable of making decisions for themselves generally, but may not be able to perform a particular task,¹³⁶ either at all - or for a variety of reasons may not be able to do so at a given time, in relation to a particular decision.¹³⁷ This 'bifurcation of competence into a universal strand (agency competence) and a particular strand (task specific competence)¹³⁸ resonates with the differences autonomy theorists identify between 'global' personal autonomy (pertaining 'to the status of an agent over the course of a life') and 'local' personal autonomy (pertaining 'to a particular decision, made at a particular time and in a particular context').¹³⁹ It therefore emphasises the importance of establishing whether the adolescent can make the particular decision, whether this be about admission to hospital, or treatment for mental disorder, *at the time* the decision needs to be made.

2.3.1.2 Basis on which competence to decide determined

Bielby's explanation as to how a person is acknowledged as having the requisite task specific competence highlights a significant difference in the law's approach to adult's ability to make health care decisions and that of adolescents.

Bielby notes that task specific competence can be gained through either 'demonstrable' or 'presumed' proficiency. The requirement that a person passes a driving test before being entitled to drive is an example of a 'demonstrable proficiency test' - the individual has met 'a benchmark standard of skill at the activity'. This is to be contrasted with 'presumed task specific competence rights' which 'are bestowed on all agents upon fulfilling a criterion the agent can reasonably expect to achieve automatically, such as reaching 18 years of age in respect of gaining the right to vote in the UK'.¹⁴⁰

Applying this distinction to health care decisions, it can be seen that adults have 'presumed' proficiency in relation to their health care decisions. Albeit a rebuttable presumption (the 'right to decide one's own fate presupposes a capacity to do so'), Lord

¹³⁶ Bielby (n 111) 359.

¹³⁷ Bielby (n 111) 359. Beauchamp and Childress ((n 58) 102) note individuals who otherwise have 'self-governing capacities, and are, on the whole good managers of their health' may 'sometimes fail to govern themselves in particular choices because of temporary constraints caused by illness, depression, ignorance, coercion, or other condition that limit their judgment or their options'.

¹³⁸ Bielby (n 111) 359.

¹³⁹ The EAP report (n 40) 9.

¹⁴⁰ Bielby (n 111) 358.

Donaldson proclaimed in *Re T (adult: refusal of treatment)*¹⁴¹ that '[p]rima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death'. The assumption of capacity¹⁴² is now one of the five principles of the MCA 2005 (which applies to individuals aged 16 years and over) with the test for incapacity being set out in sections 2 and 3 of that Act. This is discussed in more detail in Chapter 3 but in brief, individuals lack the 'mental capacity'¹⁴³ to decide under the MCA 2005 only if they are assessed as being unable to decide (the 'functional element') 'because of an impairment of, or disturbance in the functioning of, the mind or brain' (the 'diagnostic element'). If this test is not met (on a balance of probabilities¹⁴⁴) the provisions permitting acts to be undertaken on behalf of the person will not be engaged.¹⁴⁵

In contrast, the concept of *Gillick* competence can be seen as an example of 'a demonstrable task specific competence', given that the person seeking to rely on the adolescent's consent must be satisfied that the adolescent is competent.¹⁴⁶ In other words, adolescents must prove that they have the requisite task specific competence to acquire the legal capacity to consent to their medical treatment. In contrast, adolescents aged 16 and 17 do not have to demonstrate that they are *Gillick* competent in relation to giving consent to their medical treatment. This is because, as noted in Part 1 above, by virtue of section 8 of the FLRA 1969, they are presumed to have reached an age where they are able to make such decisions for themselves. Bielby describes the 'statutory presumption' of legal capacity under this provision as being 'indicative of presumption of decision-making competence'.¹⁴⁷

¹⁴¹ *Re T* (n 65).

¹⁴² *Re T* (n 65) 652-653. Skegg questions whether the presumption of capacity has any real meaning: stating that despite frequent references to this "there do not appear to be any English medical law cases in which the common law presumption of capacity led to patients being regarded as competent, when, but for that presumption, they would have been regarded as incompetent" ('Presuming Competence to Consent: Could Anything be Sillier?' (2011) 30 U. Queensland LJ 165).

¹⁴³ Despite its title, the provisions of the MCA 2005 refer to 'capacity' and 'lack of capacity' rather than 'mental capacity', the only exception being Schedule 4 of the MCA 2005, which concerns Enduring Powers of Attorney, powers that were established under legislation pre-dating the MCA 2005. Similarly, the MCA Code refers to 'individuals who lack the mental capacity to make particular decisions for themselves' in chapter 1 (at para. 1.1) and refers to 'mental capacity' as being 'the ability to make a decision' (para. 2.9), but otherwise uses the term 'capacity' when providing guidance on the implementation of the MCA 2005.

¹⁴⁴ MCA 2005 s 2(4).

¹⁴⁵ MCA 2005 s 5 ('Acts in connection with the care or treatment') applies only if the person for whom such acts are undertaken is reasonably believed to lack capacity (as defined by MCA 2005 s 2).

¹⁴⁶ Bielby (n 111) 362.

¹⁴⁷ Bielby (n 111) 362.

2.3.2 Capacity: decisional capacity and autonomy

Given its focus on what is required for individuals to be considered to be acting autonomously, Feinberg's meaning of autonomy as the actual condition of self-government links to the point made in Part 1, that adolescents' right to decide about their medical treatment, or other interventions such as admission to hospital, is dependent on meeting the requisite legal test for decisional capacity. For the purpose of adolescent psychiatric care, the legal test for decisional capacity will be that of mental capacity under the MCA 2005 (for 16 and 17 year olds) or *Gillick* competence (for under 16s). Hence, they can both be seen as acting as the 'gatekeeper' to autonomy. These legal criteria are considered in Chapter 3.

The Essex Autonomy Project, *Philosophical Models of Autonomy* (the EAP report) describes varying approaches developed by autonomy theorists on the necessary conditions to attain autonomy ('a site of much debate and disagreement'¹⁴⁸). These models, which are outlined below, demonstrate the complexity of decision-making and the tensions that might arise when determining whether an adolescent's wishes should be upheld, even if this will be detrimental to the adolescent's welfare.

First, 'internalist' models focus 'upon an agent's reflective and evaluative capacities'. Such models incorporate capacities that fall within legal tests for decisional capacity, 'such as understanding and retaining relevant information, using it to weigh up available options, and communicating decisions reached'.¹⁴⁹ Other factors concern 'the *authenticity* of the values, preferences and character traits that motivate an agent's choice and ability to identify, evaluate and in some sense, validate these', as well as 'attitudes to self' such as self-respect,¹⁵⁰ which are also relevant to questions about the validity of a person's consent, such as whether it is truly voluntary. Similarly, 'externalist' models, which take into account outside influences such as freedom from manipulation and coercion¹⁵¹ resonate with the need to ensure that the person's agreement to the proposed health care intervention, such as admission to hospital or medical treatment, is free from 'unfair or undue pressure'.¹⁵²

In addition, the EAP report contrasts procedural models, (focusing on whether individuals are acting on the basis of their own desires, goals, and values rather than promoting 'any

¹⁴⁸ The EAP report (n 40) 11.

¹⁴⁹ The EAP report (n 40) 11, these factors reflect the MCA 2005 s3.

¹⁵⁰ The EAP report (n 40) 12.

¹⁵¹ The EAP report (n 40) 11-13.

¹⁵² MHA Code para 24.34.

particular conception of the good'¹⁵³) with substantive models. The EAP report notes that a difficulty with procedural models is that they 'do not clearly distinguish between...desires that are truly the agent's rather than the product of some manipulative force'.¹⁵⁴ Substantive models of autonomy do not seek neutrality. They either place restrictions on the preferences that the individual can act upon, or stipulate conditions that must be met if the individual is to be considered autonomous.¹⁵⁵ The two main categories of substantive models of autonomy described by the EAP report are relevant to the question whether adolescent autonomy is a myth discussed above. As discussed next, they depict the two means that Taylor and others identify as being employed to circumvent adolescent autonomy.¹⁵⁶ This gives rise to the 'adolescent autonomy conundrum', a term used in this thesis to reflect that the basis on which the courts consider overriding the adolescent's refusal of health care interventions is not always clear.

2.3.3 Substantive models of autonomy and the adolescent autonomy conundrum

The 'adolescent autonomy conundrum' highlights the importance of determining the justification for overriding an adolescent's wishes when these conflict with what others perceive to be in the adolescent's best interests. The relevance of the EAP report's two substantive models of autonomy ('weakly substantive' and 'strongly substantive') to this conundrum are discussed below.

2.3.3.1 Weakly substantive models of autonomy

Weakly substantive models are relevant to the question as to how adolescents' decisional capacity is determined. They do not directly challenge an individual's right to make decisions that are wrong, bad or against the person's best interests, but instead focus on whether the person has the requisite competencies 'to choose what is right, good and in their best interests'.¹⁵⁷ As the EAP report observes, much therefore depends on the 'the evaluative attitudes and skills' that are demanded for a person to be

¹⁵³ The EAP report (n 40) 14. See also G Dworkin 'The Concept of Autonomy' in J Christman (ed) *The Inner Citadel Essays on Individual Autonomy* (Echo Point Books & Media 2014) 61.

¹⁵⁴ The EAP report (n 40) 15. See also Beauchamp and Childress ((n 58) 103) who are skeptical of this approach, for example noting that such a theory might exclude many ordinary actions which would otherwise be considered autonomous because the person has not 'reflected on their preferences at a higher level', such as 'selecting tasty snack foods when grocery shopping'.

¹⁵⁵ The EAP report (n 40) 15 – 18.

¹⁵⁶ Taylor (n 99).

¹⁵⁷ The EAP report (n 40) 17.

considered autonomous given that the conditions imposed could be extensive and exacting.¹⁵⁸

The EAP report's note of caution in relation to this model of autonomy, resonates with Taylor's view that the courts are unwilling to find that an adolescent has decisional capacity when this conflicts with the court's opinion on what is in the interests of the adolescent's welfare.¹⁵⁹ While decisional capacity is not a guarantee that the adolescent's wishes will be respected, it is a prerequisite for the law to regard adolescents as having the agency to make decisions for themselves. Albeit not arguing that 'it should be easy for a minor to show she has sufficient competence to make life or death decisions', Taylor considers that 'the focus of the assessment should be 'on the functional capacity of the child'.¹⁶⁰ Taylor's concern, is that the courts' determination of decisional capacity is driven by misgivings about the adolescent's decision, rather than an assessment of the adolescent's ability to make the decision in question (thus adopting an 'outcome' approach, rather than a functional approach, which *Gillick* was supposed to have introduced), and in some cases a failure to provide sufficient information to the adolescent.¹⁶¹ For example, Brazier and Bridge state that the 'law should not pretend to apply a "functional" test of autonomy to every patient when younger patients are in fact subjected to a "outcome test"'.¹⁶²

2.3.3.1 *Strongly Substantive Models*

Strongly substantive models of autonomy are relevant to the question as to when an adolescent's wishes can be overridden irrespective of the adolescent's decisional capacity. This is because they allow interventions on a person's choices where that person 'wishes to engage in activity which would impair their future ability to live autonomously', thus permitting 'strong paternalism'.¹⁶³ The EAP report comments that this 'effectively amounts to an intervention in autonomous choice in what is regarded as that individual's best interests'.¹⁶⁴ This describes the situation of adolescents whose wishes are overridden in their best interests, where respecting their wishes is likely to be detrimental to their welfare, for example where there are concerns that to do so may lead to serious harm or even their death.

¹⁵⁸ The EAP report (n 40) 18.

¹⁵⁹ Taylor (n 99).

¹⁶⁰ Taylor (n 99) 95.

¹⁶¹ Taylor (n 99) 95.

¹⁶² Brazier and Bridge (n 33).

¹⁶³ The EAP report (n 40) 16.

¹⁶⁴ The EAP report (n 40) 16.

Taylor observes that this approach is defended by some 'as protecting the welfare of the child', adding that 'the right to say 'yes' but not 'no' is clearly inconsistent with an approach based on autonomous decision-making'.¹⁶⁵ This is Elliston's view. She argues that 'once a child achieves the ability to be regarded as autonomous, his or her consent should be legally binding'.¹⁶⁶ On the other hand, Fortin notes 'many theorists are reluctant to allow [adolescents] the freedom to make life threatening mistakes'.¹⁶⁷

One of the theories that seeks to explain the circumstances in which overriding the autonomous choice of an adolescent may be justified, is that of Freeman's 'liberal paternalism'.¹⁶⁸ He considers that children and young people are 'entitled to have both their present autonomy recognised insofar as it exists and their capacity for future autonomy safeguarded', but that while respecting a child's decision making capacities, we must 'at the same time note the dangers of complete liberation', which '[i]nvariably imposes limitations on a child's autonomy'.¹⁶⁹ Like Freeman, Eekelaar seeks to achieve a balance between respecting the wishes of adolescents while also protecting their welfare. His model of 'dynamic self-determinism' emphasises the importance of enabling children and young people to influence the outcome of decisions about them, but self-determinism would be disapplied if this threatened the adolescent's welfare.¹⁷⁰ The adolescent autonomy conundrum is returned to in Chapter 4.

2.4 Challenging traditional notions of autonomy: Autonomy as an Ideal

Feinberg suggests that the challenge for philosophers is to fashion a concept of autonomy that sufficiently reflects the notion that autonomy is concerned with self-government 'and yet describes a character type that is genuinely worthy of admiration and emulation in the modern world',¹⁷¹ pointing out that many of the virtues that are said to be integral to autonomy are not necessarily admirable, for example, a person may be autonomous but also selfish, cold, mean, unloving, ruthless and even cruel.¹⁷²

¹⁶⁵ Taylor (n 99).

¹⁶⁶ S Elliston, *The Best Interests of the Child in Healthcare* (Routledge-Cavendish 2007) 84.

¹⁶⁷ Fortin J, *Children's Rights and the Developing Law* (3rd ed Cambridge University Press 2009) 27.

¹⁶⁸ M Freeman, *The Rights and Wrongs of Children* (Frances Pinter 1983) 54-60.

¹⁶⁹ M Freeman 'Whither Children: Protection, Participation, Autonomy?' (1993-1994 22 ManLJ 307, 327.

¹⁷⁰ J Eekelaar 'The Interests of the Child and the Child's Wishes: the Role of Self-Determinism' (1994) 8 IJLPF 42, 53.

¹⁷¹ Feinberg (n 7) 43.

¹⁷² Feinberg (n 7) 44.

Reminiscent of John Donne's axiom '[n]o man is an island',¹⁷³ he warns of the dangers in forgetting that humans are 'social animals' who are connected to others in differing ways and that it is not possible for each individual to exercise 'his own autonomous choice about what, where, how, and when he shall be, each capable of surviving and flourishing, if he so chooses, in total independence of all the others, each free of any *need* for others'.¹⁷⁴

Such comments resonate with criticisms of the western liberal concept of autonomy raised within moral and political philosophy,¹⁷⁵ in particular, feminist theorists who regard the 'self-originating, self-sufficient, coldly rational, shrewdly calculating, self-interest maximising, male paragon of autonomy',¹⁷⁶ as not only objectionable, but untrue to real life. Noting that autonomy is seen as 'a kind of iconic value' that 'everyone should aspire to be independent and in control of his life', Nedlesky is concerned that it has been 'distorted in ways that virtually guarantee the inequality of its enjoyment and that undermine everyone's ability to understand what would promote it'.¹⁷⁷

While such criticisms and concerns have emerged from the world of moral and political philosophy, they are relevant to the legal framework for adolescent psychiatric care. For example, the concept of 'relational autonomy', developed from the desire of feminist theorists to 'refigure the concept of individual autonomy from a feminist perspective'.¹⁷⁸ Challenging the impact of damaging relationships and other oppressive social contexts on an individual's opportunity to exercise autonomous choice, the concept of relational autonomy has received considerable attention from legal academics in relation to the assessment of mental capacity.¹⁷⁹ Furthermore, relational autonomy theorists emphasise the importance of developing people's capacity to make autonomous choices.¹⁸⁰ Thus, Dodds argues that in addition to taking action to ensure, and respect,

¹⁷³ 'Meditation 17 of Devotions Upon Emergent Occasions' in *No Man is an Island – A selection from the prose of John Donne*, (Folio 1997), 75.

¹⁷⁴ Feinberg (n 7) 45.

¹⁷⁵ See for example Christman and Anderson (n 42) 4.

¹⁷⁶ J Nedlesky *Law's Relations - A Relational Theory of Self, Autonomy, and Law* (OUP 2013) 152.

¹⁷⁷ Nedlesky (n 176) 42.

¹⁷⁸ C Mackenzie and N Stoljar, *Relational Autonomy - Feminist Perspectives on Autonomy, Agency and the Social Self* (OUP 2000). The authors describe their account of autonomy as falling under the 'umbrella term' of 'relational autonomy' 4.

¹⁷⁹ J Herring, 'Forging a relational approach: Best interests or human rights?' *Medical Law International*, 13(1), 32–54; L Series 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) *Medical Law International* 4080-91.

¹⁸⁰ Donnelly ((n 54) 269-272) describes this as 'autonomy as empowerment'.

informed choices of patients, health care workers should also seek to develop patients' capacity to, by developing competency skills.¹⁸¹

Such points are also relevant in the human rights context. Both the UN Convention on the Rights of the Child (UNCRC) and the UN Convention on the Rights of Persons with Disabilities (UNCRPD) place great emphasis on enabling participation, irrespective of the person's decisional capacity, thereby challenging the separation between those who are considered to be 'autonomous' and those whose status of being 'non-autonomous' means that decisions are made about them, rather than by them.

The CRPD Committee emphasises the importance of supporting disabled people to make their own decisions and respecting the person's 'rights, will and preferences'.¹⁸² The 'right to participate'¹⁸³ under Article 12 of the UNCRC, applies to all children and young people capable of *expressing* their views – this right is not concerned with their ability to make the decision in question. The CRC emphasises the importance of supporting and encouraging children and young people in giving their views, considering that adequate time and resources should be made available to ensure that children and young people are adequately prepared and have the confidence and opportunity to contribute their views".¹⁸⁴ It also highlights the importance of creating 'an environment based on trust, information-sharing, the capacity to listen and sound guidance that is conducive for adolescents participating equally including in decision-making'¹⁸⁵ and providing children and young people 'with information about proposed treatments and their effects and outcomes, including in formats appropriate and accessible to children with disabilities'.¹⁸⁶

This perspective on autonomy is crucial to decisions about adolescent psychiatric care. For example, although treatment without consent is permitted under the European Convention on Human Rights (ECHR) in certain circumstances, the failure to obtain free and informed consent to a medical intervention against the subject's will, or without the free, informed and express consent of the subject, will engage Article 8 (being an interference with the person's private life). It will constitute a breach of this right unless

¹⁸¹ S Dodds 'Choice and Control in Feminist Bioethics' in Mackenzie and Stoljar *Relational Autonomy* (n 176) 229.

¹⁸² CRPD General Comment No 1 (2014) (n 121) paras 14 – 18.

¹⁸³ A MacDonald *The Rights of the Child Law and Practice* (Jordans Publishing Limited 2011) 297

¹⁸⁴ CRC General Comment No 12 (2009), *The Right of the child to be heard*, CRC/C/GC/12 para 134(e).

¹⁸⁵ CRC General Comment No 4 (2003), Adolescent health and development in the context of the Convention on the Rights of the Child, CRC/GC/2003/4, para 8.

¹⁸⁶ CRC General Comment No 4 (2003) (n 185) para 100.

there is a justification for imposing such treatment without the person's consent.¹⁸⁷ Furthermore, the MHA Code 2015, emphasises the importance of individuals being given 'sufficient information about their care and treatment in a format that is easily understandable to them'.¹⁸⁸

2.5 Summary of Part 2

Part 2 has considered the elements necessary for adolescents to be able to consent to their adolescent psychiatric care through the prism of Feinberg's four meanings of autonomy. It has identified the following points. First, that autonomy is more complex than is often suggested by the courts when considering matters relating to consent to treatment. Secondly, that an individual's ability to make relevant decisions may be hindered by a range of factors (for example, coercion), but equally can be enhanced (for example the provision of support). Thirdly, it highlights the distinction between the three elements of consent (decisional capacity, voluntariness and sufficient information) and legal capacity. All these aspects are relevant when considering the circumstances in which adolescents can make decisions about their psychiatric care.

CONCLUSION

This chapter has considered the circumstances in which adolescents can consent to their admission to hospital and treatment for mental disorder, explaining the legal principles underpinning this aspect of the legal framework for adolescent psychiatric care. In doing so it has identified the following points, which require further consideration.

The assessment as to whether a person has the requisite decisional capacity is an essential factor in identifying whether a person has the authority to give or refuse consent to medical interventions. For adults, the test for mental (in)capacity under the MCA 2005 is described as being the gatekeeper for autonomy. For adolescents in need of psychiatric care, the MCA 2005 will also play this role for 16 and 17 year olds, whereas for under 16s, *Gillick* competence will be the gatekeeper. However, legal commentators have raised concerns in relation to both the MCA 2005 and *Gillick* competence, that

¹⁸⁷ *Juhnke v Turkey*, (2009) 49 EHRR 24 para 76. In *VC v Slovakia* (2014) 59 EHRR 29, para 108, the failure to obtain the applicant's consent to her sterilisation was held the amount to a breach of Article 3 of the ECHR, informed consent being a prerequisite to the procedure. The ECtHR noted (at para. 110) that the possible exceptions to this did not apply in that this was not an emergency, nor was the applicant "mentally incompetent" so the question whether the sterilisation "was a 'necessity' from a medical point of view" was not relevant.

¹⁸⁸ MHA Code 2015 para. 1.12.

individuals are found to lack decisional capacity when respecting their wishes is likely to have an adverse impact on their welfare. The assessment of decisional capacity is considered in Chapter 3.

The 'adolescent autonomy conundrum' requires investigation. This refers to the powers of the High Court to override a minor's refusal of health care, including psychiatric care, which may apply irrespective of the adolescent's decisional capacity. Thus, the wishes of adolescents are by-passed when they are perceived to be in conflict with their welfare. Adolescents are either held to lack the requisite decisional capacity, or their decisions are overruled irrespective of their decisional capacity. However, the basis on which the courts make this determination is not always clear. This is discussed in Chapter 4.

Although the state of being 'autonomous' is often equated with the right to make decisions about treatment (sometimes referred to as the 'right of self-determination') the two are not synonymous. Decisional capacity is a necessary, albeit not always sufficient, condition for individuals, including adolescents, to be recognised as having the right to make decisions for themselves. This is evidenced by the compulsory powers of the MHA 1983, which are discussed in Chapter 5.

The law marks out a significant difference between those who are autonomous and the situation of those who are deemed 'non-autonomous'. Notwithstanding the concerns about the basis on which adolescents' decisional capacity is determined, just as non-consensual interventions of adolescents who are autonomous requires justification, so too is a justification required for such action where the adolescent lacks decisional capacity and is therefore considered to be non-autonomous. This is explored in Chapter 6.

Some concepts of autonomy emphasise the importance of enabling people to participate in the decision-making process, irrespective of their decisional capacity and this approach is reinforced by human rights standards, particularly the UNCRC and the UNCRPD. This confirms the approach identified in Chapter 1 of the need to focus on the wishes versus welfare dynamic when considering the basis on which the legal authority for an adolescent's psychiatric care is determined.

Given that the starting point for considering whether an adolescent's views should be respected is whether that adolescent has decisional capacity, the next chapter examines how the law governing the determination of decisional capacity has developed in relation to health care decisions by adolescents. It therefore considers the tests of *Gillick*

competence and capacity for the purpose of the MCA 2005. Given that the relationship between decisional capacity and legal capacity is not as clear cut for adolescents as it is for adults, the dynamics between the two are also considered.

CHAPTER 3: DETERMINING DECISIONAL CAPACITY: *GILLICK AND BEYOND*

INTRODUCTION

The question whether an adolescent has the decisional capacity to decide about the proposed admission to hospital and treatment for mental disorder is pivotal to determining the appropriate legal route for that adolescent's psychiatric care. As discussed in Chapter 2, if the adolescent has decisional capacity that adolescent can consent to such interventions. If the adolescent refuses, informal admission is not possible. This is because section 131 of the Mental Health Act (MHA) 1983 provides that adolescents aged 16 and 17 ('young people') who have capacity (as defined under the Mental Capacity Act (MCA) 2005) and are not willing to be admitted to hospital cannot be admitted informally on the basis of parental consent.¹ In relation to such young people who are not willing to agree to their treatment for mental disorder and adolescents aged under 16 ('children') who are *Gillick* competent, the current edition of the *Mental Health Act 1983: Code of Practice* (MHA Code 2015) states that it would be 'inadvisable' to rely on parental consent to admit the adolescent to hospital on an informal basis.² Nor can the adolescent be admitted in accordance with the MCA 2005, given that this Act only applies to young people who lack capacity.

The question of decisional capacity is also relevant to the 'formal' legal routes in that, as noted in Chapter 2, commentators have identified that determining that an adolescent lacks decisional capacity is one of the ways in which the courts by-pass adolescent autonomy when adolescents' wishes are perceived to be in conflict with their welfare. As will be discussed in Chapter 5, decisional capacity is also relevant (albeit not determinative) to the use of compulsory treatment provisions of the MHA 1983, which will apply if the adolescent is detained in hospital under that Act.

Accordingly, this chapter focuses on the crucial question of how adolescents' decisional capacity in relation to their psychiatric care is determined. In relation to children the legal

¹ Mental Health Act (MHA) 1983 s131(4).

² Department of Health *Mental Health Act 1983: Code of Practice* (TSO 2015), (MHA Code 2015) para 19.39

test is whether they are 'Gillick competent' to make the relevant decision. This test emanates from the 1985 decision of the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority (Gillick)*,³ hailed by many as a 'landmark case'⁴ and described 'as marking an overdue recognition of children's legal autonomy'.⁵

In relation to young people, the legal test is whether they lack mental capacity under the MCA 2005 to make the relevant decision. Although regarding it as 'a visionary piece of legislation for its time', the 2014 report by the House of Lords Select Committee on the Mental Capacity Act 2005 found that the MCA 2005 'has suffered from a lack of awareness and a lack of understanding'.⁶ In relation to its application to 16 and 17 year olds, the Law Commission's 2017 report, *Mental Capacity and Deprivation of Liberty* states that it had 'received some evidence of poor knowledge amongst health and social care professionals about how the Mental Capacity Act applies to young people'.⁷ The Care Quality Commission (CQC) has highlighted specific concerns about the lack of awareness of the MCA 2005 amongst staff working in Children and Mental Health Services (CAMHS). Its October 2017 report, *Review of children and young people's mental health services, Phase One Report*, notes that 'staff did not always have an adequate understanding' of this Act or 'what it meant for their role as a mental health professional'.⁸

³ [1986] AC 112, [1985] 3 WLR 830 HL.

⁴ See for example J Eekelaar, 'White coats or flak jackets? Children and the courts – again' (1993) LQR 182, 183 and J Fortin, 'The Gillick decision - not just a high water mark' in S Gilmore, J Herring and R Probert (eds), *Landmark cases in family law* (Hart Publications 2011) 208.

⁵ S Cretney 'Gillick and the concept of legal capacity' (1989) LQR 105(Jul) 356, 358.

⁶ House of Lords, Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act: post legislative scrutiny* (2013-14) HL Paper 139, 7-8. A similar concern was raised in *Somerset CC v MK (Deprivation of Liberty: Best Interests Decisions: Conduct of a Local Authority)* [2014] EWCOP B25.

⁷ Law Commission *Mental Capacity and Deprivation of Liberty* (Law Com No 372, 2017) para 7.38. Some commentary concerning the general application of the MCA 2005 rather than comments on the legal framework for psychiatric care) suggests that even if the MCA 2005 applies, parental consent is the preferred option. See for example, General Medical Council *0–18 Years: guidance for all doctors* (General Medical Council 2007) para 28 and footnote 8 which refers to the use of the MCA 2005 where the person with parental responsibility is not available. See also R Johns *Capacity and Autonomy* (Palgrave Macmillan 2014), 33, who states that the MCA 2005 'appears to be of only marginal significance'.

⁸ Care Quality Commission, *Review of children and young people's mental health services, Phase One Report, October 2017*, 21. See also Care Quality Commission, *Review of children and young people's mental health services, Phase One supporting documentation: Inspection report analysis*, October 2017, 28.

Analysis and structure of this chapter

Part 1 considers the concept of *Gillick* competence, explaining its importance but also highlighting the inconsistent application of this concept.

Part 2 charts the legal and policy developments that led to the introduction of the MCA 2005. Not all the provisions of the MCA 2005 apply to 16 and 17 year olds. While some of the differences are clear from the statute itself, such as the minimum age limit for making an advance refusal of treatment being 18, others are not. Accordingly, those that are relevant to adolescent psychiatric care are highlighted. It then examines the criteria for assessing individuals' mental capacity under the MCA 2005, referring to relevant human rights standards to ascertain what, if any guidance is given on determining decisional capacity.

Part 3 summarises the key points from the MHA Code 2015's guidance on assessing capacity under the MCA 2005 and *Gillick* competence.

PART 1: GILLICK COMPETENCE

The case of *Gillick* was initiated by Mrs Victoria Gillick (a Catholic mother of five daughters all under the age of 16 years). She challenged the lawfulness of Department of Health guidance that advised doctors that in exceptional circumstances they could give contraceptive advice and treatment to under 16s without parental consent. Whereas one line of argument related to the provision of contraceptive treatment to girls under the age of 16 (proposing that this was either a criminal offence or contrary to public policy), Mrs Gillick's two other propositions on the law had far wider implications. She contended that a child under 16 lacked the legal capacity to consent to medical treatment and that parental rights would be infringed if children were allowed to do so. Thus, although the main question for the court in *Gillick* was whether children aged under 16 could consent to contraceptive treatment without the knowledge or consent of their parents, the nature of the arguments for contending that doctors would be acting unlawfully in doing so, extended beyond this narrow focus;⁹ hence its impact on parental rights more generally.

⁹ The three propositions of law relied upon by Mrs Gillick were set out in by Lord Scarman (*Gillick* (n 3) 177): '(i) parental rights should be protected from any invasion or interference neither authorised by a competent court nor expressly authorised by statute: [the parental rights case]; (ii) the provision of contraceptive treatment to girls under the age of 16 either constitutes criminal conduct in itself or is so closely analogous thereto as to be contrary to public policy: [the criminal law case]; (iii) a girl below the age of 16 is not capable in law of giving a valid

1.1 Gillick – an important milestone towards adolescent autonomy?

Gillick was important because it clarified for the first time that children (adolescents aged under 16 years), if *Gillick* competent, have the legal capacity to make decisions for themselves, thus giving birth to a 'legal being', the concept of the '*Gillick* competent child'.¹⁰ Contrary to Mrs Gillick's contention that a child under 16 lacked the legal capacity to consent to medical treatment, the majority of the House of Lords held that if they have the requisite understanding and intelligence to make the relevant decision, children can consent to their medical treatment. In effect, this decision rejected a test of legal (in)capacity, which was based on the status of age. Lord Fraser (whose judgment was supported by Lord Scarman and Lord Bridge) 'was not disposed' to hold that a girl aged under 16 would not be able to give valid consent to contraceptive advice or treatment, 'merely on account of her age'.¹¹ He concluded that there was no statutory provision that compelled him 'to hold that a girl under the age of 16 lacks the legal capacity to consent to contraceptive advice, examination and treatment provided that she has sufficient understanding and intelligence to know what they involve'.¹²

Moreover, there was no dissenting view on this general principle. Although disagreeing with the majority on a minor's ability to consent to contraceptive advice and treatment (considering that children would never be competent to make such decisions), in relation to other forms of medical treatment, Lord Templeman concurred with the opinion of Lord Fraser, Lord Scarman and Lord Bridge that under 16s could authorise other forms of treatment if they have attained an age and understanding to do so.¹³ (The other dissenting judge, Lord Brandon, expressed no opinion on this point.)

Thus, legal capacity to consent follows a finding of *Gillick* competence. Subject to ensuring that the child has the requisite competence to make the decision, health professions can rely on the consent of a child to authorise the proposed health care intervention.

As such, *Gillick* is a notable milestone in the development of law on adolescent health care in that it gave an 'important message that the concept of children's autonomy had

consent to medical treatment and in the particular context of this case to contraceptive or abortion treatment: [the age of consent point]'.¹⁰

¹⁰ Mr Justice McFarlane (as he then was), Family Division Liaison Judge, 'Mental Capacity: One Standard for All Ages', May [2011] Fam Law, 479.

¹¹ *Gillick* (n. 3) 169.

¹² *Gillick* (n 3) 169-170.

¹³ *Gillick* (n 3) 199 (Lord Brandon did not discuss this point).

a legal reality'.¹⁴ Nonetheless, some question the extent of *Gillick's* achievements for adolescents' autonomy. Gilmore considers that while the House of Lord's endorsement of respect for the views of children under 16s who can make decisions for themselves was significant and had a "tremendous influence on attitudes to how children's claims might be considered",¹⁵ the claims that *Gillick* recognised a competent child's autonomy to make decisions contrary to the child's interests have been exaggerated. Rather, *Gillick* concerned children's welfare, in which their Lordships were seeking to 'resolve the potentially conflicting claims of adults to know what is in a child's best interests.'¹⁶ He concludes that "the most *Gillick* could represent as a binding precedent would be the child's power to consent to medical treatment offered in the child's best interests".¹⁷

Gilmore is not alone in his scepticism. For example, when commenting on the conditions that a doctor should meet before giving contraceptive advice and treatment set out by Lord Fraser (often referred to as "Fraser's guidelines"), Montgomery notes that this "suggests that the doctor may not prescribe contraception unless he believes it to be in the child's best interests to do so". He adds that if this 'allows the doctor to make paternalistic judgments, then the case has done little to emancipate children. It has merely put them under the control of the doctors rather than their parents'.¹⁸ Similarly, Bainham comments that the decision in *Gillick* 'stopped well short of recognising general rights in young people to take major decisions on contraception, other medical treatment or indeed any aspect of their lives'.¹⁹ Like Montgomery, Bainham considers that the effect of Lord Fraser's guidelines 'is the substitution of one adult decision-maker (the doctor) in place of another (the parent)'.²⁰

In any event, whatever was envisaged by the House of Lords, as noted in Chapter 2, the subsequent 'treatment refusal' decisions of the Court of Appeal curtailed the advance of adolescent autonomy. Marking what was subsequently described as 'the retreat from *Gillick*' the Court of Appeal held, first in *Re R (A Minor) (Wardship: Consent to Treatment) (Re R)*²¹ and then in *Re W (A Minor) (Medical Treatment: Court's Jurisdiction) (Re W)*,²² that the courts (and possibly parents) could override the wishes of adolescents if this

¹⁴ Fortin 'The *Gillick* decision' (n 4) 208.

¹⁵ G Douglas 'The Retreat from *Gillick*' (1992) 55 MLR 569, 570

¹⁶ S Gilmore 'The Limits of Parental Responsibility' in (eds R Probert, S Gilmore and J Herring), *Responsible Parents and Parental Responsibility*, (Hart Publishing 2009), 64, 68-79

¹⁷ Gilmore 'The Limits of Parental Responsibility' (n 15) 74.

¹⁸ J Montgomery, 'Children as property?' (1988) 51 MLR 323, 339.

¹⁹ A Bainham 'The Balance of Power in Family Decisions' (1986) 45 CLJ 262, 273.

²⁰ Bainham 'The Balance of Power in Family Decisions' (n 18) 274.

²¹ [1992] Fam 11, [1991] All ER 177, [1991] 3 WLR 592 CA.

²² [1993] Fam 64, [1992] 4 All ER 627, [1992] 3 WLR 758 CA.

conflicted with their welfare. As a result, *Gillick* competence conveys a limited legal capacity for adolescents. Even where adolescents have the legal capacity to consent to their medical treatment (whether this is a child who is assessed as being *Gillick* competent or a young person to whom section 8 of the Family Law Reform Act (FLRA) 1969 applies), they do not have the legal capacity to refuse such treatment. This is because the court can authorise the treatment, thereby providing an alternative legal route for treatment to be given. Writing in 1996, Brazier and Bridge summarised the outcome of the Court of Appeal's decisions in *Re R and Re W*, as:

A child under 16 acquires the capacity to consent to treatment on evidence that she is *Gillick* competent. At 16 the minor acquires a statutory authority to consent to treatment. Nonetheless until she is of full age, parental rights to authorise treatment co exist with her own authority to do so independently, and she cannot veto treatment.²³

Although parental consent can no longer authorise an adolescent's admission to hospital and treatment for mental disorder, as noted in Chapter 2 and discussed further in Chapter 4, the court's power to override the adolescent's capacitous refusal of health care interventions remains. Thus, the High Court can provide the route to non-consensual adolescent psychiatric care where an adolescent with decisional capacity refuses to be admitted to hospital and/or treated for mental disorder, but for some reason the MHA 1983 does not apply, or there is no time for a mental health assessment (discussed in Chapter 5) to be undertaken.

1.2 Determining *Gillick* competence

The discussion below examines the approach of the courts to the concept of *Gillick* competence and how it is assessed. It starts with the decision in *Gillick* itself, arguing that the House of Lords provides little guidance on the criteria to be met if a child is to be considered '*Gillick* competent'. This is followed by the treatment refusal cases of *Re R and Re W*, highlighting the areas of confusion generated by the Court of Appeal's approach to *Gillick* competence in these decisions.

The judiciary's lack of clarity on what a child needs to demonstrate to be *Gillick* competent may in part be because at the time *Gillick* was decided the law in this area was underdeveloped, with the test for capacity to consent to medical treatment being

²³ M Brazier and C Bridge 'Coercion or Caring: Analysing Adolescent Autonomy' in (1996) 16 Legal Studies 84, 86.

'based on the usual common law criterion of understanding in broad terms the nature and likely effects of what is to take place'.²⁴ Both the House of Lords decision and the Court of Appeal cases of *Re R and Re W* pre-dated the flurry of case-law from the early 1990s onwards in which the courts started to develop the criteria for determining individuals' ability to make decisions about their medical treatment,²⁵ which led to the introduction of the MCA 2005 (discussed in Part 2 below). Nonetheless, as discussed below, the absence of clear criteria on what is meant by *Gillick* competence has led to wide-ranging interpretations being applied to this concept.

1.2.1 *The Gillick competent child and the House of Lords decision*

Although Lord Fraser and Lord Scarman both sought to describe in *Gillick* the attributes of a child who would have the legal capacity to consent, as Fortin notes they did so in differing ways, so that the inconsistencies between them 'have provided commentators with scope for endless disagreement from the time *Gillick* was first reported'.²⁶ Both Lords Fraser and Scarman referred to the child's understanding and intelligence but as Montgomery has noted, the problem is that "[w]hat the House of Lords failed to do is to determine exactly what it is the child must understand".²⁷

In relation to the general question of whether a child can have the legal capacity to consent to treatment, Lord Fraser considered that this depends on the child being 'capable of understanding what is proposed, and of expressing his or her own wishes'.²⁸ Lord Scarman referred to a child who has achieved 'a sufficient understanding and intelligence to enable him or her to understand fully what is proposed', which, like Lord Fraser, he considered would be a question of fact.²⁹ Lord Bridge made no comment on this issue save to say that he agreed with both Lords Fraser and Scarman. Lord Templeman considered that this would depend on 'the nature of the treatment and the age and understanding of the infant'.³⁰

Both Lord Fraser and Lord Scarman considered the issue of contraceptive advice and treatment and examination separately but these are specific to the type of treatment proposed and therefore provide little guidance on general criteria for *Gillick* competence.

²⁴ Law Commission *Incapacitated Adults and Decision-Making: An Overview*, Consultation Paper No. 119 (Law Com CP No 119, 1991) para 2.20.

²⁵ Law Com CP No 119 1991 (n 23) paras 2.18 – 2.25 discusses the then current law on consent and capacity to consent to medical treatment.

²⁶ Fortin 'The *Gillick* decision' (n 4) 202-203.

²⁷ Montgomery (n 17) 51 Mod. L. Rev 323

²⁸ *Gillick* (n 3) 169.

²⁹ *Gillick* (n 3) 189.

³⁰ *Gillick* (n 3) 200.

The conditions Lord Fraser considered doctors should be satisfied are met before giving such advice and treatment without parental consent ('Fraser's guidelines'³¹) merely state that 'the girl (although under 16 years of age) will understand his advice'.³² Lord Scarman considered for a child to be competent to consent to contraceptive treatment it 'is not enough that she should understand the nature of the advice which is being given: she *must have a sufficient maturity* to understand what is involved',³³ setting out the additional factors that would be involved in this type of treatment, such as 'the risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate'.

Although considering *Gillick* to be a major step forward for the rights of the child, Eekelaar foresaw a significant problem arising from the approach taken by Lord Scarman and Lord Fraser. Given that they both "stressed that full capacity was no simple matter",³⁴ he predicted that there would "undoubtedly be a temptation to believe that unless a child takes the same view of its interests as an adult (or a court) holds, it falls short of maturity".³⁵

Thus, Eekelaar anticipated one of the concerns identified in Chapter 2 as being one of the factors of the 'adolescent autonomy conundrum' in that the courts would be influenced in their determination whether the adolescent had decisional capacity by whether they agreed with the adolescent's decision. This was one of the criticisms made of the courts in relation to adolescents refusing life-saving medical treatment on grounds of their religious beliefs.³⁶ On the other hand, a concern raised by Brazier and Bridge, specifically in relation to the Court of Appeal's decisions in *Re R* and *Re W*, was the failure of the court to consider such cases in the context of autonomy in that the court

³¹ *R(Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin) 2006] QB 539, 2 WLR 1130 Silber J considered that these were intended by Fraser to be conditions which had to be satisfied.

³² *Gillick* (n 3) 174 (Lord Fraser). Taken together, the guidelines set out by Lord Fraser make clear that the doctor would have to have very good reasons for giving such treatment without parental consent. The other four are: 'that he cannot persuade her to inform her parents or allow him to inform her parents that she is seeking contraceptive advice'; 'that she is likely to begin to or to continue having sexual intercourse with or without contraceptive treatment'; that 'unless she receives contraceptive advice or treatment her mental or physical health or both are likely to suffer' and 'that her best interests require him to give her contraceptive advice, treatment, or both without the parental consent'.

³³ *Gillick* (n 3), emphasis added.

³⁴ J Eekelaar 'The Eclipse of Parental Rights' (1986) 4 LQR 8. See also S Gilmore and J Herring "'No" is the hardest word: consent and children's autonomy' (2011) CFLQ 23(1) 3, 5; E Cave 'Maximisation of minor's capacity' (2011) CFLQ 23(4) 434.

³⁵ Eekelaar (n 33).

³⁶ Cases such as *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386 and *Re L (Medical Treatment: Gillick Competency)* [1998] 2 FLR 810. See for example, Fortin J, *Children's Rights and the Developing Law* (3rd ed Cambridge University Press 2009) 154.

would have been justified in overriding the adolescents' wishes, irrespective of their age. Even if they had been adults, authorising their treatment would have been justified because the adolescents lacked the decisional capacity to refuse their psychiatric care.³⁷ Both adolescents 'were very sick young women', both suffering from 'illness which distorted their judgment, deprived them of the capacity to make a choice' so in neither case was their age the issue.³⁸ Cave points out that whereas *Gillick* competence was designed to address a specific issue, it has been used for much wider purposes and as such it 'has shown signs of strain'.³⁹

Brazier and Bridge consider that action would have been justified because the adolescents involved were not exercising autonomous choice (albeit they concede that there then remains the question of whether action can be taken where the adolescent has made an autonomous choice – thus reflecting the second aspect of the adolescent autonomy conundrum, namely when might an interference be justified on grounds of age). Brazier and Bridge's concern is that a combination of seeking to avoid the use of the Mental Health Act (MHA) 1983 for adolescents (due to the 'perceived stigma of invoking mental health legislation'⁴⁰) and a lack of understanding of autonomy, 'resulted in judges apparently overruling 'competent' choices which analysis shows to be in no real sense autonomous choice'.⁴¹ In essence therefore, Brazier and Bridge's concern is that the Court of Appeal did not consider the adolescents' decisional capacity sufficiently. This is considered next. The Court of Appeal's decisions in *Re R* and *Re W*, both of which raise concerns about the assessment of *Gillick* competence (for differing reasons) are considered below.

1.2.2 *The Retreat From Gillick: Re R*

In *Re R*, the question was how the concept of *Gillick* competence applies to a 15 year-old girl who at times was considered to be 'of sufficient maturity and understanding to comprehend the treatment being recommended' but at other times 'her rationality and capacity to understand recommendations were severely impaired'. Two key problems arise from this case.

³⁷ Brazier and Bridge (n 22).

³⁸ Brazier and Bridge (n 22) 96. L Hagger *The Child as Vulnerable Patient* (Ashgate 2009) agrees with this analysis of the decisions in *Re R* and *Re W*. She comments that the conditions of these minors were not unique to their age group as both 'mature minors' and adults may be unable to make decisions because of a mental disturbance.

³⁹ E Cave 'Goodbye Gillick Identifying and resolving problems with the concept of child competence' (2014) *Legal Studies* 34(1) 103.

⁴⁰ Brazier and Bridge (n 22) 85.

⁴¹ Brazier and Bridge (n 22) 109.

First, although not decisive in this case (the court having agreed with Waite J that R was not ‘*Gillick* competent’⁴²), Lord Donaldson’s description of what the concept of *Gillick* capacity involves is a ‘particularly demanding test’.⁴³ In the Judge’s view this is ‘not merely an ability to understand the nature of the proposed treatment’, it also requires ‘a full understanding and appreciation of the consequences both of the treatment in terms of intended and possible side effects’ as well as ‘the anticipated consequences of a failure to treat’.⁴⁴

Secondly, the Court of Appeal’s approach conflated two separate and distinct issues that may impact upon an individual’s decisional capacity. The first concerns the person’s general decision-making ability; whether the person concerned has the requisite cognitive skills – the intelligence and understanding, to make certain decisions about her life. Adults are presumed to have such skills. While in certain areas legislation (such as section 8 of the FLRA 1969 in relation to medical treatment) confers a similar presumption that adolescents aged 16 and 17 have acquired these skills, under 16s have to demonstrate that they have acquired these skills. Hence for under 16s, the first question is whether they have sufficient understanding and maturity to make the decision in question as there is no presumption that they do. Writing before the introduction of the MCA 2005, Brazier and Bridge suggest that the ‘only significant difference between the *Gillick* competent child and the adult lies in the onus of proof’; whereas with the adult the health professional can presume competence, the health care professional ‘must satisfy herself that an older child does in fact enjoy the necessary intelligence and understanding to be deemed *Gillick* competent’.⁴⁵

The second issue is whether the person’s ability to make decisions has been adversely affected by other factors, such as ill health or intoxication. This relates to the areas discussed in Chapter 2 in the context of Feinberg’s ‘actual condition of self-government’ that identifies a range of conditions that might hinder a person from acting autonomously,

⁴² When commencing his judgment Lord Donaldson explained that the court had acceded to the Official Solicitor’s request for guidance to be provided on the extent powers of the courts in such cases. Prior to doing so he had noted that Waite J in *Re R* (n 20) and the judge in an earlier case decided in September 1990 (*Re E (A Minor) (Wardship: Medical Treatment)* [1992] 2 F.C.R. 219) had both accepted that if the child had been competent the child’s refusal could not have been overridden. *Re E* concerned a fifteen year old boy, “A”, who was refusing, with his parents support, a blood transfusion, without which he was likely to die, for religious reasons (he and his parents were Jehovah’s Witnesses). In the light of *Gillick* (n 3) the Judge approached the case on the basis that if E was competent to make the decision, his decision should be upheld, but found him not to be competent.

⁴³ Fortin ‘The *Gillick* decision’ (n 4).

⁴⁴ *Re R* (n 19) 26.

⁴⁵ Brazier and Bridge (n 22) 90.

who might otherwise have the ability to act autonomously. It is not surprising that this was not considered by the House of Lords in *Gillick*. The issue was whether the child had reached a stage where she was mature enough to make decisions about her health care, not the possible impact of a mental disorder on the theoretical child's⁴⁶ decision-making abilities. The focus of the House of Lords was whether being aged under 16 meant that a child was under a legal incapacity to make treatment decisions for herself. It was not concerned with the question whether other factors might give rise to a legal incapacity. However, even if a child has attained the sufficient level of maturity to make certain decisions, at a particular time that a specific decision needs to be made, that child may be unable to do so, for reasons unrelated to her (im)maturity, such as serious mental health problems, which was the case with R, which as Brazier and Bridge note can impact on individuals of all ages.

Both Judges who considered this issue in *Re R*⁴⁷ seemed to be of the view that *Gillick* competence concerns matters relating solely to an adolescent's maturity. Lord Donaldson expressed this by observing that the House of Lords was considering 'the staged development of a normal child' and that it was 'an assessment of mental and emotional age, as contrasted with chronological age',⁴⁸ whereas Farquharson LJ stated that *Gillick* was 'concerned with mentally normal children'.

Lord Donaldson doubted that R met his test of *Gillick* competence, stating that 'even if she was capable on a good day of a sufficient degree of understanding to meet the *Gillick* criteria', (which he doubted⁴⁹) on others she was not, due to her 'mental disability', which meant that 'she was not only "*Gillick* incompetent" but was actually sectionable'.⁵⁰ He added that '[n]o child in that situation can be regarded as "*Gillick* competent" and the judge was wholly right in so finding in relation to R'. Farquharson LJ found 'it difficult to import the criteria applied in *Gillick's* case to the facts of the present case'. Like Lord Donaldson, he recognised that with R they were 'not here solely concerned with the developing maturity of a 15-year-old child but with the impact of mental illness on her'.

⁴⁶ S Van Praagh, 'Adolescence, autonomy and Harry Potter: the child as decision-maker' (2005) Int.JLC 335, 350 reminds us that the House of Lords were not required to undertake such an assessment, given that 'no *Gillick* daughter had expressed any interest, as far as we know, in talking to a doctor about contraception'.

⁴⁷ In *Re R* (n 20) Lord Justice Staughton also skirted around this issue – having noted that at times R had 'the capacity to make a rational and informed decision' but at other times, when the medication is 'desirable', she did not have capacity, he concluded (at 27) that that Waite J had been correct to find that R could authorise the medication.

⁴⁸ *Re R* (n 20) 26.

⁴⁹ Those involved in R's care had determined that R was *Gillick* competent, whereas Lord Donaldson questioned whether she understood 'the implications of treatment being withheld'.

⁵⁰ *Re R* (n 20) 26.

In his view the *Gillick* test was ‘not apt in a situation where the understanding and capacity of the child varies from day to day according to her illness’ and therefore did not apply ‘to an on/off situation of that kind’.⁵¹ As Brazier and Bridge note, ‘the concept of fluctuating competence is hopelessly confused’. However, this is not a problem unique to under 18s.⁵² Indeed, the *Mental Capacity Act 2005 Code of Practice* (the MCA Code)⁵³ advises on how this might be addressed.⁵⁴

The implications of the decision in *R* is that if adolescents’ mental ill-health means that they lack decisional capacity some of the time, then they will be considered to lack *Gillick* competence at any time. This was reflected in the MHA Code 2008 which stated that if the child’s *Gillick* competence fluctuated significantly ‘careful consideration should be given to whether the child is truly *Gillick* competent at any time to take a relevant decision’.⁵⁵ Such advice (which is not included in the MHA Code 2015) is in stark contrast to the MCA Code’s advice on assessments of incapacity under the MCA 2005 in that it states that ‘an assessment must only examine a person’s capacity to make a particular decision when it needs to be made’.⁵⁶

1.2.3 *The Retreat from Gillick: Re W*

A different cause of concern is raised in *Re W* in that Lord Donaldson’s approach to the question whether the court was justified to intervene confuses two points. The Judge considered that there was no need to consider *W*’s ‘*Gillick* competence’ on the basis that under section 8 of the FLRA 1969 the “16- or 17-year old is conclusively presumed to be *Gillick* competent or, alternatively, the test of *Gillick* competence is bypassed and has no relevance”.⁵⁷

While this is correct in the sense that by virtue of section 8 of the FLRA 1969, young people have the right (legal capacity) to make treatment decisions and therefore do not need to demonstrate that they have the decisional capacity to do so, similar to the criticism of *Re R*, Lord Donaldson does not take into account the fact that *W*, may not have been able to exercise this right due to factors that impaired her decisional capacity. This is despite his acknowledgement in *Re R* that ‘the consent by a child between the

⁵¹ *Re R* (n 20) 32.

⁵² Brazier and Bridge (n 22) 95.

⁵³ Department for Constitutional Affairs, *Mental Capacity Act 2005 Code of Practice* (2007) (the MCA Code).

⁵⁴ The MCA Code (n 52) paras 4.26- 4.27.

⁵⁵ Department of Health *Mental Health Act 1983 Code of Practice* 2008 (the MHA Code 2008) para 36.41

⁵⁶ The MCA Code (n 51) paras 4.26 – 4.27

⁵⁷ *Re W* (n 21) 77.

ages of 16 and 18 is no more effective than that of an adult if, due to a mental disability, the child is incapable of consenting'.⁵⁸

This returns to the contention of Brazier and Bridge that the court operated on the basis that it could act to override the wishes of the adolescent because of the adolescent's age, whereas it could have maintained the principle of adolescent autonomy by deciding to override W's wishes on the basis that she lacked the decisional capacity to decide about her medical treatment.

Although Lord Donaldson took W's decisional capacity into account, this was in relation to considering the weight to be attached to her wishes. He expressed his doubts that W 'was of a sufficient understanding to make an informed decision'. He distinguished W from minors who might refuse treatments on the basis of religious beliefs on the basis that 'it is a feature of anorexia nervosa that it is capable of destroying the ability to make an informed choice. It creates a compulsion to refuse treatment or only to accept treatment when it is likely to be ineffective'.⁵⁹ Given that he considered W's refusal of the treatment to be 'part and parcel of the disease', Lord Donaldson considered that W's wishes 'clearly have a much reduced significance'.⁶⁰

The outcome for W, like R, would have been the same if the court had limited its authority to override the wishes of an adolescent in the interests of the adolescent's welfare to cases in which the adolescent lacks decisional capacity, rather than maintaining that its 'theoretically limitless' powers under its *parens patriae* jurisdiction included overriding the wishes of adolescents, irrespective of their decisional capacity. However, not only did these decisions have a huge impact on the law relating to adolescents by holding that their refusals of medical treatment could be overridden, it also gave a very muddled message about the concept of *Gillick* competence and its application.

1.2.4 Assessing *Gillick* competence and the MCA 2005

Cases post-*Gillick* have referred to a variety of "tests", such as the one set out by Lord Donaldson,⁶¹ Lord Scarman's general comment ("a sufficient understanding and intelligence to enable him or her to understand fully what is proposed"),⁶² or Lord Fraser's general comment ("capable of understanding what is proposed, and of expressing his or

⁵⁸ *Re W* (n 21) 24.

⁵⁹ *Re W* (n 21).

⁶⁰ *Re W* (n 21) 81.

⁶¹ Johnson J, *Re S* (a minor) (consent to treatment) [1994] 2 FLR 1065.

⁶² *Re E* (A Minor) (*Wardship: Medical Treatment*) [1992] 2 FCR 219.

her own wishes”⁶³). In other cases it is not clear what ‘test’, if any, the courts have applied. For example, in *Re K, W and H (Minors) (Consent to Treatment)*, which concerned the treatment of three children placed in St Andrew’s private psychiatric hospital, Thorpe J simply stated that he has was ‘in no doubt that none of these three is Gillick competent’.⁶⁴ In *R v Kirklees Metropolitan Borough Council ex parte C* the Court of Appeal referred to evidence that W (aged 12) was not in the right frame of mind to make her own decision.⁶⁵ Other decisions have referred to a child ‘who is able to understand all the relevant advice and the consequences of that advice’,⁶⁶ and ‘sufficient understanding and intelligence within Lord Fraser’s definition’.⁶⁷

In contrast, in the 2014 case of *Re JA (Medical Treatment: Child Diagnosed with HIV)*,⁶⁸ which concerned a 14 year old boy, J, who was refusing treatment for HIV, Baker J stated that to be *Gillick* competent, a child must:

- (a) understand the nature and implications of the treatment, which would include the likely effects and potential side effects;
- (b) understand the implications of not pursuing the treatment, including the nature, likely progress and consequences of any illness that would result from not receiving the treatment;
- (c) retain the above information long enough for the decision making process to take place and
- (d) be of sufficient intelligence and maturity to weigh up the information and arrive at a decision.⁶⁹

Baker J’s approach gives some support to the predication made by Mr Justice McFarlane, (now Lord Justice McFarlane) when writing extra judicially in 2011.⁷⁰ McFarlane considered that given their familiarity with the MCA 2005, and notwithstanding that it does not apply to those under 16,⁷¹ “it is difficult to contemplate that a High Court judge would apply a different test to the 2005 Act when dealing with a younger person”.⁷²

⁶³ *An NHS Trust v ABC & A Local Authority* [2014] EWHC 1445 (Fam); [2014] Fam Law 1229.

⁶⁴ [1993] 1 FCR 240, [1993] 1 FLR 854.

⁶⁵ [1993] 2 FLR 187, 191.

⁶⁶ *An NHS Trust v A* [2014] EWHC 1445 (Fam) [2014] Fam Law 1229, [12]

⁶⁷ *An NHS Trust v ABC & A Local Authority* (‘ABC’), [2014] EWHC 1445 (Fam) [2014] Fam Law 1229 [15].

⁶⁸ [2014] EWHC 1135 (Fam) [2015] 2 FLR 1030, [2015] MedLR 26.

⁶⁹ *Re JA* (n 64) [67].

⁷⁰ McFarlane (n 9) 484.

⁷¹ Mental Capacity Act (MCA) 2005 s2(5).

⁷² McFarlane (n 9) 484.

Although Baker J's test is not the same as the test under the MCA 2005, points a) to c) reflect the requirements of section 3(1) and (2) MCA 2005 to understand and retain the relevant information while paragraph (d) dovetails *Gillick's* focus on "intelligence and maturity" with the MCA 2005's criterion of being able to "use or weigh that information as part of the process of making the decision".⁷³ As McFarlane notes,⁷⁴ support for this argument is found in the approach taken by Wall J in *Re C (Detention: Medical Treatment)*⁷⁵, a pre-MCA 2005 decision in which the test for capacity for adults applicable at that time⁷⁶ was applied to decide whether a 16 year old had capacity to 'give or refuse consent to medical treatment'.⁷⁷

PART 2: THE MENTAL CAPACITY ACT 2005

The MCA 2005 provides the legal framework for taking action and making decisions on behalf of individuals aged 16 or over who lack mental capacity to make such decisions for themselves, requiring that such decisions are taken in the person's 'best interests'.⁷⁸

The introduction of the MCA 2005 and the MCA Code have established a marked difference between the process for assessing the decisional capacity of individuals aged 16 and over and those aged under 16 years of age. The MCA 2005 sets out the criteria for assessing whether a person has the mental capacity to make decisions while the MCA Code provides detailed guidance on how to carry out this assessment. The stated aim of the MCA 2005 and its Code is to protect people who lack capacity to make decisions for themselves as well as 'to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so'.⁷⁹ Thus, the individuals wishes and feelings are an key factor in determining what is in that person's best interests.⁸⁰ In contrast, as noted in Part 1, the criteria for assessing whether an

⁷³ MCA 2005 s 3(1)(c).

⁷⁴ McFarlane (n 9) 484.

⁷⁵ [1997] 2 FLR 180; [1997] 3 FCR 49. For a discussion on this case see P de Cruz 'Adolescent Autonomy, Detention for Medical Treatment and *Re C*' (1999) 62 MLR 595.

⁷⁶ *Re C (An Adult: Refusal of Treatment)* [1994] 1 WLR 290, 295E.

⁷⁷ *Re C (Detention: Medical Treatment)* (n 70), 65. The same approach was adopted by Cazalet J in relation to a 17 year old in *Re B (A Minor) (Treatment and Secure Accommodation)* [1997] 1 FCR, 618, 625. Cave argues that there are limitations to the application of the MCA 2005 to under 16s. See E Cave 'Goodbye *Gillick* Identifying and resolving problems with the concept of *child competence*' Legal Studies, Vol 34 No 1 (2014) 103.

⁷⁸ MCA 2005 s 1(5); see also MCA 2005 s 4.

⁷⁹ MCA 2005 Code (n 51) 19.

⁸⁰ MCA 2005 s 4(6). See also *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67; [2014] AC 591 and *Wye Valley NHS Trust v Mr B* [2015] EWCOP 60; [2015] Med. L.R. 552.

adolescent is *Gillick* competent is uncertain and is subject to wide interpretation by the judiciary.

As discussed in Chapter 2, one of the consequences of the introduction of the MCA 2005 is that the term ‘capacity’ is generally used to mean ‘mental capacity’, with very little reference to ‘legal capacity’, the suggested reason for this being that in relation to adults, in areas such as health care, adults are presumed to have the legal capacity to make decisions for themselves. Despite its title, the provisions of the MCA 2005 refer to “capacity” and “lack of capacity” rather than “mental capacity”, the only exception being Schedule 4 of the MCA 2005, which concerns Enduring Powers of Attorney, powers that were established under legislation pre-dating the MCA 2005.

Similarly, the MCA Code refers to “individuals who lack the mental capacity to make particular decisions for themselves” in chapter 1 (at para. 1.1) and refers to “mental capacity” as being “the ability to make a decision” (para. 2.9), but otherwise uses the term “capacity” when providing guidance on the implementation of the MCA 2005. Nonetheless, as is made clear below when considering the test for incapacity under the MCA 2005, the operation of the MCA 2005 is dependent on the person lacking ‘mental capacity’ to make the decision in question.

The discussions below focus on four main areas; the first concerns the background to the MCA 2005; second, a brief overview is provided on how the MCA 2005 applies to adolescents and its relevance to adolescent psychiatric care; third the provisions for assessing whether an individual lacks the mental capacity to make a decision and fourth notes the connection between the provisions of the MCA 2005 and human rights standards.

2.1 Background

The MCA 2005 emerged from a lengthy process of reform spanning nearly fifteen years, which was initiated in 1991 by the Law Commission with the publication of its Consultation Paper No. 119: *Mentally Incapacitated Adults and Decision-Making: An Overview*.⁸¹ The Law Commission’s decision to launch an “investigation into the

⁸¹ Law Com CP No 119 1991 (n 23) [1.9] refers to the relevant law as being ‘fragmented, complex and in many respects out of date’. In chronological order, the key publications following Law Com CP No 119 are as follows: Law Commission *Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction*, (Law Com CP No 128, 1992); Law Commission *Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research* (Law Com CP No 129, 1993); Law Commission *Mentally Incapacitated Adults and Other Vulnerable Adults* (Law Com No 130, 1993); The Law Commission *Mental Incapacity* (Law Com No 231, 1995); Lord

adequacy of legal and other procedures for decision making on behalf of mentally incapacitated adults” was in response to concerns that had been raised with the Commission about deficiencies in the law relating to decision-making on behalf of mentally incapacitated adults,⁸² which was considered to be ‘fragmented, complex and in many respects out of date’, lacking coherence, with ‘many gaps’.⁸³

One of the cases identified by the Law Commission as stimulating debate in relation to this area of law was *Re F (Mental Patient: Sterilisation)*,⁸⁴ in which the House of Lords held that treatment can be given to mentally incapacitated adults if this was in their best interests,⁸⁵ thus recognising that there are circumstances in which an adult might not be able to give or refuse consent. Such inability to decide may arise because the person ‘cannot by reason of mental disability understand the nature or purpose of an operation or other treatment’ or for other reasons, such as unconsciousness.⁸⁶

The period during which the Law Commission carried out its research on the law relating to mental incapacity coincided with a raft of significant decisions of direct relevance to this topic. One such significant decision was that of *Re T (adult: refusal of treatment)*⁸⁷ in 1992, in which the Court of Appeal held unanimously (albeit for differing reasons⁸⁸) that certain factors may vitiate an adult’s refusal of treatment, such as a lack of capacity due to a ‘long-term mental incapacity or retarded development or by temporary factors such as unconsciousness or confusion or the effects of fatigue, shock, pain or drugs’,⁸⁹ undue influence or deception.⁹⁰

Thorpe J’s judgment in *Re C (Adult: Refusal of Treatment)*⁹¹ the following year was described by the Law Commission as being ‘perhaps the first reported case to give any

Chancellor’s Department *Who Decides? Making Decisions* (Cm 3803, 1997); Lord Chancellor’s Department *Making Decisions – The Government’s proposals for making decisions on behalf of mentally incapacitated adults* (CM 4465 1999); *Draft Mental Incapacity Bill* (Cm 5859-I 2003) with commentary and explanatory notes (Cm 5895-II 2003); Joint Committee on the Draft Mental Incapacity Bill (2002-3, HL-189-1, HC-1083-1); Mental Capacity Bill, June 2004. See Ashton G and others *Court of Protection Practice* (Jordan Publishing 2016) 75 – 79 and Jones R *Mental Capacity Act Manual* (7th ed Sweet and Maxwell 2016) 8 - 11 for a summary of the stages of reform.

⁸² Law Com No 119, 1991 (n 23) [1.1].

⁸³ Law Com No 119, 1991 (n 23) [1.9].

⁸⁴ [1990] 2 AC 1.

⁸⁵ This case was considered in Law Com No 119, 1991 (n 23) [2.20] – [2.24].

⁸⁶ *Re F* (n 84) [55] (Lord Brandon), [72] (Lord Goff).

⁸⁷ [1993] Fam 95.

⁸⁸ Law Commission *Mental Incapacity* (Law Com No 231, 1995) [3.15] (footnote 21) notes that the judges in *Re T* (n 82) approached the question of the patient’s capacity differently.

⁸⁹ *Re T* (n 82) 115 (Lord Donaldson).

⁹⁰ *Re T* (n 82) 118 – 120 (Butler-Sloss).

⁹¹ [1994] 1 WLR 290.

clear guidance on questions of capacity in relation to medical treatment decisions'.⁹² It also provides an example of cross-fertilisation between law-making (by the judiciary) and policy proposals for legislative reform (by the Law Commission). Thorpe J remarked that his approach to deciding on the capacity of C, a man with a diagnosis of "chronic paranoid schizophrenia", to refuse the amputation of his gangrenous leg was similar to the approach proposed by the Law Commission in its consultation paper 129, *Mentally Handicapped Adults and Decision-Making*.⁹³ His judgment resonates with the Law Commission's proposals on two important counts. The first is that Thorpe J considered:

...the question to be decided is whether it has been established that C's capacity is so reduced by his chronic mental illness that he does not sufficiently understand the nature, purpose and effects of the proffered amputation.⁹⁴

This reflects the Law Commission's view that 'a person should be considered incapacitated unless the absence of an independent will has been caused by a mental disorder'.⁹⁵ The second is that the Judge held that there were three stages to the decision-making process "...first, comprehending and retaining the information, second, believing it and, third, weighing it in the balance to arrive at a choice".⁹⁶ This is similar to the Law Commission's proposal:

A mentally disordered person should be considered unable to take the medical treatment in question if he is unable to understand an explanation in broad terms and simple language of the basic information relevant to taking it, including information about the reasonably foreseeable consequences of taking or failing to take it, or is unable to retain the information long enough to take an effective decision.⁹⁷

⁹² Law Commission *Mental Incapacity* (Law Com No 231, 1995) [3.15].

⁹³ Law Com CP (No 129, 1993) (n 81). The paragraph to which the Judge refers (para 2.20) states: 'We do not consider that a person should be considered incapacitated unless the absence of an independent will has been caused by a mental disorder'. However, it may well be that Thorpe J was also referring to the earlier discussion (paras 2.8- 2.19) which considered the basis for determining whether a person is unable to make the relevant decision and includes points similar to Thorpe J's three-stage test. This seems to be the view of the Law Commission, when discussing this case in Law Com No 231 1995 (n 85) para 3.15 when stating that Thorpe J 'mentioned that we had proposed a similar approach in our consultation paper'.

⁹⁴ *Re C* (n 84) 295.

⁹⁵ Law Com No 129, 1993 (n 86) para 2.20.

⁹⁶ *Re C* (n 84) 295.

⁹⁷ Law Com No 129, 1993 (n 86) para 2.12.

Explicit reference was also made to the Law Commission's work in this area by the Court of Appeal in *Re MB (Medical Treatment)*⁹⁸ in 1997. Lady Justice Butler-Sloss (giving the judgment for the court) referred to Thorpe J's three-stage test in *Re C* as well as the criteria proposed by Law Commission's 1995 report, *Mental Incapacity*,⁹⁹ for determining whether 'a person is without capacity',¹⁰⁰ both of which are reflected in her conclusion on determining incapacity. The Court of Appeal held that a person 'lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent or to refuse treatment'.¹⁰¹ The Judge considered such an inability to make a decision will occur in two situations. First, if the person 'is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question' and second if the 'patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision'.¹⁰² These points are now reflected in the MCA 2005, which as discussed below, sets out the circumstances in which a person will be held to lack the mental capacity to make the decision in question.¹⁰³ Before considering this, a brief explanation is provided on how the MCA 2005 applies to adolescents and how this is relevant to adolescent psychiatric care.

2.2 Adolescents and the Mental Capacity Act 2005

The MCA 2005 applies when considering whether adolescents aged 16 or 17 are able to consent to their admission to hospital and/or treatment for mental disorder.¹⁰⁴ This means that the presumption of (mental) capacity will apply but that where there are concerns that the young person may not have capacity to make the decision this will be assessed in accordance with criteria set out in sections 2 and 3 of the MCA 2005 (considered below) and the principles in section 1 of the Act, which include (in addition to the presumption of mental capacity), that individuals are not to be treated as unable to make decisions 'unless all practicable steps' have to help them to do so 'have been

⁹⁸ [1997] 2 FLR 426.

⁹⁹ Law Com No 231 1995 (n 85).

¹⁰⁰ *Re MB* (n 91) 433 – 434.

¹⁰¹ *Re MB* (n 91) 433 – 434.

¹⁰² *Re MB* (n 91) 437.

¹⁰³ See clause 2 of the Law Commission's draft Mental Incapacity Bill (Law Com No 231 1995 (n 85) 222). Although not an exact replication of this clause, the essence of the Law Commission's proposals is reflected in sections 2 and 3 of the MCA 2005.

¹⁰⁴ Although there are some circumstances in which the MCA 2005 provides for children, these are not concerned with matters relevant to adolescent psychiatric care given that they cover the child's property or finances (section MCA 2005 s 18(3)). Offences of ill-treatment and wilful neglect of people who lack capacity under s 44 can be committed against individuals of any age.

taken without success'¹⁰⁵ and that they are not to be so treated merely because they make 'an unwise decision'.¹⁰⁶

Although the general provisions of the MCA 2005 apply to all people over the age of 16, for the following reasons young people are not on the same footing as adults under this Act.¹⁰⁷

First, the Deprivation of Liberty Safeguards (DoLS) are not applicable to those aged under 18, albeit as discussed in Chapter 6, whether the intervention gives rise to the adolescent's deprivation of liberty is as important a question for under 18s as it is for adults.

Second, irrespective of their capacity to do so, decision-making powers under the MCA 2005 intended to enable individuals to prepare, if they so choose, for the time when they may lack capacity are not applicable to under 18s. They cannot make advance refusals of treatment under the MCA 2005,¹⁰⁸ nor can they appoint others to be their lasting powers of attorney in either personal welfare, or financial matters.¹⁰⁹ It would appear that the reasons for limiting such powers is to avoid encroaching upon the roles of the courts and those with parental responsibility, whose powers are considered to be unaffected by the provisions of the MCA 2005 and therefore continue until the young person reaches 18. The Law Commission explained there was 'little point in our recommending that an anticipatory refusal of treatment' given the 'settled if controversial law that the court in the exercise of its statutory and/or inherent jurisdiction (and possibly any person who has parental responsibility) may overrule the refusal of a minor, competent or not to accept medical treatment'.¹¹⁰ Here the Law Commission is referring to the Court of Appeal's decisions in *Re R*¹¹¹ and *Re W*¹¹² discussed above. Similarly, in addition to concerns about the uncertainty of the law in relation to minors and attorneys, the Law Commission was reluctant to create a potential conflict with existing powers by allowing young people to appoint attorneys to act on their behalf if in the future they should lack the capacity to

¹⁰⁵ MCA 2005 s 1(3).

¹⁰⁶ MCA 2005 s1(4).

¹⁰⁷ The application of the MCA 2005 to 16 and 17 year olds is considered by C Parker 'Decision-making: the legal framework' in S Broach, L Clements and J Read (eds) *Disabled Children: A Legal Handbook* (Legal Action Group 2016).

¹⁰⁸ MCA 2005 s 24(1).

¹⁰⁹ MCA 2005 s 9(2)(c).

¹¹⁰ Law Com No 231 1995 (n 85) para 5.18.

¹¹¹ *Re R* (n 20).

¹¹² *Re W* (n 21)

make those decisions themselves.¹¹³ In relation to health care, it noted that if a minor could appoint a person to make decisions on his/her behalf in such areas ‘there would also be very significant complications with the law in relation to parental responsibility and the inherent jurisdiction of the High Court’.¹¹⁴

Third, section 8 of the FLRA 1969 relates only to the young person’s medical treatment. It does not cover procedures such as organ donation that are not for the benefit of the young person, or research. In such cases, there is no presumption of legal capacity and so young people are in the same position as their younger siblings and therefore before undertaking such procedures health professionals would need to be satisfied that the young person is *Gillick* competent.¹¹⁵

While this is not relevant in relation to adolescent psychiatric care, it is another example of the distinction between legal capacity and mental capacity. As noted in Chapter 2, while for understandable reasons the difference between the two has been given little attention since the introduction of the MCA 2005, it is relevant when considering the law relating to adolescent health care.

Fourth, the second and third points noted above highlight an inconsistency in the MCA 2005 Code which states:

the [MCA 2005’s] starting point is to confirm in legislation that it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at a time when the decision needs to be made.¹¹⁶

While this may be a correct statement of the law for adults, the MCA Code’s advice in relation to section 8 of the FLRA 1969, as well as the current law in relation to the court’s powers to override the young people demonstrate that adolescents aged 16 and 17 do not have “full legal capacity to make decisions for themselves” in all cases.

¹¹³ Law Com No 231 1995 (n 85) para 7.20 noted that the law in this area ‘remains complex and it may be that the appointment itself is voidable by the minor if not for his or her benefit’.

¹¹⁴ Law Com No 231 1995 (n 85) [7.20].

¹¹⁵ See MCA 2005 Code (n 52) para 12.12 which states that in such cases ‘anyone under 18 is presumed to lack legal capacity, subject to the test of ‘*Gillick* competence’ (testing whether they are mature and intelligent enough to understand a proposed treatment or procedure)’.

¹¹⁶ MCA 2005 Code (n 52) para 1.2.

2.3 Assessing capacity under the Mental Capacity Act 2005

The provisions under the MCA 2005 setting out the basis for assessing whether a person lacks capacity are set out below, followed by consideration of relevant human rights standards, in particular Article 12 of the CRPD.

2.3.1 People who lack capacity under the MCA 2005

Section 2(1) of the MCA 2005 states:

For the purpose of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in the functioning of, the mind or brain.

This provision follows the Law Commission's recommendation that the test for incapacity should incorporate both a "functional approach" and a "diagnostic threshold".¹¹⁷ In order for a person to lack capacity under the MCA 2005 it must be established on a balance of probabilities¹¹⁸ that she is unable to make the particular decision, at the particular time ("the functional element") due to "an impairment of, or a disturbance in the functioning of, the mind or brain" ("the diagnostic element"). Under the functional approach, which had gained support during the consultation process and 'has the merit of being the approach adopted by the most established tests in English law', 'the assessor asks whether an individual is able, at the time when a particular decision has to be made, to understand its nature and effects'.

The functional approach was one of three approaches to incapacity identified by the Law Commission in its initial Consultation Paper 119, the two others being the "status approach" and the "outcome approach". The "status approach" focuses on a specific characteristic of an individual, such as age or diagnosis, "without further inquiry into how membership of that category affects his competence as an individual".¹¹⁹ This was considered to be "quite out of tune with the policy aim of enabling and encouraging people to take for themselves any decision which they have the capacity to take".¹²⁰ It also raises human rights concerns.¹²¹ The "outcome approach", which focuses on the

¹¹⁷ Law Com No 231, 1995 (n 85) paras 3.3-3.21.

¹¹⁸ MCA 2005 s 2(4).

¹¹⁹ Law Com No 231 1995 (n 85) para 3.45.

¹²⁰ Law Com No 231 1995 (n 85) para 3.3.

¹²¹ See for example, *Winterwerp v. the Netherlands* (1982) 4 EHRR 188 in which the European Court of Human Rights found that the automatic removal of an individual's legal capacity to

“final content of an individual’s decision” so that a decision “which is inconsistent with conventional values, or with which the assessor disagrees, may be classified as incompetent” was dismissed on the basis that it “penalises individuality and demands conformity at the expense of personal autonomy”.¹²² The Court of Appeal has since emphasised when referring to the role of the Court of Protection (established under the MCA 2005) that its “jurisdiction is not founded upon professional concern as to the ‘outcome’ of an individual’s decision”.¹²³

While recognising that the arguments for and against using a “diagnostic” hurdle were “finely balanced”, the Law Commission recommended that it was necessary to link the inability to decide with some form of diagnosis, “in particular, in ensuring that the test is stringent enough *not* to catch large numbers of people who make unusual or unwise decisions”.¹²⁴

The MCA Code of Practice states that “an impairment of or disturbance in the functioning of the mind or brain” is anticipated as covering a wide range of conditions. In addition to “psychiatric illness, learning disability, dementia, brain damage”, the “diagnostic element” might include “even a toxic confusional state, as long as it has the necessary effect on the functioning of the mind or brain, causing the person to be unable to make the decision”.¹²⁵ Other conditions include physical or medical conditions that cause drowsiness or loss of consciousness, concussion following a head injury and the symptoms of alcohol or drug use.¹²⁶

2.3.2 Test for “inability to decide”

Section 3 of the MCA 2005 elaborates on what is meant by “unable to make a decision”, as required by section 2 of the Act, with section 3(1) setting out four reasons why a person may be unable to make a decision. The first is that a person is unable to make a decision if she is unable to “understand the information relevant to the decision”. Section 3(2) provides that a person is not to be regarded as unable to understand the relevant information if she is able to understand an explanation that is presented to in a manner appropriate for her (for example, simple language or visual aids). The information

administer his property on being detained in a psychiatric hospital was in violation of ECHR art 6 (the right to fair trial).

¹²² Law Com No 231, 1995 (n 85) 3.3.

¹²³ *PC v City of York* [2013] EWCA Civ 478, [2014] Fam 10, [53].

¹²⁴ Law Com No 231 1995 (n 85) para. 3.8

¹²⁵ MCA 2005 Explanatory Notes (EN – 120), para 22.

¹²⁶ MCA Code para 4.12.

relevant to the decision includes “information about the reasonably foreseeable consequences of a) deciding one way or the other, or b) failing to make the decision”.¹²⁷

Second, the person must be able to “retain that information” (even if this is only for a short period of time,¹²⁸ so long as this is “long enough to use it to make an effective decision”¹²⁹). Third, the person must be able to “use or weigh that information as part of the process of making the decision”. Finally, the person must be able to communicate her decision “(whether by talking, using sign language or any other means)”.¹³⁰

As noted above, the question of the person’s ability to decide forms only one part of the two-stage capacity test under section 2 of the MCA 2005. For the person to lack capacity, the inability to make a decision must be linked to the diagnostic element described in section 2 of the MCA 2005.¹³¹ The Court of Appeal emphasised in *PC v City of York*,¹³² that the first crucial question is whether the person is able to decide or not, considering the points set out in section 3 of the MCA 2005 (described above).

A person may meet the test for inability to decide but not the diagnostic element included in section 2 of the MCA 2005. For example, the Court of Appeal has affirmed that there may be circumstances where adults’ ‘ability to make decisions for themselves has been compromised by matters other than those covered by the MCA 2005’. This might be because they are under constraint, subject to coercion or undue influence, or “[f]or some other reason deprived of the capacity to make the relevant decision or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent”.¹³³ In relation to young people the Code of Practice to the MCA 2005, refers to the possibility that they may be ‘overwhelmed’ by the decision in question, so that they are unable to make decision but not ‘because of an impairment of, or disturbance in the functioning of the mind or brain’ which means that the young person does not lack capacity under the MCA 2005.¹³⁴ The MHA Code 2015 suggests that such (rare) cases might arise because the young person is in ‘an unfamiliar and novel

¹²⁷ MCA 2005 s 3(4).

¹²⁸ MCA 2005 s 3(3).

¹²⁹ MCA 2005 Code 4.20.

¹³⁰ MCA 2005 s 3(1) (d).

¹³¹ *PC v City of York* (n 115) [58] (McFarlane LJ): ‘There is, however, a danger in structuring the decision by looking to s 2(1) primarily as requiring a finding of mental impairment and nothing more and in considering s 2(1) first before then going on to look at s 3(1) as requiring a finding of inability to make a decision. The danger is that the strength of the causative nexus between mental impairment and inability to decide is watered down’.

¹³² *PC v City of York* (n 115).

¹³³ *DL v Local Authority* [2012] EWCA Civ 253, [2012] Fam 1 [53] – [54].

¹³⁴ MCA 2005 Code para 12.13.

situation'. It advises that the young person be given information and support, as well as time to make the decision.¹³⁵ The Law Commission 2017 report also refers to a young person who is unable to decide but for reasons falling outside the MCA 2005, referring to the young person who is not *Gillick* competent, explaining 'they do not have sufficient maturity and intelligence to understand the nature and implications of the proposed decision'.¹³⁶

2.3.3 Concerns about the assessment of mental capacity under the MCA 2005

Despite the criteria in the MCA 2005 and the guidance in the MCA Code, evidence submitted to the House of Lords Select Committee on the Mental Capacity Act 2005 highlighted that in practice there are significant problems with mental capacity assessments, such as being undertaken by health and social care professionals who were not sufficiently aware of the Act and the guidance.¹³⁷ In relation to the courts' approach to mental capacity assessments, echoing the comments noted in Chapter 2, Richardson comments that 'existing case-law indicates that courts will take a flexible approach to the legal definition to enable them to reach their preferred outcome'.¹³⁸

2.4 The MCA 2005 and human rights standards

A finding that a person lacks the capacity to make decisions for him or herself is regarded as a serious interference with that person's human rights, for example the European Court of Human Rights (ECtHR) has found violations of Articles 6 (right to fair trial)¹³⁹ and 8 (right to respect for private and family life),¹⁴⁰ in cases where the applicant's legal capacity has been removed.

This is an area which has come under increased scrutiny with the introduction of the UN Convention on the Rights of Persons with Disabilities (UNCRPD). While an analysis of the wide range of differing and conflicting views is beyond the scope of this thesis, the following points are included so as to highlight the areas in which the assessment of

¹³⁵ MHA Code 2015 (n 2) paras 19.31 – 19.33.

¹³⁶ Law Com 2017 (n 7) 7.35.

¹³⁷ House of Lords Select Committee on the Mental Capacity Act 2005 *Mental Capacity Act 2005: Post Legislative Scrutiny* (2013-2014 HLM139) paras 60-70.

¹³⁸ G Richardson *Mental capacity in the shadow of suicide: What can the law do?* (2013) *International Journal of Law in Context* 9(1) 87, 90. See also G Owen and others 'Mental Capacity and Decisional Autonomy: An Interdisciplinary Challenge' (2009) *Inquiry* 53: 79-107.

¹³⁹ *Salontaji-Drobnjak v Serbia* (App. 36500/05) 13 October 2009, [127] – [128], *Shtukurov v. Russia* (2012) 54 EHRR 27 paras 69 – 76.

¹⁴⁰ *Shtukurov v. Russia* (n 128) paras 93 – 94; *Salontaji-Drobnjak v Serbia* (n 128) paras 144 – 145; *X and Y v. Croatia* (Application no. 5193/09) 3 November 2011, para 102.

mental (in)capacity under the MCA 2005 might be considered incompatible with the UNCRPD.¹⁴¹

In its general comment on Article 12 UNCRPD (Equal recognition before the law), which provides for the right of people with disabilities to “enjoy legal capacity on an equal basis with others in all aspects of life”, the Committee on the Rights of Persons with Disabilities (the CRPD Committee) states that denying legal capacity to people with disabilities on the basis of disability and/or decision-making skills is a “discriminatory denial of legal capacity”. This concern appears to be directed towards adults given that in relation to children with disabilities (which covers all those aged under 18 years), no reference is made to legal capacity albeit the CRPD Committee advises that laws should be reviewed “to ensure that the wills and preferences of children with disabilities are respected on an equal basis with other children”.¹⁴² The Issue Paper on Article 12 published by the Council of Europe’s Commissioner for Human Rights (the CoE Human Rights Commissioner) makes clear that it is focused on adults, referring to legal capacity in the context of “people of majority age” and “Europeans above 18 years”.¹⁴³

Both the CRPD Committee and the CoE Human Rights Commissioner raise concerns about the basis on which people with disabilities are divested of their legal capacity. The CRPD Committee observes:

In most of the State party reports that the Committee has examined so far, the concepts of mental and legal capacity have been conflated so that where a person is considered to have impaired decision-making skills, often because of a cognitive or psychosocial disability, his or her legal capacity to make a particular decision is consequently removed.¹⁴⁴

In a similar vein, the CoE Human Rights Commissioner notes that within all European jurisdictions different models are used “to attribute incapacity to persons with disabilities”, referring to the “status approach”, the “outcomes approach” and the “functional approach”, considering all three to be ‘objectionable’.

¹⁴¹ The MCA 2005 and its compatibility with the UNCRPD is discussed by E Cave ‘Determining Capacity to Make Medical Decisions: Problems Implementing the Mental Capacity Act 2005’ (2015) *Statute Law Review* 36 (1): 86.

¹⁴² Committee on the Rights of Persons with Disabilities General Comment No. 1 (2014) *Article 12: Equal Recognition before the law* CRPD/C/GC/1 para 36.

¹⁴³ Commissioner for Human Rights ‘Who Gets to Decide? Right to Legal Capacity for Persons with Intellectual and Psychosocial Disabilities’ *CommDH/IssuePaper* (2012)2.

¹⁴⁴ CRPD General Comment No. 1 (n 134) para 14.

Also of note is that the 'concept of capacity is not developed in the Strasbourg jurisprudence'.¹⁴⁵ To date, the ECtHR has not delved into the intricacies the legal aspects of decision making (specifically, assessing whether individuals are able to make the decisions in question). It tends to adopt the term applied by the national authorities involved (such as 'mental capacity'¹⁴⁶ and 'legal capacity'¹⁴⁷) without seeking to define them.

Whereas the CoE Human Rights Commissioner considers that the functional approach 'may yet have a future' if it is used as a means of determining what type of support a person needs rather than 'a yardstick by which to withdraw capacity',¹⁴⁸ the CRPD Committee argues that the functional approach is also flawed. This is because a) it is "discriminatorily applied" to disabled people and b) "presumes to be able to accurately assess the inner-workings of the human mind" and failure to pass this test means that the person will be denied the right to equal recognition before the law (legal capacity).¹⁴⁹

That the CRPD Committee's view on the functional approach to assessing individuals' ability to decide, calls into question the compatibility of the MCA 2005 with the CRPD, was considered by the Essex Autonomy Project (the EAP) in a report submitted to the Ministry of Justice.¹⁵⁰ Albeit finding areas in which the MCA 2005 is not compliant with the CRPD, including the diagnostic element (because there appears to be no justification for the disproportionate impact this has on people with disabilities) the EAP concluded that the functional element of the test for lacking capacity was not one of them. The EAP is of the view that individuals who lack the ability to make decisions in a particular domain, 'even when support is provided, cannot accurately be described as acting autonomously in that domain' adding that 'they lack the potential for self-legislating self determination that lies at the core of the concept of autonomy'.¹⁵¹ Accordingly:

It is therefore reasonable to use a functional test of decision-making ability as a basis for differential treatment in advancing the aim of fostering and protecting individual autonomy, particularly when this aim may conflict with the equally legitimate aims of (*inter alia*) protecting a

¹⁴⁵ *R (B) v S (Responsible Medical Officer, Broadmoor Hospital)* [2006] EWCA Civ 28, [2006] 1 WLR 810, [50] (Lord Phillips).

¹⁴⁶ *MH v UK* (2014) 58 EHRR 35.

¹⁴⁷ For example, *Stanev v Bulgaria* (2012) 55 EHRR 22.

¹⁴⁸ Commissioner for Human Rights (n 130) 9.

¹⁴⁹ CRPD General Comment No. 1 (n 134) para 15.

¹⁵⁰ W Martin, S Michalowski, T Jütten, M Burch, 'Achieving Compliance: Is the Mental Capacity Act of England and Wales Compatible with the UN Convention on the Rights of Persons with Disabilities? If not What Next?' (Essex Autonomy Project 2014).

¹⁵¹ The EAP CRPD report (n 142) 19.

disabled person's right to life, or ensuring their protection and safety in situations of risk.¹⁵²

Such comments highlight that the tension that can arise between respecting an adolescent's wishes and protecting that adolescent's welfare is one that also arises in relation to adults.

PART 3 GUIDANCE IN THE MHA CODE 2015

The MHA Code 2015 provides detailed guidance on assessing decisional capacity. Chapter 13, provides a general overview of the provisions of the MCA 2005, highlighting the importance of this Act. The Code also refers to the MCA 2005's 'strong emphasis on the need to support individuals to make their own decisions' and that '[a]ll individuals should be encouraged to participate in decision making and professionals should carefully consider the individuals wishes at all times'.¹⁵³ Chapter 19, which focuses on children and young people, provides guidance on assessing under 18s generally, including the need to provide information and support to help the adolescent make the decision.

Chapter 19 provides additional information on the MCA 2005 and also explains that there may be times where the young person is not able to make the decision but not lack capacity under the MCA 2005 (the 'overwhelmed' young person referred to in Part 2). The MHA Code emphasises the importance of providing support to the young person in such situations.¹⁵⁴

In relation to *Gillick* competence, the MHA Code suggests the following questions for practitioners to consider when assessing *Gillick* competence, which are based on the criteria set out in section 3(1) (a)-(d) of the MCA 2005. These ask whether the child:

- i) is able to understand the relevant information;
- ii) can 'hold the information in their mind long enough so that they can use it to make the decision';
- iii) is 'able to weigh up that information and use it to arrive at a decision'; and
- iv) 'communicate their decision (by talking, using sign language or any other means)'.¹⁵⁵

¹⁵² The EAP CRPD report (n 142) 19.

¹⁵³ MHA Code 2015 para 13.10.

¹⁵⁴ MHA Code 2015 para 19.22.

¹⁵⁵ MHA Code 2015 para 19.36.

The MHA Code states that unlike the test for incapacity under the MCA 2005, the reasons for a child's lack of competence is immaterial. The child may be unable to make the decision 'because they have not as yet developed the necessary intelligence and understanding' to do so, or for another reason, such as 'because their mental disorder adversely affects their ability to make the decision; – either way 'the child will be considered to lack *Gillick* competence'.¹⁵⁶ Furthermore, it states that the child's 'competence to consent should be assessed carefully in relation to each decision that needs to be made'.¹⁵⁷

CONCLUSION

Given its importance in determining the basis on which adolescent psychiatric care can be provided, this chapter has examined the two legal tests for decisional capacity, namely *Gillick* competence and the test for (in)capacity under the MCA 2005. Set out below are the key points from this analysis, focusing on two areas of interest, namely potential areas of confusion and the human rights implications of the tests for decisional capacity

(1) Potential Areas of Confusion

- (i) There has been a lack of clarity on the meaning of *Gillick* competence. This was because although in *Gillick* the House of Lords established that under 16s can in certain circumstances consent to their treatment, they did not fully explain what would be required of a child to be considered competent to make decisions for him or herself. This has led to a wide variation of interpretations by the judiciary on how to apply the concept of '*Gillick* competence'.
- (ii) How *Gillick* competence applies to adolescents with mental health problems was not clear with *dicta* by the Court of Appeal in *Re R* suggesting that adolescents with fluctuating *Gillick* competence should be regarded as lacking *Gillick* competence. However, the MHA Code 2015 has introduced guidance to practitioners on factors to consider when assessing *Gillick* competence and states that the assessment should be decision-specific.

¹⁵⁶ MHA Code 2015 para 19.37.

¹⁵⁷ MHA Code 2015 para 19.35.

- (iii) The MCA 2005, which applies to adolescents aged 16 and 17, provides a framework for assessing mental capacity through statutory criteria and guidance in the MCA Code of Practice. However, concerns have been raised about the value-neutrality of mental capacity assessments of mental capacity

(2) Human Rights Implications of Decisional Capacity

- (i) With the advent of the UNCRPD questions have been raised about the compatibility of the MCA 2005, given that it challenges the very concept of 'mental incapacity'. This raises a complex issue but given that it is not central to clarifying the legal framework for adolescent psychiatric care, it is not explored further in this thesis.
- (ii) As noted in Chapter 2, commentators have highlighted that a finding that the adolescent lacks decisional capacity is one of the ways in which the courts have limited adolescent autonomy, a point supported by the McFarlane's observation that in the 20 years since *Re W* 'the court does not seem to have been obliged actually to override the consent of a competent young person'.¹⁵⁸ The approach adopted by the courts to adolescents' refusal of treatment is considered in the next chapter.

¹⁵⁸ McFarlane (n 9) 484.

CHAPTER 4: MINORS' VIEWS ABOUT MAJOR DECISIONS: THE 'BEST INTERESTS OF THE CHILD' AND ADOLESCENTS' REFUSAL OF TREATMENT

INTRODUCTION

Under its 'theoretically limitless'¹ powers, the High Court can authorise the non-consensual treatment and related care (including sedation, restraint, and deprivation of liberty²) of all under 18s, irrespective of their decisional capacity, if this is in the adolescent's best interests.³ Thus, while the High Court must take into account the adolescent's wishes, these can be overridden if the court considers that it is in the adolescent's welfare to do so.⁴

In relation to adolescent psychiatric care, an application can be made to the High Court where an adolescent needs to be admitted to hospital and treated for mental disorder, but there is no alternative legal authority for such an intervention.⁵ For example, seeking a declaration that emergency medical treatment can be given to the adolescent might be necessary where the adolescent has decisional capacity and is refusing treatment, but there is insufficient time to carry out a mental health assessment for detention in hospital under the Mental Health Act (MHA) 1983. A non-emergency situation might arise where the criteria for detention under the MHA 1983 have been considered, but found not to be met.⁶

¹ *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1992] Fam 64 CA, 81 (Lord Donaldson). See also *Spencer v Anderson (Paternity Testing: Jurisdiction)* [2016] EWHC 851 (Fam) [55]-[56] and Ministry of Justice, *Practice Direction D – Inherent Jurisdiction (Including Wardship) Proceedings* 16 < www.justice.gov.uk/courts/procedure-rules/family/practice_directions/pd_part_12d > accessed 9 August 2017.

² *An NHS Foundation Hospital v P* [2014] EWHC 1445 (Fam) [2014] Fam Law 1229 [17].

³ *Re W* (n 1). The requirement to consider the child's welfare under CA 1989 s1(1) applies when the court is exercising powers under its inherent jurisdiction; see *Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, [2000] 4 All ER 961 CA. In that case Robert Walker LJ noted (p 242) that the requirement to consider the 'welfare of the child' was synonymous with consideration of the best interests of the child. In *P* (2014) (n 2) [12] Baker J cited *Re W* (n 1) and *Re P (Medical Treatment: Best Interests)* [2003] EWHC 2327 (Fam), (2004) 2 FLR 1157 when stating that the court can 'override the child's wishes in her best interests'.

⁴ *Re W* (n 1).

⁵ Department of Health *Mental Health Act 1983: Code of Practice* (TSO 2015), (MHA Code 2015) para 19.52.

⁶ As was the case in *Trust A v X (A Child)* [2015] EWHC 922 (Fam), [2016] 3 WLR 1401 which is discussed in Chapter 6.

This chapter is concerned with the basis on which the court exercises its powers to authorise such non-consensual treatment of adolescents. It considers two cases in which the court assumed that the adolescent had decisional capacity, but nonetheless authorised the medical treatment, contrary to the adolescent's wishes. The first case is the Supreme Court of Canada's decision in *AC and Others v Manitoba (Director of Child and Family Services) (Manitoba)*.⁷ The decision illustrates the complexities involved where the conflict between the wishes of an adolescent and what others perceive to be in that adolescent's welfare is at its most extreme; namely when the adolescent refuses life-saving treatment.⁸ As Fortin observes, the court's 'lengthy survey of international approaches to this problem showed that other jurisdictions were finding it equally difficult to allow adolescents to reject life-saving treatment'.⁹ Indeed, Abella J commenced her leading judgment by noting that the issue before the court 'engages the most intensely complicated constellation of considerations and its consequences are inevitably profound'.¹⁰ Furthermore:

...What is clear from the above survey of Canadian and international jurisprudence is that while the courts have readily embraced the concept of granting adolescents a degree of autonomy that is reflective of their evolving maturity, they have generally not seen the 'mature minor' doctrine as dictating guaranteed outcomes, particularly when the consequences for the young person are catastrophic.¹¹

An adolescent refusing treatment in circumstances likely to lead to her death was also the critical issue before the court in the second case examined in this chapter, namely *An NHS Foundation Trust v P (P 2014)*.¹² This is the most recent case concerning an adolescent's refusal of life-saving treatment considered under national law and the second since the introduction of the Human Rights Act (HRA) 1998.¹³ Like *Manitoba*, the court in *P 2014* appears to have proceeded on the basis that the adolescent had decisional capacity because such a finding was not crucial to the decision (a point explicitly acknowledged in *Manitoba*). For the adolescents concerned, the issue to be decided by the court was whether their wishes could be overridden in their best interests.

⁷ (2009) SCC 30 [2009] 2 SCR 181.

⁸ The complexity of the legal, ethical and emotional issues that arise from such cases are explored in Ian McEwan's novel *The Children Act* (Jonathan Cape 2014).

⁹ Fortin J 'Children's rights – flattering to deceive?' (2014) CFLQ 26(1), 61.

¹⁰ *Manitoba* (n 6) [1].

¹¹ *Manitoba* (n 6) [69].

¹² *P 2014* (n 2).

¹³ *Re P [2003]* (n 3) did not consider the Human Rights Act (HRA) 1998.

In both cases, the court held that the circumstances merited the provision of medical treatment despite the adolescent's objection.

Analysis and structure of this chapter

Part 1 sets out the context for adolescent treatment refusal cases. It does so by considering the decision in *Manitoba*, which provides a useful lens through which to focus on the human rights implications of such cases. The differing approaches by the judges in *Manitoba* to the wishes versus welfare dynamic in circumstances where to uphold the wishes of the adolescent would lead to that adolescent's death revolve around two key issues. The first is the basis on which an adolescent's decisional capacity is assessed. The second issue is the relevance of that adolescent's decisional capacity to the determination of that adolescent's best interests.

These issues are encapsulated in the 'adolescent autonomy conundrum' noted in Chapter 2. This term describes the concern raised by commentators that 'adolescent autonomy' is by-passed in treatment refusal cases, either by finding that the adolescent lacks decisional capacity because the court disagrees with the adolescent's decision, or the court exercising its powers to override the views of a minor, irrespective of the adolescent's decisional capacity. The point of concern is which one of these two possible reasons does the court rely upon when making its decision to override the wishes of the adolescent.

If the adolescent has decisional capacity the question then arises as to why it is justifiable to override an adolescent's wishes in circumstances in which it would not be possible for an adult.

Part 2 considers the impact of the HRA 1998 on the role of the national courts when adjudicating on adolescent treatment refusal cases. It does so by applying the 'human rights decision-making framework' questions identified in Chapter 1. The 'justification' question concerns the circumstances in which the courts authorise adolescents' non-consensual treatment. The 'wishes versus welfare dynamic' question considers the extent to which the determination that such non-consensual treatment is justified takes into account the views of the adolescent and if the adolescent's decisional capacity has any relevance to this determination.

The 'human rights comparison' question focuses on the two main ECHR rights engaged in circumstances where an adolescent refuses life-saving medical treatment, namely Article 8 (which includes the right to physical and psychological integrity), being relevant

to the adolescent's wish to have her wishes respected, and Article 2 (right to life), being relevant to the welfare concerns given that its positive duty to take steps to protect the life of an adolescent is likely to be engaged. The scope of these rights and the relevance of the concept of best interests of the child under Article 3 of the UN Convention on the Rights of the Child (UNCRC), are considered, focusing on General Comment 14 of the CRC, which sets out how the best interests of the child is to be interpreted and applied.

The Conclusion summarises the key issues identified through this analysis and areas of potential confusion and uncertainty.

PART 1. TREATMENT-REFUSAL BY ADOLESCENTS: A HUMAN RIGHTS PERSPECTIVE

The purpose of Part 1 is to identify the key issues that arise from adolescents' refusal of treatment and examine how they connect to human rights principles. It does so by considering how the relevant issues were addressed by the Supreme Court of Canada in *Manitoba*, which concerned an adolescent ('AC'), who at the relevant time was nearly 15 years old and who had, with the support of her parents, refused blood transfusions on the basis of her religious belief (she was a Jehovah's Witness). The Supreme Court of Canada held (Binnie J dissenting) that the state's legislation empowering the court to authorise medical treatment against the wishes of a 'mature minor', if it considered this to be in the child's best interests, was not unconstitutional.

1.1 Manitoba: Context

A significant factor in AC's case was that the judge at first instance who had ordered AC's treatment in her best interests had accepted without any review on this point that she had 'capacity'.¹⁴ The Judge had done so because he considered AC's capacity 'was irrelevant to his task' given that as she was aged under 16 there were no restrictions on 'the court's ability to order medical treatment in the child's "best interests"'.¹⁵ The

¹⁴ *Manitoba* (n 6) [12]. The Child and Family Services (CFS) Act CCSM. c.C80, s 28(8) states that, subject to s28(9) (which concerned 16 and 17 year olds, so not therefore applicable to AC), the court may authorize medical treatment 'that the court considers to be in the best interests of the child'. The lack of judicial determination of AC's capacity was noted by Abella J [119].

¹⁵ Abella J noted (*Manitoba* (n 6) [12]) that at the 'urging of [AC's] counsel', the Judge 'agreed to proceed on the assumption that A.C. had "capacity" to make medical decisions because, in his view, her capacity was irrelevant to the task'. Binnie J at [173] considered the view that AC's capacity was irrelevant to be at the heart of the problem with the court's approach.

subsequent proceedings were therefore pursued on the basis that AC had capacity.¹⁶ Under state law, if AC had been 16 or 17, her decision could not have been overridden unless the court determined that she lacked decisional capacity, as defined by the relevant legislation,¹⁷ whereas as she was under 16, no such limit applied and the judge could order her medical treatment if it was in her best interests.

Given the finding that she had decisional capacity, AC argued first that she was a 'mature minor' and as such the best interests test under the relevant legislation did not apply to her but this was rejected by the majority. Abella J concluded that 'no state court has gone so far as to suggest that the "mature minor" doctrine effectively "reclassifies" mature adolescents as adults for medical purposes'¹⁸, whereas McLachlin CJ considered that the common law regarding mature minor was ousted by the relevant legislation.¹⁹

Accordingly, the discussions below focus on AC's second, alternative argument, namely that the relevant provisions were unconstitutional because they infringed her rights under the Canadian Charter of Rights and Freedoms ('the Canadian Charter'). AC argued that by depriving her of the right to demonstrate her capacity to make decisions about her medical treatment, the relevant statutory provision contravened her right to liberty and security²⁰ (which under the Canadian Charter incorporates respect for personal autonomy and is therefore engaged if individuals are treated without their consent).²¹ It was not, however, the 'constitutionality of a cut-off age of 16' that AC objected to, instead 'she challenges the constitutionality of depriving those under 16 of an opportunity to

¹⁶ *Manitoba* (n 6) [15] the Court of Appeal had confirmed that the AC's capacity was not in issue.
¹⁷ CFS Act (n 13) s 25(9): 'The court shall not make an order under subsection (8) with respect to a child who is 16 years of age or older without the child's consent unless the court is satisfied that the child is unable (a) to understand the information that is relevant to make a decision to consent or not consent to the medical examination or the medical or dental treatment; or (b) to appreciate the reasonably foreseeable consequences of making a decision to consent or not to consent to the medical examination or the medical or dental treatment.'

¹⁸ *Manitoba* (n 6) [66]. Earlier in her judgment [54] Abella J had noted that *Re W and Re R (a minor) (wardship: medical treatment)* [1992] Fam 11 [1991] 4 All ER 177 CA 'definitively established that even "mature minors" were subject to the court's inherent *parens patriae* jurisdiction'.

¹⁹ *Manitoba* (n 6) [126]. In contrast, Binnie J considered at [175] 'proof of capacity entitles the "mature minor" to personal autonomy' in making medical treatment decisions 'free of parental or judicial control'. Binnie J at [202] cited *Van Mol (Guardian ad Litem of) v Ashmore* 1999 BCCA 6, 168 DLR (4th) 637 [75], stating that in this case the British Columbian Court of Appeal 'rightly viewed the young person with capacity as entitled to make the treatment decision, not just to have "input" into a judge's consideration of what the judge believes to be in the young person's best interests'. It should be noted however that while the court in *Van Mol* was concerned with the question of informed consent (whether this should be obtained from the parents or the adolescent) and not the role of court where an adolescent refuses treatment.

²⁰ Canadian Charter of Rights and Freedoms (the Canadian Charter) s. 7: 'Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.'

²¹ *Manitoba* (n 6) [100] – [103] (Abella J), [136] (McLachlin CJ).

prove that they too have sufficient maturity to direct the course of their medical treatment'.²² Although AC also argued that the legislation contravened her right to freedom of conscience and religion²³ and amounted to age discrimination,²⁴ the main legal analysis focused on whether the provisions authorising treatment against the wishes of children aged under 16, if considered to be in their best interests, was an arbitrary interference with AC's right to liberty and security of person and therefore unconstitutional.

1.2 Manitoba: Adolescents' treatment refusal the approach taken by the court

The discussions below identify some key points raised in the *Manitoba* decision which will also be of relevance to the national court when considering similar cases. They fall under two broad categories, the first being concerned with the justification for the interference and the second concerns the role of the best interests of the child.

1.2.1 Justification for interference with an individual's human rights

The key question for the court in *Manitoba* was whether the state's legislation was an arbitrary interference with AC's right to liberty and security (and therefore unconstitutional), or whether such an interference could be justified (all the judges agreed that the court order imposing medical treatment on AC engaged her right to liberty and security of the person). Although Abella J (with LeBel, Deschamps and Charron JJ concurring) and Chief Justice McLachlin (with Rothstein J concurring) agreed that the relevant legislation was not arbitrary, their reasons for doing so differed in an important respect. Both noted that the aim of the legislation was to protect children from harm, which was a legitimate and significant concern but that this needed to be balanced against, what Abella J described as society's 'corresponding interest in nurturing children's potential for autonomy by according weight to their choices in a manner that is reflective of their evolving maturity'.²⁵

Significantly both considered that the difficulties in determining whether the child had attained sufficient maturity to exercise her autonomy justified the state's continued

²² *Manitoba* (n 6) [25].

²³ Canadian Charter s 2(a).

²⁴ Canadian Charter s 15(1) 'Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.'

²⁵ *Manitoba* (n 6) [105].

authority. Abella J emphasised that where the adolescent is refusing medical treatment that is considered necessary to protect the adolescent's life or health:

In this very limited class of cases, it is the ineffability inherent in the concept of "maturity", that justifies the state's retaining an overarching power to determine whether allowing the child to exercise his or her autonomy in a given situation actually accords with his or her own best interests.²⁶

McLachlin CJ referred to the 'impracticability of reliably testing' for factors relating to an adolescent's maturity as the reason for the court's involvement in the 'crucial and often exigent context of authorizing necessary medical treatment'.²⁷ Both also concluded that although constituting 'a deprivation of liberty and security of person'²⁸ the provision was not arbitrary,²⁹ it neither amounted to age discrimination,³⁰ nor infringed her freedom of religion.³¹

The point of difference lies in the judges' reasons why the legislation was not arbitrary. Whereas Abella J concluded that the balance to be achieved between autonomy and protection was through the best interest standard, which if properly interpreted (discussed below) 'provides that a young person is entitled to a degree of decisional autonomy commensurate with his or her maturity',³² McLachlin CJ focused on the need for special protection. She considered that treating under 16s (who do not have the right to refuse treatment 'even if they have the 'requisite understanding') differently from 16 and 17s (who do have such a right) was justified given that it was a 'legitimate response' to 'heightened concerns about younger adolescent's maturity and vulnerability to subtle and overt coercion and influence' and the difficulties in assessing their maturity and voluntariness.³³

In contrast, Binnie J's view was that once the adolescent attains the requisite decisional capacity she has the right to make that decision and the justification for state interference falls away. This is because 'the legitimate object and basis of state intervention in the life

²⁶ *Manitoba* (n 6) [86].

²⁷ *Manitoba* (n 6) [143].

²⁸ Canadian Charter s7.

²⁹ *Manitoba* (n 6) [114]-[115] (Abella J) [139] – [147] (McLauchlin CJ). See also [29] in which Abella J states that there is 'no constitutional justification for ignoring the decision-making capacity of children under the age of 16' under the relevant provisions.

³⁰ *Manitoba* (n 6) [111] (Abella J) [150] – [152] (McLauchlin CJ) and Canadian Charter s15.

³¹ *Manitoba* (n 6) [113] (Abella J) [153] – [156] (McLauchlin CJ) and Canadian Charter s2(a).

³² *Manitoba* (n 6) [114].

³³ *Manitoba* (n 6) [139] – [147].

of the young person, has by reason of the judge's finding of maturity, ceased to exist'.³⁴ In other words, Binnie J considered that the justification for state interference depends on the adolescent's lack of decisional capacity – it is 'this *lack* of capacity and maturity that provides the state with a legitimate interest in taking the decision-making power away from the young person and vesting it in a judge'.³⁵ It is noteworthy however, that while Binnie was of the view that once the adolescent has decisional capacity, best interest is not relevant, as discussed below, he considered that the test for decisional capacity incorporates many of the points that the two other Judges considered relevant when deciding if the adolescent's best interests required that her wishes should be overridden. As noted below, the discussions in *Manitoba* are relevant to the application of ECHR rights and link to the wider theoretical discussions on autonomy.

1.2.1.2 Treatment without consent: relevant ECHR rights

Whereas in *Manitoba* the question was whether the state legislation was unconstitutional, a similar point applies within the national context, namely with the intervention accords with the ECHR rights introduced into national law by the Human Rights Act (HRA) 1998. In HRA 1998 terms, AC's complaints would have been framed within Article 8 of the ECHR (arguing that non-consensual treatment infringed the adolescent's right to private life). Her claim could also have been pursued in conjunction with Article 14 of the ECHR (freedom from non-discrimination)³⁶ and Article 9 ECHR (freedom of thought, conscience and religion). In addition, the administration of medical treatment without consent has the potential to engage Article 3 of the ECHR (prohibition from torture, inhuman or degrading treatment or punishment) and Article 5 of the ECHR (right to liberty), while Article 2 of the ECHR (right to life), may provide the justification for treating without consent if the positive duty under this right to take steps to prevent the adolescent's death is engaged.

1.2.1.3 Theoretical perspectives on autonomy, rights and protection

There is a significant difference between the approach adopted by Binnie J and that of McLachlin CJ's. In his 'strong dissenting judgment',³⁷ Binnie J advocates 'an autonomy-based approach'. He considered that given the judge's acceptance that AC had capacity, there was no justification for interfering with her right to decide about her medical treatment, this being fundamental to her right to liberty and security under the Canadian

³⁴ *Manitoba* (n 6) [176].

³⁵ *Manitoba* (n 6) [176].

³⁶ Although this article is not a freestanding right, it might be relevant, for example with in conjunction with ECHR art 8.

³⁷ Fortin 'Children's rights – flattering to deceive?' (n 7) 61.

Charter. In contrast, the approach taken by McLachlin CJ emphasises the vulnerability of under 16s, raising concerns that extend beyond issues of decisional capacity to those relating to factors that might undermine the validity of the child's consent, for example noting the 'danger of excessive parental and peer influence overwhelming free and voluntary choice is ever present'.³⁸ Thus, McLachlin CJ's concern appears to be that adolescents aged under 16 years may not be able to be truly autonomous.³⁹

McLachlin CJ's concern to protect under 16s even if they have decisional capacity resonates with the theories noted in Chapter 2 that support such non-consensual interventions. For example, Freeman's 'liberal paternalism' justifies this on the basis of protecting the adolescent's future autonomy.⁴⁰ In contrast, in holding that the wishes of the adolescent take precedence over any welfare (best interests), Binnie J's stance is akin to the will theory of rights noted in Chapter 1 which holds that for individuals to have rights, they must have the ability to exercise such rights. In consequence once adolescents have attained the ability to exercise their rights (which, from a legal perspective, is evidenced by attaining decisional capacity) their decisions must be respected, whatever the consequences.

1.2.2 *The role of 'best interests of the child'*

The discussions in *Manitoba* give rise to three key points in respect of the meaning and application of the best interests of the child.

First, is the question of when this concept is engaged. Given that it was accepted that AC had 'capacity', Binnie J considered that AC was entitled to make her decision 'regardless of what the judge thinks to be in her best interest'⁴¹ – as she had capacity, the concept of best interests was not engaged. In contrast, both McLachlin CJ and Abella J considered that the best interests standard set out by the legislation continued to be applicable, regardless of AC's decisional capacity.

Secondly, Abella J's 'robust conception of the "best interests of the child" standard' is similar to the UNCRC model of best interests as articulated under General Comment 14, which was discussed in Chapter 1. Abella J emphasised the importance of respecting

³⁸ *Manitoba* (n 6) [145].

³⁹ *Manitoba* (n 6) [143].

⁴⁰ M Freeman, *The Rights and Wrongs of Children* (1982) 54 – 58; M Freeman 'The Limits of Children's Rights' in Veerman P and Freeman M (eds) *The Ideologies of Children's Rights* (Martinus Nijhoff Publishers 1992) 38 – 39). See also J Eekelaar 'The Emergence of Children's Rights' (1986) 6 Oxford J. Legal Studies, 171.

⁴¹ *Manitoba* (n 6) [166].

adolescent's autonomous wishes while also maintaining the state's role in protecting their interests. Referring to a 'sliding scale of scrutiny',⁴² the Judge noted that this will be 'most intense in cases where a treatment decision is likely to seriously endanger a child's life or health'. She identifies the strong link between the adolescent's views, the adolescent's ability to make 'a mature, independent decision' and 'best interests', noting that there will be cases in which the courts are 'so convinced of a child's maturity that the principles of welfare and autonomy will collapse together and the child's wishes will become the controlling factor'.⁴³ By affording an adolescent 'a degree of bodily autonomy and integrity commensurate with his or her maturity' such an interpretation of best interests:

...navigates the tension between an adolescent's increasing entitlement to autonomy as he or she matures and society's interests in ensuring that young people who are vulnerable are protected from harm.⁴⁴

When applied to adolescents this interpretation of best interests therefore 'reflects and addresses an adolescent's evolving capacities' so that 'as his or her maturity increases it is, by definition, in a child's best interests to respect and promote his or her autonomy to the extent that his or her maturity dictates'.⁴⁵

Thirdly, the relationship between 'best interests', 'maturity' and decisional capacity and how they are assessed is not clear. Although the legal proceedings in *Manitoba* were based upon the finding that AC had 'capacity', all three judges referred the factors involved in determining whether a child had the 'maturity' to make the decision. Binnie J considered maturity to be relevant to the question of capacity, whereas Abella J considered it to be relevant to the best interests determination.

As part of determining what was in the adolescent's best interests, Abella J referred to the need for a 'careful and comprehensive evaluation of maturity' where the adolescent is refusing life-saving treatment 'to determine whether his or her decision is a genuinely independent one, reflecting a real understanding and appreciation of the decision and its potential consequences'.⁴⁶ She also set out a list of factors to assist courts 'in assessing the extent to which a child's wishes reflect true, stable and independent choices', which highlight, in addition to assessing the understanding of the child, the need to consider

⁴² *Manitoba* (n 6) [22].

⁴³ *Manitoba* (n 6) [87].

⁴⁴ *Manitoba* (n 6) [108].

⁴⁵ *Manitoba* (n 6) [88].

⁴⁶ *Manitoba* (n 6) [95].

matters such as the risks and benefits of the treatment proposed, as well as personal factors that might affect the child's ability to reach an independent decision.⁴⁷

Although covering this issue in less detail than Abella J, McLachlin CJ and Binnie J referred to the child's maturity as being of relevance to decisional capacity, both endorsing the Director of Child and Family Services' definition of capacity which refers to "ethical, emotional maturity": in short wisdom and a sense of judgment', but also added that capacity is not the only factor, equally important is 'whether the choice is made voluntarily and whether it is in fact, an informed decision'.⁴⁸ McLachlin CJ, considered that this 'more robust conception of capacity', which has similarities to the factors outlined by Abella J, 'reflects the legislative concern that minors most susceptible to outside influence have their interest in truly voluntary and informed choice most carefully safeguarded'.⁴⁹ Binnie J went further in that he considered that this approach to capacity is reflected in the statutory test for decisional capacity for 16 and 17 year olds, namely that the adolescent understands the relevant information and appreciates the reasonably foreseeable consequences of making the decision.⁵⁰

The relevance of these judicial comments is that they placed great emphasis on the need to assess not just the child's cognitive abilities but also factors that relate to what might be considered to be aspects of 'maturity, such as 'wisdom and a sense of judgment', but also reflect the need to ensure that the child is making an independent decision.

This is of significance because if it is to be relevant to the decision-making process in any way, much hinges upon the criteria adopted for decisional capacity. It is of crucial importance to Binnie J's approach since the test for decisional capacity determines whether, or not, adolescents can decide for themselves. The concept of decisional capacity is also relevant to the approach taken by Abella J given that she considers that the weight that is accorded to the adolescent's views 'will ultimately correspond to a court's conclusions about the extent to which the child is capable of making decisions in his or her own best interests'. The Judge added:

By permitting adolescents under 16 to lead evidence of sufficient maturity to determine their medical choices, their ability to make decisions is ultimately calibrated in accordance with maturity, not age, and no

⁴⁷ *Manitoba* (n 6) [96].

⁴⁸ *Manitoba* (n 6) [147] (McLachlin CJ), [203] (Binnie J).

⁴⁹ *Manitoba* (n 6) [147].

⁵⁰ *Manitoba* (n 6) [204] Binnie J notes at [205] that AC's capacity had been accepted.

disadvantaging prejudice or stereotype based on age can be said to be engaged.⁵¹

Thus, in *Manitoba*, the adolescent's 'maturity' is key. The justification for overriding an adolescent's refusal of treatment centres on an assessment of the adolescents 'maturity' to make the decision in question, not on an assumption that the adolescent is too young to do so.

1.3 Summary of Part 1

The differing approaches adopted by the members of the Supreme Court of Canada *Manitoba* provide a clear illustration of the underlying tension within children's rights between the notions of 'autonomy' and 'protection' (thus the wishes versus welfare dynamic) as well as reflecting alternative views on how this tension is addressed. At one end of the spectrum, Binnie J advocated that once the adolescent has decisional capacity then the best interests of the child becomes an irrelevance. At the other end of the spectrum, the McLachlin CJ considered that under 16s require protection due to the range of factors that might undermine their ability to make independent and informed decisions. Abella J, was somewhere in the middle in that she considered that the concept of best interests applied but that the views of the adolescent are central to determining what is in the adolescent's best interests. Abella J envisaged that in some cases the level of the adolescent's maturity will be such that the adolescent's 'wishes become the controlling factor'.⁵²

Of further significance, and one which raises an issue of uncertainty, is that factors that fall within the broad concept of 'maturity' are relevant to the approaches of both Binnie J and Abella J. For Binnie J, they relate to whether the child has decisional capacity, whereas for Abella J they are core to determining what is in the adolescent's best interests. Thus, the 'adolescent autonomy conundrum' may be more of a 'Catch 22', given that 'maturity' is going to be relevant to both the question of adolescent's decisional capacity and what is in their best interests. When the adolescents' wishes are in direct conflict with their welfare, the likelihood of being held to be mature is perhaps rather slim. Crucially, however, in the Supreme Court's view, the justification for the court's involvement in such cases arises from concerns about the adolescent's immaturity to make decisions, *not simply age*.

⁵¹ *Manitoba* (n 6) [111].

⁵² *Manitoba* (n 6) [87].

Part 2, returns to the national arena, which holds that the courts can override the wishes of adolescents, if to do so is in their best interests and it may do so, even if that adolescent has decisional capacity. It considers the basis on which such decisions are made and how they compare with human rights standards, in particular the ECHR.

PART 2: ADOLESCENT'S REFUSAL OF TREATMENT: DECISIONS BY THE COURTS

The question whether, and if so in what circumstances, the refusal of medical treatment by adolescents can be overridden continues to provoke debate.⁵³ However, to date, the human rights implications of such decisions have been subject to little examination from the judiciary in the post-HRA era.

Of the two reported cases relating to adolescents' refusal of life-saving treatment since the HRA 1998 came into force, the first made no mention of the adolescents ECHR rights.⁵⁴ In the second case, *An NHS Foundation Trust Hospital v P (P 2014)*,⁵⁵ the court held that the wishes of an adolescent aged 17½ years ('P') who was refusing life-saving treatment following an overdose should be overridden.

While recognising that P's wishes were important and 'are of course, entitled to be taken into account as part of her article 8 rights', the judge in *P 2014*⁵⁶ considered that P's rights under Article 8 of the ECHR were 'not absolute' and were 'outweighed by her rights under Article 2'.⁵⁷ Baker J held that the court 'is under a heavy duty to take what steps it can to protect P's life' and that it was 'in P's best interests' to be treated 'notwithstanding the fact that she is refusing treatment'.⁵⁸ Such an approach was anticipated by Fortin who suggested that in response to an adolescent's refusal of life-saving treatment 'the

⁵³ See for example, Fortin, J., *Children's Rights and the Developing Law*, (3rd Edition, Cambridge University Press 2009) 158 – 163 and Fovargue, S., and Ost, S. 'Does the theoretical framework change the legal end result for mature minors refusing medical treatment or creating self-generated pornography?' (2013) *Medical Law International* 13(1) 6.

⁵⁴ *Re P (Medical Treatment: Best Interests)* [2003] EWHC 2327 (Fam). Writing in 2016, M Brazier and E Cave *Medicine, Patients and the Law* (6th ed, Manchester University Press 2016) state that the only other post-HRA 1998 case relating to adolescent's refusal of treatment (*vaccinations*) is that of *F (Mother) v F (Father)* [2013] EWHC 2683, [2014] 1 FLR 1328. The HRA 1983 was not mentioned in this decision.

⁵⁵ *P (2014)* (n 2).

⁵⁶ *P (2014)* (n 2).

⁵⁷ *P (2014)* (n 2) [15].

⁵⁸ *P (2014)* (n 2) [16].

court may choose to promote his right to life under Article 2 of the ECHR rather than his right to respect for his personal autonomy under Article 8'.⁵⁹

The discussion below does not seek to criticise the outcome of the court's decision in (*P* 2014). Given the 'extreme urgency' of the situation, which 'did not afford time for lengthy submissions or analysis',⁶⁰ as well as the dire consequences of P not being treated, Baker J's approach was, as Brazier and Cave note, 'understandable'.⁶¹ However, they add 'is this the right way to bring about the result?'.⁶² The following analysis highlights why this question is so important.

First, it should be noted that this is an area that extends beyond adolescent psychiatric care. Commentators focusing on issues of consent to treatment for under 18s more generally raise concerns that such decisions create a lack of clarity for clinicians, adolescents and their families alike.⁶³ Of particular concern is the Court of Appeal's emphatic view in its 1992 decision of *Re W* that parents had the power to override their child's refusal of medical treatment, irrespective of the adolescent's decisional capacity.⁶⁴ This remains the legal position despite NHS guidance suggesting otherwise.⁶⁵ For this reason, this area of law is regarded as being in 'a contradictory and unsatisfactory state'.⁶⁶ This is less of a problem in relation to adolescent psychiatric care. As discussed in Chapter 2, the combination of the provisions in the MHA 1983 concerning 16 and 17 year olds' admission to hospital and the advice of the MHA Code 2015 on the admission to hospital and treatment for mental disorder of all adolescents, limit the circumstances in which parental consent can be relied upon to where the adolescent lacks decisional

⁵⁹ Fortin J, 'Children's rights – flattering to deceive? (2014) CFLQ 26(1) 51, 62.

⁶⁰ *P* (2014) (n 2) [2].

⁶¹ Brazier and Cave (n 52) para 14.21.

⁶² Brazier and Cave (n 52) para 14.21.

⁶³ J Brierley J and V Larcher V 'Adolescent autonomy revisited: clinicians need clearer guidance' (2016) *Journal of Medical Ethics*; 42, 482. See also E Cave and Z Stavrinides in *Medical Practitioners, Adolescents and Informed Consent* School of Law, University of Leeds April 2013.

⁶⁴ R Heywood observes in 'Mature Teenagers and Medical Intervention Revisited: A Right to Consent, A Wrong to Refuse' CLWR 37(2) 191,194, when discussing *Re W* and *Re R* (n 17): '[o]ne common (mis) perception of the two decisions is that they are limited to situations involving the refusal of *life-saving* treatment'.

⁶⁵ See Department of Health, *Reference Guide to Consent for Examination of Treatment* (2nd ed 2009) p 34, para 15. Having noted that the courts have 'found that parents can consent to their competent child being treated even where the child/young person is refusing treatment' the guidance then states: 'However, there is no post-Human Rights Act 1998 authority for this proposition, and it would therefore be prudent to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the child.'. Brazier and Cave (n 52) 470 and Cave and Stavrinides (n 62) 21, consider that the authority of parents to override their child's competent refusal is ripe for legal challenge.

⁶⁶ Brazier and Cave (n 52) p 469.

capacity. Furthermore, the MHA 1983 provides the legal authority to override the adolescent's refusal in cases where parental consent is thought insufficient to authorise the proposed intervention, thereby obviating the need to go to court.

Secondly, the lack of clarity is not only about the uncertainty of the role of parents. It also relates to the basis on which courts decide to override the adolescent's wishes. The court may do so because the adolescent lacks decisional capacity to make decisions about the treatment, or because the adolescent's minority allows the court to override the adolescent's wishes irrespective of the adolescent's decisional capacity. Greater clarification from the courts on the justification for authorising non-consensual health care interventions and how the wishes of the adolescent have been taken into account in reaching such a decision is required in the post-HRA era. This is illustrated by considering the court's approach in *P (2014)*⁶⁷ through the lens of the 'human rights decision-making questions' set out in Chapter 1. The following analysis therefore first considers the reasons for the decision to override P's wishes ('the justification question'); secondly the extent to which this takes into account the wishes of the adolescent ('the wishes versus welfare question'); and thirdly, how this compares to human rights standards ('the human rights comparison question').

2.1 Justification for overriding the refusal of an adolescent

In *P (2014)* having concluded that there was insufficient evidence to hold that P lacked capacity under the MCA 2005, Baker J considered whether he could make a declaration authorising P's treatment 'notwithstanding her refusal to give her consent'.⁶⁸ Having noted that it is the court's duty to 'have the child's welfare as its paramount consideration',⁶⁹ the Judge determined that it was in P's best interests and in reaching this decision placed great emphasis on the positive obligation under Article 2 of the ECHR to protect her life, which he considered outweighed P's wishes not to receive the medical treatment necessary to prevent her death.

While noting that under 18s with decisional capacity 'have the legal capacity to consent to treatment', Baker J then stated that where 'a *Gillick*-competent child refuses to give her consent to the treatment, the court may in the exercise of its inherent jurisdiction, override the child's wishes in her best interests and give its consent to her treatment'.⁷⁰

⁶⁷ *P (2014)* (n 2).

⁶⁸ *P (2014)* (n 2) [1].

⁶⁹ *P (2014)* (n 2) [13]; Children Act (CA) 1989 s1.

⁷⁰ *P (2014)* (n 2) [12]. The Judge refers to under 18s who are *Gillick* competent as having the legal capacity to consent. In relation to 16 and 17s this is provided for by FLRA 1969 s 8.

This reflects the common-law position of under 18s, which was summarised by Abella J when undertaking her survey of international jurisprudence in *Manitoba* as follows:

The Court of Appeal confirmed in *Re R* and *Re W* that a child's 'Gillick competence' or 'mature minor' status at common law will not necessarily prevent the court from overriding that child's wishes in situations where the child's life is threatened. In such cases the court may exercise its *parens patriae* jurisdiction to authorize treatment based on an assessment of what would be most conducive to the child's welfare, with the child's views carrying increasing weight in the analysis as his or her maturity increases.⁷¹

Thus, *P (2014)* illustrates that, as noted in Chapter 2, despite the national courts emphasis on giving greater respect to adolescent autonomy since the introduction of the HRA 1998, this does not extend to upholding adolescents' refusal of treatment, where the consequence of doing so is likely to be fatal. Traditionally the courts have resisted the idea of allowing adolescents to 'martyr themselves'⁷² and Baker J's decision to override P's refusal, notwithstanding the lack of evidence to hold that she lacked the mental capacity under the MCA 2005 to make such a decision, conforms to that view. It shows that Feldman's observation of 2002 that 'the courts regard the preservation of a minor's life as being more important than respecting her autonomy, even if she is competent'⁷³ holds true today. Even if an adolescent has decisional capacity, the adolescent's wishes will be trumped by concerns about his or her welfare.

This returns to the adolescent autonomy conundrum noted in Chapter 2, which highlights the two ways in which the courts might override an adolescent's refusal, one determining that the adolescent lacks the requisite decisional capacity, the second being the powers of the court to override the wishes of a minor. They are relevant to P's case for the reasons set out below.

2.1.1 Intervention on the basis of the adolescent's lack of decisional capacity

The first potential route, to hold that the adolescent lacked decisional capacity was considered by Baker J in *P (2014)*. He first considered whether P lacked capacity under the MCA 2005 to make decisions about her medical treatment, but concluded that he did

⁷¹ *P (2014)* (n 2) [56].

⁷² *Re E (A Minor) (Wardship: Medical Treatment)* [1992] 2 FCR 219; [1993] 1 FLR 386.

⁷³ D Feldman, *Civil Liberties and Human Rights in England and Wales* (2nd ed OUP 2002) 293.

not have sufficient evidence to establish this, noting that while her treating clinician had doubts, her psychiatrist thought that she had capacity.

As Brazier and Cave note, Baker J did not have the luxury of time to explore this matter.⁷⁴ Presumably, however, if P had been an adult he would have sought to determine, in the light of the evidence available and on a balance of probabilities,⁷⁵ whether P had capacity or not, as defined by the MCA 2005. This is because under national law, unless found not to have the decisional capacity to do so, the decisions of adults must be respected (save where they are detained under the MHA 1983⁷⁶) even if this will mean that they will die.⁷⁷ The ECtHR has also stated that ‘an individual’s right to decide by what means and at what point his or her life will end’, falls within the right to respect for private life within the meaning of Article 8 provided that the person is ‘capable of freely reaching a decision on this question and acting in consequence’.⁷⁸ However, where there is doubt as to the person’s decisional capacity, the ECtHR expects this to be explored.⁷⁹

While not in themselves substantiating a conclusion that P lacked capacity, a number of factors about her case, at the very least raise questions on this point. P had very recently been detained in hospital under the MHA 1983, had just tried to take her own life and ‘said that her life was “shit”’.⁸⁰ Furthermore, as noted above, there were conflicting opinions from the medical practitioners responsible for P’s care on whether or not P lacked capacity under the MCA 2005.

2.1.2 *Intervention on the basis of minority*

P (2014) indicates that the court’s view is that because the adolescent has not yet reached adulthood, she needs protection. This point was articulated by Johnson J in *Re P (2003)* when he referred to Nolan LJ’s comment in *Re W* that ‘it is the duty of the court to ensure so far as it can that children survive to attain [adulthood]’.⁸¹ In that case, which concerned an adolescent, ‘John’ who was nearly 17 and was refusing potentially life-

⁷⁴ Brazier and Cave (n 52) 469.

⁷⁵ MCA 2005 s 2(4).

⁷⁶ MHA 1983 is discussed in chapter 5

⁷⁷ G Richardson ‘Mental capacity in the shadow of suicide: What can the law do?’ (2013) *International Journal of Law in Context* 9(1) 87.

⁷⁸ *Haas v Switzerland* (2011) 53 EHRR 33 [51].

⁷⁹ *Arskaya v Ukraine* (App 45076/05) 5 December 2013, para 87: ‘despite S showing symptoms of a mental disorder, the doctors took the refusals at face value without putting in question S’s capacity to take rational decisions concerning his treatment’. The ECtHR considered (para 88) that this should have been considered at the time, adding ‘From the standpoint of Article 2 of the Convention a clear stance on this issue was necessary at that time in order to remove the risk that the patient had made his decision without a full understanding of what was involved’.

⁸⁰ *P (2014)* (n 2) [3] – [5].

⁸¹ *Re W* (n 3) [9].

saving blood treatments, the Judge did not refer to John's decisional capacity. However the Judge noted that John had instructed his solicitor that he did not want the treatment under any circumstances. Furthermore, the Judge noted that John had told his solicitor that the decision was his, not his that of his parents.⁸² Nonetheless, Johnson J considered it to be in John's wider best interests for the treatment to be authorised.

A comparison with *Manitoba* questions whether it is enough to conclude that because of the adolescent's age, non-consensual medical interventions are justified. Whereas in *Manitoba*, Binnie J considered that interventions could only be justified if the adolescent lacked decisional capacity, the majority view was that the court had authority to consider the adolescent's best interests even if the adolescent had capacity. Nevertheless, in giving her leading judgment for the court, Abella J made clear that the issue was whether the adolescents had 'sufficient maturity to determine their medical choices...', adding the crucial point, '...their ability to make decisions is ultimately calibrated in accordance with maturity, not age.'⁸³

2.2 The relevance of the wishes of the adolescent

The Court of Appeal's decision in *Re W* makes clear that the wishes of adolescents are an important factor in determining their best interests. All three judges emphasised this. For example, although concluding that the views of under 18s views could be overridden, Lord Donaldson noted that a refusal of medical treatment was an important consideration that 'increases with the age and maturity of the minor'.⁸⁴ Lord Justice Balcombe considered that the views of the adolescent were 'merely one aspect of the application of a test that the welfare of the child is the paramount consideration'. In his view:

It will normally be in the best interests of a child of sufficient age and understanding to make an informed decision that the court should respect its integrity as a human being and not lightly override its decision on such a personal matter as medical treatment, all the more so if that treatment is invasive.⁸⁵

Balcombe LJ therefore considered that in relation to a young person who is capable of making decisions for herself, the court 'should as a matter of course, ascertain the wishes of the child and will approach its decision with a strong predilection to give effect to the

⁸² *Re P (2003)* (n 3) [11]

⁸³ *Manitoba* (n 6) [111]

⁸⁴ *Re W* (n 1), 84.

⁸⁵ *Re W* (n 1) 88.

child's wishes'.⁸⁶ Furthermore, even if the minor was not competent 'the child's wishes, if known, must be a material factor'.⁸⁷ Lord Justice Nolan also made the connection between the views of the adolescent and the adolescent's best interests:

In considering the welfare of the child, the court must not only recognise but if necessary defend the right of the child, having sufficient understanding to take an informed decision, to make his or her own choice. In most areas of life it would be wrong in principle but also futile and counter productive for the court to adopt any different approach.⁸⁸

Thus, under national law, the views of the adolescent are also considered to be a significant factor in determining the best interests of that adolescent. The question is how this principle is applied when respecting the wishes of the adolescent is likely to have a fatal outcome. Notwithstanding their emphasis on taking into account the adolescent's wishes, the Court of Appeal in *Re W* were unanimous in their view that in some circumstances the court would intervene despite the adolescent's wishes. In *P (2014)* Baker J cited Balcombe LJ's crucial caveat:

...if the court's powers are to be meaningful, there must come a point in which the court, while not disregarding the child's wishes can override them in the child's own interests. Clearly such a point will have come if the child is seeking to refuse treatment in circumstances which would in all probability lead to the death of the child or severe permanent injury.⁸⁹

As noted below, a human rights perspective provides no clear answer to the difficult question on whether to override the wishes of the adolescent when not to do so may mean that the adolescent will die. Nevertheless, it does offer a means of moderating these conflicts. It also identifies that the notion of maturity is key. This was identified in *Manitoba* as being crucial to the determination of the best interests of the adolescent.

2.3 Adolescents refusal of treatment: the human rights dimension

The following discussion considers the two ECHR rights identified as being central to the court's decision on whether to override an adolescent's refusal of life-saving treatment, namely Articles 2 and 8, together with the relevance of the UNCRC to such decisions.

⁸⁶ *Re W* (n 1) 88.

⁸⁷ *Re W* [88].

⁸⁸ *Re W* (n 1) [93] cited in *P (2014)* (n 2) [14].

⁸⁹ *P (2014)* (n 2) [4].

To date the circumstances in which adolescents refusing medical treatment can be given treatment against their wishes has not been considered by the ECtHR. Nonetheless the ECtHR has developed extensive jurisprudence on both Articles 2 and 8 of the ECHR. Reference to the UNCRC in the discussion reflects the Supreme Court of the United Kingdom's view that the UNCRC has a significant role when considering the application of ECHR to under 18s⁹⁰ and its emphasis on the UNCRC's best interests of the child under Article 3(1).⁹¹

Three main areas are considered. First, the tension between 'protection' and 'autonomy' within the ECHR rights and the UNCRC is noted, demonstrating that the 'wishes versus welfare dynamic' is an integral part of these rights. Secondly, key points from the CRC's General Comment 14 are highlighted. While it does not answer the question of which prevails, the adolescent's wishes, or her welfare, General Comment 14 includes pointers that help to tease out the issues as well as highlighting the importance of a clear decision-making process and justification for the decision reached. Thirdly, the importance of the concept of 'maturity' is noted as being an area that requires further consideration.

2.3.1 Human rights standards and the wishes versus welfare dynamic

The tension between the imperative to protect individuals in certain circumstances and the importance of respecting individuals 'autonomy' is evident when considering the scope and application of the ECHR articles 2 and 8 and the core principles and rights of the UNCRC. The tension within articles 2 and 8 are considered first, followed by the UNCRC.

2.3.1.1 Article 8 of the ECHR and treatment without consent

In relation to Article 8, the ECtHR considers that the right to make treatment decisions is an essential feature of the principles of self-determination and that personal autonomy falls within the rights protected by Article 8.⁹² However, a non-consensual intervention will not be a violation of this right if it can be justified under Article 8(2). In *P (2014) Baker J* considered that the decision to give treatment to P without her consent engaged Article 8. This accords with the ECtHR's approach. Although to date it has made no observations on the right of minors to refuse treatment, the ECtHR acknowledges that 'proper regard must be had to the minor's personal autonomy'⁹³ and it has held Article 8 to be engaged

⁹⁰ *R(SG) v Secretary of State for Work and Pensions* [2015] UKSC 16; 1 WLR 1449..

⁹¹ *R(SG)* (n 90).

⁹² *Jehovah's Witnesses of Moscow and Others v Russia* (2011) 53 EHRR 4.

⁹³ *P and S v Poland*, (App 57375/08) 30 October 2012 [2013] 1 FCR 476 para 109. The case concerned a 15 year old who had been raped; with the complaint concerning the difficulties she

where treatment has been given to children too young to make such decisions for themselves without the consent of their parents.⁹⁴

To ascertain whether a breach of Article 8 of the ECHR has arisen requires an assessment, based on the facts of the case,⁹⁵ to determine whether the interference was lawful ('in accordance with the law'), pursued one or more of the aims set out in Article 8(2) (referred to as 'legitimate aim(s)') and was 'necessary in a democratic society',⁹⁶ thereby engaging the proportionality principle referred to in Chapter 1. Furthermore, where there has been an interference with an individual's Article 8 rights, the ECtHR has emphasised repeatedly that the person concerned must be involved in the decision-making process.⁹⁷

In cases such as that of *P(2014)*, given that the authorisation of the medical treatment is within the scope of the High Court's inherent jurisdiction, and the purpose of the intervention is to protect the adolescent's life ('health' being one of the legitimate aims listed in Article 8(2)) the first and second requirements are likely to be met. The question will be whether the non-consensual medical treatment is a proportionate response to the risk identified (which in this case is that unless the adolescent is given medical treatment, she is likely to die).⁹⁸ The approach adopted by the UK Supreme Court to this point is to consider four questions, namely, whether the interference is 'for a legitimate aim which is important enough to justify interfering with a fundamental right'; whether the interference is 'rationally connected to achieving that aim'; 'no more than reasonably necessary to achieve it'; and finally 'in the light of this, striking a fair balance between the rights of the individual and the interests of the community'.⁹⁹

and her mother encountered when they sought to arrange a termination. The ECtHR considered that parents of a minor did not automatically have 'the right to take decisions concerning the minor's reproductive choices'.

⁹⁴ *Glass v United Kingdom* (2004) 39 EHRR 341; *MAK v United Kingdom* (2010) 51 EHRR 14

⁹⁵ So as 'to avoid the mechanical application of domestic law to a particular situation' - *Nada v Switzerland* (2013) 56 EHRR 18 GC.

⁹⁶ *Tysiac v Poland* (2007) 45 EHRR 42 para 109.

⁹⁷ See for example in relation to health care matters *Tysiac* (n 91) [117] and *VC v Slovakia* (2014) 59 EHRR 29, para 141. See also discussion on the 'rule of personal presence' emanating from ECHR case law in relation to legal capacity and deprivation of liberty in L Series, P Fennell and J Doughty, *The Participation of P in Welfare Cases in the Court of Protection* (Cardiff University 2017), 50 – 51.

⁹⁸ The national authorities must show that there was a 'pressing social need' that corresponds with the legitimate aim being relied upon the justification for the action taken and that the restriction on the particular right is 'proportionate to the legitimate aim pursued' *Dudgeon v United Kingdom*, (App 7525/76) 22 October 1981 para 51: "'necessary" in this context does not have the flexibility of such expressions as "useful", "reasonable", or "desirable", but implies the existence of a "pressing social need" for the interference in question'.

⁹⁹ *R (Nicklinson) v Ministry of Justice* [2014] UKSC 38 [2015] AC 657; [2014] 3 All ER 843 [80] [310], (Lady Hale citing *R(Quila) v Secretary of State for the Home Department* [2011] UKSC

In relation to an adolescent's treatment refusal, the points arising from this are likely to be as follows. First, taking action to save an adolescent's life is a legitimate aim and is important enough to justify interfering with a fundamental right. In relation to the second point, the provision of medical treatment is the means for meeting the legitimate aim of protecting the adolescent's life so would be 'rationally connected' to that legitimate aim. In relation to the third point, if working to guidance such as the MHA Code 2015, the medical intervention will accord with the least restrictive principle,¹⁰⁰ so would be no more than reasonably necessary to achieve the legitimate aim.

The fourth point, 'striking a fair balance between the rights of the individual and the interests of the community', is where the tension arises. To some extent in relation to adolescent's treatment refusals this is more a question of balancing the rights of the adolescent's physical integrity with the state's positive duty to protect the adolescent's health and life. However, there is the wider issue as to whether it is in the interests of the community to allow the views of an adolescent to be overridden even though the adolescent has been assessed as having the decisional capacity to make the decision and the adolescent's wish is to refuse the treatment, knowing that death will be the likely outcome of that decision. As will be discussed in Chapter 5 in relation to compulsory treatment on grounds of a person's mental disorder, the ECtHR has increased its scrutiny of the reasons for non-consensual interventions, referring to the need to strike a balance between the competing interests of society and individual's right to self-determination.¹⁰¹

2.3.1.2 Article 2 and the operational duty to prevent death

Although there is less clarity from the ECtHR on the circumstances in which the positive duty under Article 2 of the ECHR to take action to prevent a person's death arises,¹⁰² the court's finding in *P (2014)*¹⁰³ that it was under a positive duty 'to take preventative measures to protect an individual whose life is at risk',¹⁰⁴ accords with the UK Supreme Court's decision in *Rabone v Pennine Care NHS Foundation Trust* ('*Rabone*').¹⁰⁵ The case concerned a 24 year old woman, Melanie Rabone, who had been admitted to a

45; [2012] 1 AC 621 [45] and *Bank Mellat v HM Treasury (no 2)* [2013] UKSC 39, [2014] AC 700 [20]. See also [80] (Lord Neuberger) and [337] (Lord Kerr).

¹⁰⁰ MHA Code 2015 (n 13) paras 1.2 – 1.6.

¹⁰¹ *Pleso v Hungary* (2012) (App 41242/08) 2 October 2012.

¹⁰² *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2, [2012] 2 AC 72, [21] (Lord Dyson) noted that the precise circumstances in which the operational duty arises had not been articulated by the ECtHR and that 'the existence of a "real and immediate risk" to life is a necessary but not sufficient condition for the existence of the duty'.

¹⁰³ *P (2014)* (n 2).

¹⁰⁴ *Rabone* (n 101) [15].

¹⁰⁵ *Rabone* (n 101) [15].

psychiatric hospital on an informal basis following a suicide attempt and had subsequently taken her own life during a weekend leave from hospital. The court held that a positive duty (referred to as ‘the operational duty’) under Article 2 of the ECHR was owed by the relevant NHS Trust to Ms Rabone ‘to take reasonable steps to protect her from the real and immediate risk of suicide’. The court identified factors that give rise to this positive duty, such as the state’s assumption of responsibility for the person’s welfare and safety, the vulnerability of the person (for example her mental health problems) and the risk of suicide. An additional factor in relation to adolescents is their minority status; as Lady Hale observed, the state has ‘a positive obligation to protect children and vulnerable adults from the real and immediate risk of serious abuse or threats to their lives of which the authorities are or ought to be aware and which it is within their power to prevent’.¹⁰⁶

Nonetheless, a finding that the operational duty is engaged under Article 2 of the ECHR is only a first step; the second step being to consider whether, or not, it has been met.¹⁰⁷ Whether a breach of this operational duty has arisen depends on factors that can be divided into two main categories. First, is the ‘nature and degree of the risk’ as well what action, in the circumstances, it would be reasonable to expect the authorities to take to prevent the person’s death. Second, is ‘a question of proportionality and respecting the rights of others, including the rights of those who require to be protected’.¹⁰⁸ As to this last point, Lady Hale referred to the ECtHR’s decision in *Keenan v the United Kingdom* (*Keenan*), noting that the ECtHR acknowledged that there would be limits on the preventative action taken given that the authorities ‘similarly must discharge their duties in a manner compatible with the rights and freedoms of the individual concerned’.¹⁰⁹ *Keenan* concerned the suicide of a prisoner who was known to have mental health problems. Noting the tension between autonomy and protection, the ECtHR stated that there were steps that could be taken ‘to diminish the opportunities for self-harm, without infringing on personal autonomy’. It then added that whether more stringent measures were necessary ‘and whether it is reasonable to able them will depend on the circumstances of the case’.¹¹⁰

While respect for the adolescent’s wishes falls squarely in Article 8’s domain, it is also relevant to Article 2 ECHR as noted by Lady Hale when she commented in *Rabone* that

¹⁰⁶ *Rabone* (n 101) [104].

¹⁰⁷ *Watts v the United Kingdom* 53586/09 04/05/2010 para 83.

¹⁰⁸ *Rabone* (n 101) [104].

¹⁰⁹ *Rabone* (n 101) [104].

¹¹⁰ *Keenan v the United Kingdom* (2001) 33 EHRR 38 para 92.

'[a]utonomous individuals have a right to take their own lives if that is what they truly want'.¹¹¹ Thus, in relation to the application of the operational duty under Article 2 ECHR, Lady Hale observes that there is 'a difficult balance to be struck between the right of the individual patient to freedom and self-determination and her right to be prevented from taking her own life'.¹¹² However, Lady Hale's comments concerned an adult.

That there is a significant difference between how the law treats under 18s to that of adults is illustrated by Baker J's reference in *P 2014* to the 'strong presumption in favour of taking in all steps that would prolong life'.¹¹³ As the Court of Appeal pointed out in *R(Burke) v General Medical Council and Others*,¹¹⁴ there is a counter-balance to this in that while there is a duty at common law to care for the patient (in this regard for adults as well as under 18s) once the patient is accepted into hospital, a fundamental aspect being the 'duty to take such steps as are reasonable to keep the patient alive', but such a duty 'will not, however, override the competent patient's wish not to receive [the medical treatment]'.¹¹⁵ While the Court of Appeal's comments reiterate that individuals with decisional capacity can refuse medical treatment, even if this is likely to bring about the person's death, this principle, as *P(2014)* confirms, applies only to the 'competent' wishes of adults, not adolescents.

2.3.1.3 The UNCRC and Adolescent's Treatment Refusal

The protective role of the UNCRC is made clear by its Preamble which notes that by reason of their 'physical and mental immaturity' under 18s need 'special safeguards and care' and Article 3(2) requires states 'to ensure necessary protection and care for the child'.¹¹⁶ However, adolescents are also entitled to respect for their 'emerging autonomy' while Article 12 of the UNCRC requires that the views of the child are given 'due weight in accordance with the age and maturity of the child'. As UNICEF points out, the challenge is how to ensure that the protection of adolescents is provided 'in ways that

¹¹¹ *Rabone* (n 101) [100], but note [105] in which Lady Hale noted that Ms Rabone's 'mental disorder meant that she might well lack the capacity to make an autonomous decision to take her own life'.

¹¹² *Rabone* (n 101) [107].

¹¹³ *P (2014)* (n 3) [14] referring to comments by Munby J (as he then was) in *R (Burke) v General Medical Council* [2004] EWHC 1879 (Admin), [2005] QB 424, 2 WLR 431.

¹¹⁴ [2005] EWCA Civ 1003, [2006] QB 273, [2005] All ER (D) 445 (Jul) 31.

¹¹⁵ *Burke* CA (n 113) [32].

¹¹⁶ Although this requirement is to take into account the rights and duties of parents or others with responsibilities for the child, as noted in Hodgkin R and Newell P, *Implementation Handbook for the Convention on the Rights of the Child* (3rd ed UNICEF 2007) at 40, there are areas in which parents have no role, such as the environment and where parents and others are not able or willing to protect the child 'the State must provide a "safety net", ensuring the child's well-being in all circumstances'.

both enable young people to extend their boundaries, exercise choices and engage in necessary risk-taking, while not exposing them to inappropriate responsibility, harm and danger'.¹¹⁷ In a similar vein, the CRC's general comment '*Adolescent health and development in the context of the Convention on the Rights of the Child*' notes that adolescents up to the age of 18 are 'holders of all the rights' under the UNCRC: 'they are entitled to special protection measures and, according to their evolving capacities, they can progressively exercise their rights'.¹¹⁸

Freeman regards the concept of the best interests of the child (Article 3(1) of the UNCRC) and the right of the child to be heard (Article 12 of the UNCRC) as encapsulating the tension between wishes and welfare that is integral to children's rights. He notes that 'Article 12 emphasises the centrality of a child's views, Article 3 the priority to be given to concerns of welfare'.¹¹⁹ In contrast, the CRC considers that there is no tension between them. It points to the 'inextricable links' between the two and their 'complementary roles' in that Article 3(1) 'aims to realize the child's best interests' and Article 12 'provides the methodology for hearing the views of the child or children and their inclusion in all matters affecting the child, including the assessment of his or her best interests'.¹²⁰

This tension is also observed by MacDonald. He explains that the CRC regards these 'twin propositions' as being complementary rather than being competitive, because 'a child's best interests cannot properly be determined without the participation of the child and that in ensuring the participation of the child the child's best interests must be respected'. Nonetheless, he concludes 'it is only realistic to acknowledge' that in some circumstances the child's right to protection will prevail over the right to participate.¹²¹

Furthermore, MacDonald argues that although the CRC considers that 'as children acquire capacities, so they are entitled to an increasing level of responsibility for the regulation of matters affecting them',¹²² the right to participate in decision-making under Article of the 12 UNCRC 'should not be confused with the right to self-determination', given that 'Art 12 does not confer complete autonomy on children as the article does not

¹¹⁷ G Landsdown on behalf of the UNICEF Innocenti Research Centre, *The Evolving Capacities of the child* (Save the Children and UNICEF 2005), 32.

¹¹⁸ CRC General Comment No 4 (2003), *Adolescent health and development in the context of the Convention on the Rights of the Child*, CRC/GC/2003/4, para 1.

¹¹⁹ M Freeman 'Whither Children: Protection, Participation, Autonomy?' (1993-1994 22 ManLJ 307, 320.

¹²⁰ General comment 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para 1)' (CRC General Comment 14) para 43.

¹²¹ A MacDonald *The Rights of the Child: Law and Practice* (Jordan Publishing 2011) 6.8

¹²² General comment no. 12 *The right of the child to be heard* (CRC/C/GC/12) (CRC General Comment 12) para 85.

stipulate that a child's views, whilst expressed as of right, must be acceded to'.¹²³ That Article 12 does not convey a right to decide is also made clear in the CRC's General Comment on this article, which explains that if the child or young person "is capable of forming her or his own views in a reasonable and independent manner", such views must be considered "as a significant factor in the settlement of the issue" with the child or young person being informed of the outcome of the process, and how his or her views were considered.¹²⁴ Thus, UNICEF notes that while Article 12 refers to taking the child's views into account, 'adults retain responsibility for the outcome. The outcome will be decided by adults but informed and influenced by the views of the child'.¹²⁵

In any event, the CRC acknowledges that there may be conflicts between the different aspects to be considered when assessing a child's best interests, commenting:

There may be situations where "protection" factors affecting a child (e.g. which may imply limitation or restriction of rights) need to be assessed in relation to measures of "empowerment" (which implies full exercise of rights, without restriction). In such situations, the age and maturity of the child should guide the balancing of the elements. The physical, emotional, cognitive and social development of the child should be taken into account to assess the level of maturity of the child.¹²⁶

Although the UNCRC does not specify whether, and if so, when an adolescent's wishes might be respected notwithstanding the serious, or even fatal outcome of doing so, as noted below, its General Comment 14 requires decision-makers to justify why the action proposed is considered to be in the adolescent's best interests.

2.3.2 General Comment 14

Like Abella J's interpretation of the best interests standard in *Manitoba*, the UNCRC model of best interests, as set out in General Comment 14, envisages a process in which the relevant welfare concerns are considered alongside the wishes of the adolescent, with the 'evolving capacities of the child' operating as the moderator between the two.

General Comment 14 requires the decision-makers to justify why the action proposed is in the child or young person's best interests. It refers to this concept of best interests as comprising of three elements. The first, is a substantive right (best interests to be

¹²³ MacDonald (n 115) para 6.6.

¹²⁴ CRC General Comment 12 para 44.

¹²⁵ G Lansdown *The Evolving Capacities of the Child* (Save the Children and UNICEF 2005) 4.

¹²⁶ CRC General Comment 14 (n 120) para 84.

assessed 'and taken as a primary consideration when different interests are being considered').¹²⁷The second element is an interpretative principle (where a legal provision is open to interpretation, the one 'which most effectively serves the child's best interests should be chosen').¹²⁸ The third, is 'a rule of procedure', which requires that whenever a decision is to be made that affects a minor, 'the decision-making process must include an evaluation of the possible impact' on that child or young person. This third aspect means that 'the justification of a decision must show that the right has been explicitly taken into account'.¹²⁹

Applying the approach adopted in General Comment 14, decisions made in relation to adolescents refusing medical treatment (and matters relating to adolescent care more generally), highlights the following key points.

First, the views of the adolescent are integral to the determination of the adolescent's best interests, their views must be given due weight according to their age and maturity'.¹³⁰

Secondly, a 'vital element of the process is communicating with children to facilitate meaningful child participation and identify their best interests'.¹³¹

Thirdly, where there is a conflict, 'the age and maturity of the child should guide the balancing of the elements', and that the 'physical, emotional, cognitive and social development of the child should be taken into account to assess the level of maturity of the child'.¹³²

Fourthly, reasons must be given. Significantly, the CRC Committee expects an explanation of 'how the right has been respected in the decision', namely 'what has been considered to be in the child's best interests; what criteria it is based on; and how the child's interests has been weighed against other considerations, be they broad policy or individual cases'.¹³³

Fifthly, if 'the decision differs from the views of the child, the reason for this should be clearly stated'.¹³⁴ Thus, where the decision-maker, such as the court has decided to

¹²⁷ CRC General Comment No. 14 (n 120) para 6(a).

¹²⁸ CRC General Comment No. 14 (n 120) para 6(b).

¹²⁹ CRC General Comment No. 14 (n 120) para 6(c).

¹³⁰ CRC General Comment No. 14 (n 120) para 53.

¹³¹ CRC General Comment No 14 (n 120) para 89.

¹³² CRC General Comment No 14, (n 120) para 83.

¹³³ CRC General Comment No 14 (n 120) para 6 (c).

¹³⁴ CRC General Comment No 14 (n 120) para 97.

override the decision of the adolescent, an explanation as to why the welfare concerns outweighs the adolescent's wishes is required.

2.3.3 Age and maturity and the 'evolving capacities of the child'

The above discussion highlights the importance role of the concept of the 'evolving capacities of the child' and the 'age and maturity' of the child, within the UNCRC generally and in relation to determining the best interests of the child, in particular. As noted in Chapter 1, these both focus on issues such as the experience and understanding of the adolescent in relation to the matter being decided. The judgments in *Manitoba* highlight that the question of maturity is relevant to both determining the adolescent's decisional capacity as well as determining an adolescent's best interests. Abella J, suggested a range of factors to consider when assessing an adolescent's maturity, such as whether 'the adolescent's views are stable and a true reflection of his or her core values and beliefs' and whether 'the adolescent's illness or condition have an impact on his or her decision-making ability'.¹³⁵

Under national law, the test of *Gillick* competence is a functional test that focuses on the adolescent's understanding and intelligence and is regarded as an assessment of the adolescent's 'maturity'.¹³⁶ Although the MCA 2005 applies to adolescents aged 16 and 17, the Law Commission in its 1995 report, *Mental Incapacity*, considered that this would not affect the powers of the court to 'overrule the refusal of a minor, competent or not, to accept medical treatment',¹³⁷ while the Code of Practice to the MCA 2005 refers to the young person who is 'overwhelmed' by the decision. Thus, the concept of 'maturity' is one that applies to 16 and 17 year old as well as under 16s and might therefore be considered when considering whether a young person such as P, or a young person who is refusing treatment on religious grounds has the *Gillick* competence (maturity) to decide about life-saving treatments.

General Comment 14 does not resolve the question of how adolescent's maturity is determined, nor how this impacts upon either an adolescent's decisional capacity or a best interests determination. However, it makes clear, like *Manitoba*, that assessing the maturity of the adolescent should be the focus of the court, while emphasising that where

¹³⁵ *Manitoba* (n 6) [96].

¹³⁶ In *Manitoba* (n 6) [48] Abella J notes that the "'mature minor" principle' was first articulated in *Gillick*. See also *Re JA (A Minor) (Medical Treatment: Child Diagnosed with HIV) Re* [2014]. EWHC 1135 (Fam), [2015] 2 FLR 1030 [70] and National Mental Health Development Unit, *The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder: A Guide for Professionals* (Department of Health, 2009) para 2.11.

¹³⁷ Law Commission *Mental Incapacity* (Law Com No 231 1995) para 5.18.

adolescent's refusal is overridden, the justification for the non-consensual intervention is explained.

2.4 Summary of Part 2

Part 2 has considered the approach of the national courts to adolescents' refusals of treatment. It has highlighted that the wishes versus welfare dynamic is present in human rights standards. Although there is very little guidance within human rights standards on whether and, if so, in what circumstances, non-consensual treatment can be given to adolescents who have decisional capacity, a framework for making such decisions is provided by the CRC's General Comment 14. By adhering to such a decision-making process the courts would explain the reasons for overriding the adolescent's wishes in the adolescent's best interests. In doing so this would be clarify the basis on which the courts consider it justified to authorise the non-consensual treatment of adolescents, in particular whether adolescents can be treated without their consent in circumstances where it would not be possible to treat adults, and the reason for that distinction.

CONCLUSION

This chapter has highlighted the significance and complexity inherent in the court's role in deciding whether to override adolescents' refusal of life-saving medical treatment. Key points are as follows:

(1) Potential areas of uncertainty: Adolescent Autonomy Conundrum

This chapter has confirmed the concern raised by commentators that there are two ways in which adolescents' wishes are by-passed when they are perceived to be in conflict with their welfare. Adolescents are either held to lack the requisite decisional capacity, or their decisions are overruled irrespective of their decisional capacity. Furthermore:

- i) There are differing opinions as to when an adolescent's decision might be overruled, as highlighted in the judgments in *Manitoba*. The significant divide in *Manitoba* was that Binnie J considered that the adolescent's right to refuse medical treatment crystallised when she attained decisional capacity. At that point the concept of best interests becomes irrelevant. His fellow judges however, considered that the court continued to have a role, regardless of the adolescent's decisional capacity.

- ii) The fact that the court can override the adolescent's wishes if it considers it is in the adolescent's best interests to do so, may mean that the adolescent's decisional capacity is not considered relevant. In *P (2014)*, although the Judge proceeded on the basis that P had decisional capacity, there were indications that at the time she was refusing life-saving treatment she may not have had the requisite decisional capacity.
- iii) While the MCA 2005 applies to 16 and 17 year olds, indications are that the test of *Gillick* competence are thought to apply to them as well. The MCA 2005 is only engaged if the adolescent meets the 'diagnostic' test as well as 'functional' test. It is feasible that young people aged 16 and 17 may not meet the functional test due to a lack of maturity and/or understanding rather than because of factors meeting the diagnostic test under the MCA 2005.

(2) Human Rights Implications

- i) The circumstances in which it is justified to override the wishes of an adolescent who has the requisite decisional capacity ('the mature minor') when the consequences of not doing so would be, as Abella J, describes 'catastrophic' are not clear. Consideration of Articles 2 and 8 of the ECHR show that the duty to protect life under Article 2 does not necessarily trump an individual's Article 8 rights – the duty to protect the person from harm being balanced against the right of the individual to make decisions about their treatment. However, the relevant cases concern adults, not adolescents so how this is to be balanced in cases where an adolescent has decisional capacity is unclear.
- ii) General Comment 14 sets out a model of best interests which provides a clearer decision-making process (even if not necessarily altering the outcome) and one that requires an explanation as to how the adolescent's wishes have been taken account when considering her welfare and why such wishes are not followed. The application of this approach would place greater emphasis on seeking and taking into account the adolescent's views while also giving a clearer account of the justification for non-consensual treatment.

Whereas the issues discussed in this chapter concern the powers of the court over minors, as noted in Chapter 1, in relation to adolescent psychiatric care, an application to the court will only be necessary if the criteria for detention under the MHA 1983 are not met. The provisions of this Act and how they relate to adolescents is considered next.

CHAPTER 5: ADMISSION AND TREATMENT UNDER THE MENTAL HEALTH ACT 1983: CARE UNDER COMPULSION

INTRODUCTION

The Mental Health Act (MHA) 1983, together with the *Mental Health Act 1983: Code of Practice* (MHA Code 2015),¹ sets out the circumstances in which individuals, of any age, can be detained in hospital and treated for ‘mental disorder’ without their consent. When such compulsory powers are engaged, the notion of individual ‘autonomy’ is subjugated by the legislative objective of the MHA 1983, namely that of protection – whether this is in the interests of the individual’s health or safety, or the protection of others.² In such cases, care under compulsion can apply irrespective of the individual’s decisional capacity. Thus, whether they are an adult or an adolescent, where individuals have a mental disorder, which is considered to present a risk to either themselves or to other people, their wishes can become secondary to welfare concerns.³

As Bartlett and Sandland note, detaining a person under the MHA 1983 is ‘among the strongest of state powers’ given that ‘it carries with it not merely the power to deprive an individual of his or her own liberty, but also the power to treat that individual with extremely strong medications – medications that are intended to alter their mood or their perceptions’.⁴ Their emphasis that ‘[t]hese are extremely intrusive powers, and require strong and clear justifications’⁵ resonates with Lady Hale’s axiom:

People suffering from mental disorders have the same human rights as everyone else and are entitled to enjoy those rights without discrimination on account of their mental status. So we must start from the proposition that they are entitled to the same freedom and autonomy as everyone

¹ Department of Health *Mental Health Act 1983: Code of Practice* (TSO 2015), (MHA Code 2015)

² Mental Health Act (MHA) 1983 sections 2(2)(b) and 3(2)(c).

³ P Fennell ‘Best Interests and Treatment for Mental Disorder’ (2008) *Health Care Anal* 16: 225, 255 states that the MHA 1983 includes ‘the *parens patriae* power to detain and treat “mentally disordered” people without consent in the interests of their own health or safety; and the police power to detain and treat without consent for the protection of other persons’. See also P Fennell *Mental Health Law and Practice* (Jordans 2011) para 1.3; P Bartlett and R Sandland *Mental Health Law Policy and Practice* (3rd ed OUP 2007) 238 – 247.

⁴ Bartlett and Sandland (n 3) 238.

⁵ Bartlett and Sandland (n 3) 238.

else, unless there is some justification within the scheme of the Convention for interfering in this.⁶

Identifying the circumstances in which it might be justified to apply the compulsory powers of MHA 1983 to adolescents in need of psychiatric care and how this compares to relevant human rights standards forms the focus of this chapter.

Analysis and structure of this chapter

This chapter examines the compulsory powers under the MHA 1983 and the guidance in the MHA Code 2015 by applying the 'human rights decision-making framework' questions identified in Chapter 1. The MHA Code 2015 is included in this analysis given that it provides guidance on the application of the MHA 1983 and as noted in Chapter 1, is statutory guidance that should be followed.⁷ Chapter 19 of the Code considers the specific issues relevant to under 18s, but guidance provided in other chapters is also relevant to adolescent psychiatric care.

The 'justification' question concerns the circumstances in which the MHA 1983 authorises adolescents' detention in hospital, the type and location of in-patient provision and compulsory treatment for mental disorder. The 'wishes versus welfare dynamic' question considers the extent to which the determination that such compulsory powers are justified takes into account the views of the adolescent and if the adolescent's decisional capacity has any relevance to this determination. The 'human rights comparison' question compares the justification for engaging such compulsory powers under the MHA 1983 and the extent to which this takes into account the views of the adolescent with the requirements under the European Convention on Human Rights (ECHR) and other relevant human rights standards.

The discussion is divided into four parts, which consider the following areas:

Part 1: the circumstances in which the powers to detain in hospital and treat without consent under the MHA 1983 may be engaged.

Part 2: the procedures for detention in hospital under the MHA 1983.

Part 3: the decisions on the location and type of hospital in which adolescents are placed

Part 4: the provisions under the MHA 1983 that authorise treatment without consent.

⁶ *Rabone v Pennine NHS Foundation Trust* [2012] UKSC 2, [2012] 2 AC 72 [95].

⁷ MHA Code 2015 (n 1) 12.

In addition to examining the human rights implications of the relevant provisions of the MHA 1983, Parts 1 – 4 identify areas of potential confusion and uncertainty in the Act's application.

The Conclusion summarises the key points from this analysis. It notes that there is no overlap between the MHA 1983 and other legal routes to adolescent psychiatric care, but identifies concerns relevant to adolescents receiving in-patient psychiatric care. These fall into three broad categories, namely, problems with the application of the tests for decisional capacity; gaps in the provisions of the MHA 1983 and that the compatibility with the ECHR is questionable in some areas, in particular those relating to the compulsory powers under this Act.

PART 1: ADOLESCENT PSYCHIATRIC CARE AND THE APPLICATION OF THE MENTAL HEALTH ACT 1983

Part 1 considers four areas relevant to the circumstances in which the MHA 1983 might apply to adolescents in need of psychiatric care, which are as follows:

1. The definition of mental disorder
2. Whether there is any overlap between the MHA 1983 and other legal routes for adolescent psychiatric care
3. Adolescents and detention under the MHA 1983
4. The conflict between the MHA 1983 and the UN Convention on the Rights of Persons with disabilities (UNCPRD).

1.1 Mental disorder: the gateway to the Mental Health Act 1983

As with adults, the compulsory powers of the MHA 1983 cannot be applied to adolescents unless they have a mental disorder (the additional requirements for detention under the MHA 1983 are discussed in Part 2 below). This gateway to compulsion is broad, the definition of 'mental disorder' being 'any disorder or disability of the mind',⁸ albeit as outlined below, its scope is narrowed somewhat by the Act itself, and by the MHA Code 2015.

⁸ MHA 1983 s 1.

1.1.1 Mental disorder to be 'clinically recognised'

The MHA Code 2015 advises that the presence of mental disorder should be determined 'in accordance with good clinical practice and accepted standards', with the MHA Code 2.4.). However, the non-exhaustive list of 'clinically recognised conditions which could fall within the definition of mental disorder', includes a wide range of conditions that might affect adolescents, such as depression, anxiety, phobic disorders and eating disorders, in addition to the broad category of '[b]ehavioural and emotional disorders of children and young people' which is also listed.⁹ The number of adolescents with such mental disorders is unclear given that the last national survey was undertaken in 2004¹⁰ (another survey is promised for 2018¹¹). The 2004 survey found that that one in ten children aged between five and 16 'had a clinically diagnosed mental disorder' but a more recent report notes that there is 'emerging evidence of a rising need'.¹²

1.1.2 Limitations under the MHA 1983

The MHA 1983 incorporates two limitations in relation to the definition of mental disorder. First, dependence on alcohol or drugs alone is excluded from the definition of mental disorder. Accordingly, the Act would only apply to an adolescent with an alcohol or drug dependence, if such dependence was 'accompanied by, or associated with, a mental disorder that does fall within the Act's definition'.¹³ The second limitation concerns the 'learning disability qualification', the effect of which is that whereas an adolescent with a learning disability can be admitted to hospital for under section 2 of the MHA 1983 ('Admission for assessment') that adolescent cannot be detained under section 3 ('Admission for treatment') 'unless their disability is associated with abnormally

⁹ MHA Code 2015 (n 1) Figure 1, 26. Although the MHA 1983 Code 2015 advises clinicians that they should determine whether a person has a mental disorder 'in accordance with good clinical practice and accepted standards', (MHA Code 2.4.) the list of 'clinically recognised conditions' covers an extensive range of conditions. See M Mitchell 'The Diagnosis and Management of Complex Mental Illness in Young People' 150, in A Harbour *Children with Mental Disorder and the Law: A Guide to Law and Practice* (Jessica Kingsley Publishers 2008).

¹⁰ Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005) *Mental health of children and young people in Great Britain 2004* a survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive, (Palgrave Macmillan 2005). The lack of reliable data in relation to children and adolescent's mental health was raised as a significant concern in the 2014 report of the Health Committee - *Children's and adolescents' mental health and CAMHS* (2014-2015 HC 342) paras 23 – 24.

¹¹ HM Government, *The Government response to the Five Year Forward View for Mental Health*, (Department of Health 2017) 17- 18.

¹² Department of Health, NHS England, *Future in Mind – Promoting protecting and improving our children and young people's mental health and wellbeing* (Department of Health 2015) 31

¹³ MHA Code 2015 (n 1) para 2.11.

aggressive or seriously irresponsible conduct on their part'.¹⁴ Given that the MHA Code 2015 does not consider autistic spectrum disorders (including Asperger's syndrome) to be a learning disabilities, this qualification will not apply to adolescents with these conditions. However, the Code suggests that the use of the Act where the abnormally aggressive or seriously irresponsible conduct is likely to be rare.¹⁵

1.2 The MHA 1983: potential overlap with other legal routes

The MHA Code 2015's principle of 'least restrictive option and maximising independence' is that '[w]here it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained',¹⁶ thereby reinforcing the notion that the use of such powers is regarded as a 'measure of last resort'. The MHA 1983 will only need to be engaged if the adolescent cannot be admitted informally under section 131 of the MHA 1983. As noted in Chapter 4, an application to the court should only be made where the MHA 1983 is not applicable. Accordingly, there is no overlap between the compulsory powers under MHA 1983 and other legal routes for adolescent psychiatric care. However, the key issue will be whether the adolescent can be 'safely and lawfully admitted' under section 131. The possible areas of uncertainty in this regard are noted briefly below, followed by an explanation as to why section 25 of the Children Act (CA) 1989 does not provide an alternative legal route to an adolescent's admission to hospital and treatment for mental disorder.

1.2.1 Informal admission under section 131 of the MHA 1983

As noted in Chapter 2, in accordance with section 131 of the MHA 1983 an adolescent might be admitted informally on the basis of the adolescent's consent, parental consent, or in the case of a young person who lacks capacity under the Mental Capacity Act (MCA) 2005, in accordance with the MCA 2005. However, the crucial question is whether these legal routes can be relied upon to authorise the adolescent's admission to hospital and on-going in-patient psychiatric care. For example, while an adolescent's consent is sufficient legal authority for the adolescent to be admitted to hospital and treated for mental disorder, compulsory admission under the MHA 1983 should be considered if there is 'a strong likelihood' that the adolescent 'will have a change of mind about informal

¹⁴ MHA Code 2015 (n 1) para 2.15 (referring to MHA 1983 s1(2A)). Guidance on determining whether the person's learning disability is associated with abnormally aggressive behaviour or seriously irresponsible conduct is provided at paras 20.7-20.17.

¹⁵ MHA Code 2015 (n 1) para 2.17.

¹⁶ MHA Code 2015 (n 1) para 1.2.

admission, either before or after they are admitted'.¹⁷ Moreover, as will be explored in detail in Chapter 6, changes to the MHA 1983 and the MHA Code 2015 in relation to adolescent psychiatric care, as well as recent case-law, have limited the circumstances in which it is possible to rely on either parental consent, or the MCA 2005.

1.2.2 Section 25 of the Children Act 1989 and 'secure accommodation'

Section 25 of the Children Act (CA) 1989 provides for the circumstances in which a court can order a child or young person to be placed in 'secure accommodation'.¹⁸ Although in the past the use of such 'secure accommodation orders' were used as an alternative legal regime to authorise an under 18 year old's detention in a psychiatric hospital,¹⁹ for the following reasons, this is no longer a viable option. First, the two regimes differ in scope and objectives. An application for a secure accommodation order can only be made by a local authority in respect of certain 'looked after children' (in relation to 16 and 17 year olds this is limited to young people for whom the local authority is under a duty to accommodate),²⁰ or by a health body that is accommodating a child or young person who is not a looked after child.²¹ Secondly, the purpose of a secure accommodation order is to contain the adolescent, not to assess or treat the adolescent's mental disorder. Adolescents will meet the criteria under section 25 of the CA 1989 if they need secure accommodation because they have a history of absconding from other types of accommodation and if they do are 'likely to suffer significant harm', or if 'kept in any other description of accommodation', they are likely to injure themselves or others.²² Thirdly, there are no powers to treat adolescents without their consent under section 25 of the CA 1989. Whereas in the past, reliance was placed on parental consent for the authority to treat,²³ given the MHA Code 2015's guidance,²³ this would only be possible where the adolescent lacks decisional capacity and the provision of treatment falls within the 'scope

¹⁷ MHA Code 2015 (n 1) paras 14.14 – 14.16. See *AM v South London and Maudsley NHS Foundation Trust* [2013] UKUT 365 (AAC) [20].

¹⁸ The interrelationship between secure accommodation and the MHA 1983 is discussed by Harbour (n 9) chp 3 and R Sandland in L Gostin, P Bartlett, P Fennell, J McHale and R MacKay (eds), *Principles of Mental Health Law and Policy* (OUP 2010) paras 18.55 – 18.64.

¹⁹ *Re K, W and H (minors) (medical treatment)* [1993] 1 FCR 240, [1993] 1 FLR 854, CA.

²⁰ By virtue of Children (Secure Accommodation) Regulations 1991/1505 reg 5(2), Children Act (CA) 1989 s 25 (secure accommodation) cannot be applied to young people accommodated under the CA 1989 s 20(5). *Re W (A Child)* [2016] EWCA Civ 804, [2016] 4 WLR 159 confirms that 16 and 17 year olds accommodated under the CA 1989 s 20(3) are not excluded from the ambit of CA 1983 s 25, thereby by dispelling the view that secure accommodation cannot be sought for any young person aged 16 or 17.

²¹ Children (Secure Accommodation) Regulations 1991/1505 reg 7.

²² Children Act 1989 s 25(1).

²³ *Re K, W and H* (n 19) This case is discussed by P Bates 'Children in secure psychiatric units: Re K, W, and H – 'out of sight, out of mind?' (1994) *Journal of Child Law* 6(3) 131.

of parental responsibility'.²⁴ Moreover, case-law has established that a psychiatric hospital is not 'secure accommodation' under section 25 because its primary purpose is 'to achieve treatment', with the restriction on her liberty being incidental to the treatment.²⁵ Where an adolescent is detained in hospital under the MHA 1983, section 25 of the CA 1989 cannot be applied.²⁶

Debates over the use of the MHA 1983 and section 25 secure accommodation are more likely to arise where agencies disagree on the appropriate intervention for the adolescent concerned (and therefore which agency is responsible for providing and resourcing that intervention). That such conflicts arise is illustrated by the case of *Re P (Application for Secure Accommodation Order)*²⁷ which concerned P, a 16 year old who had a history of serious self-harm. Having noted that P's psychiatrist accepted there was a high risk that P would try to harm herself again, but was not able to identify a mental disorder, Bellamy J commented that he 'was left with the impression that the real problem was to do with the scarcity of CAMHS Tier 4 inpatient beds and that that was the reason why it was proposed that P be diverted into secure accommodation'.²⁸ The shortage of beds was highlighted by a 2014 report of NHS England, which estimated that at least 50 more beds were required.²⁹ The impact of the lack of in-patient CAMHS provision is discussed further in Part 3.

1.3 Adolescents and the application of the MHA 1983

As the Care Quality Commission (CQC) notes the '[l]ack of accurate reliable and robust data has been persistently identified in the literature' relating to CAMHS.³⁰ Information regarding the application of the MHA 1983 in relation to under 18s is particularly sparse.

²⁴ MHA Code 2015 (n 1) para 19.40.

²⁵ *Re C (Detention: Medical Treatment)* [1997] 3 FCR 49, [1997] 2 FLR 180 a view endorsed by Sir James Munby P in *Re X (A Child); Re Y (A Child)*. [2016] EWHC 2271 (Fam) [2017] Fam 80, 3 WLR 1718 [33].

²⁶ Children (Secure accommodation) Regulations 1991/1505, reg 5(1).

²⁷ 2015 EWHC 2971 (Fam).

²⁸ *Re P (Secure accommodation)* (n 26) [18].

²⁹ *CAMHS Tier 4 Report Steering Group, Children and Adolescent Mental Health Services Tier 4 Report* (NHS England 2014).

³⁰ Care Quality Commission, *Review of children and young people's mental health services Phase One supporting documentation: Summary of recent policy and literature*, October 2017, 46. See also Children's Commissioner for England, *Children's Commissioner Briefing: Children's Mental Healthcare in England*, October 2017, 9.

Although the numbers of individuals detained under the MHA 1983 continues to rise,³¹ it is not possible to assess whether more under 18s are being detained than in the past. This is because up until January 2016, data on the numbers of under 18s detained under the MHA 1983 was not collected nationally. Mental health statistics, which include CAMHS, are now published for each month, but the data is 'experimental and not yet considered reliable'.³² In January 2016, 179 under 18s were detained under either section 2 or section 3 of the MHA 1983, in November 2016, the figure was 286, whereas in July 2017 it was 265.³³

Whereas the CQC suggests that in a break with the past, there are now more (adult) patients detained under the MHA 1983 than informal patients,³⁴ the situation appears to differ for adolescents. Albeit just a 'snapshot', figures from October 2016 show that only a third of the inpatients aged under 18 were detained in hospital under the MHA 1983.³⁵

The CQC suggests that there may be 'a greater proportionate use of the MHA today for children and young people than in the past, 'because of recent changes in emphasis on the "scope of parental responsibility" in the Code of Practice'.³⁶ This may well be true, although as noted in Chapter 2, there are other changes to the legal framework for adolescent care that may lead to more adolescents being detained under the MHA 1983. In any event, as the CQC observes, an increase in the use of the MHA 1983 for this age group may be a positive change given the safeguards provided by the MHA 1983 which are not available to informal patients. Adolescents who are detained under the MHA 1983 have the right to the advocacy services of Independent Mental Health Advocates (IMHAs), whose role is to help detained patients exercise their rights. They also have the right to apply (with free legal advice and representation to help them do so)³⁷ to a Mental Health Tribunal, an independent judicial body which reviews the basis for, and

³¹ Care Quality Commission *Monitoring the Mental Health Act in 2015/16* (CQC 2015/16) 18, albeit noting that this must allow for 'some caution as the dataset is not complete'

³² CQC 2015/16 (n 31) 47.

³³ These figures are taken from the Mental Health Services Monthly Statistics (Final January Monthly Data 2016, Final November Monthly Data 2016, Final Monthly Data July 2017), available at NHS Digital <<http://content.digital.nhs.uk/mentalhealth>> accessed 31 October 2017.

³⁴ The Care Quality Commission (CQC) reported 'the highest ever year-on-year rise (10%) to 58,400 detentions (excluding holding powers³⁴) in Care Quality Commission *Monitoring the Mental Health Act in 2014/15*' (CQC 2014/15) 17.

³⁵ CQC 2015/16 (n 31) 29.

³⁶ CQC 2015/16 (n 31) 29. That it was common for parental consent to be relied upon to authorise under 18s admission to hospital was noted by Joint Committee on the Draft Mental Health Bill *Draft Mental Health Bill* (2004-05 HL 79-1, HC 95-1) para 206. See also *Re K, W and H* [1993] 1 FLR 854; Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957 (Percy Commission) *Report* (Cmnd. 169 1956-57) para 359; J Fortin, *Children's Rights and the Developing Law* (3rd edn, Cambridge University Press) 172.

³⁷ MHA 1983 s72.

has the power to order discharge from, the person's detention in hospital.³⁸ Section 132 of the MHA 1983 requires that detained patients are informed of their rights for each period of detention.³⁹

There is also a lack of comprehensive information on adolescents who are detained under the MHA 1983. Since its inception in 2009, the CQC has published annual reports on its findings from monitoring the use of the MHA 1983. However, these reports provide a very partial insight on the situation of under 18s. Not all of the annual reports make specific reference to them while those that do focus on specific issues of concern,⁴⁰ rather than providing a systematic approach to collecting relevant information on the operation of the MHA 1983 which can be compared from year to year; for example, the numbers of under 18s who are detained under the MHA 1983, the numbers placed on adult wards and any concerns about non-compliance with the procedures for treatment under Part IV of the Act.

An obvious and significant gap is that these reports are concerned with individuals who are detained whereas, if the snapshot noted above is correct, the majority of under 18s are informal patients. Given that such issues will be relevant to whether detention under the MHA 1983 is required, it is of serious concern that the first report of its 'in depth thematic review of children and young people's mental health services',⁴¹ the CQC states that CAMHS staff 'did not always have an adequate understanding of important guidance and legislation such as the [MHA 1983] and [MCA 2005]' or if they did know about this legislation 'did not understand what it meant for their role as a mental health

³⁸ Thus, performing the role required under Article 5(4) to provide an independent review of the lawfulness of the person's detention and to order the person's release if the detention is unlawful. See *X v United Kingdom* (1982) 4 EHRR 188 para 61 and *Stanev v Bulgaria* (2012) 55 EHRR 439 paras 168 – 171.

³⁹ MHA 1983 s132(1)(b) and MHA Code 2015 (n 1) paras 4.21 – 4.22. The right to be promptly and adequately informed under Article 5(2) applies to all individuals who are deprived of their liberty – see *Van der Leer v the Netherlands* (1990) 12 EHRR 567. Although this is not covered in the duty on hospital managers to provide certain information to detained patients (MHA 1983 s132) the MHA Code 2015 (n 1) (paras 4.14 – 4.15) provides that detained patients should be told the reasons for their detention; see also paras 14.95 and 14.100 regarding the Approved Mental Health Professional's (AMHP's) responsibility to provide reasons for the decision to detain.

⁴⁰ For example, Care Quality Commission *Monitoring the Mental Health Act in 2011/12* (CQC 2011/12) noted concerns about staffing on a CAMHS ward (63); CQC 2014/15 (n 34) raised concerns about the lack of understanding of competence and capacity (50 – 51).

⁴¹ The Care Quality Commission was asked to undertake this review by the Government. See HM Government, *The Government response to the Five Year Forward View for Mental Health*, (Department of Health 2017) 2.

professional'.⁴² This point is returned to in Chapter 5 when considering recommendations for change.

1.4 The MHA 1983 and the Convention on the Rights of Persons with Disabilities

As noted in Chapter 1, the UNCRPD challenges the very existence of the MHA 1983. Whereas pre-UNCRPD the issue was 'not whether compulsion was permissible, but what its appropriate boundaries were'⁴³ there is now a sharp divide across international and European human rights standards. Some permit the detention and non-consensual treatment of individuals on grounds of mental disorder in certain circumstances. Others prohibit the use of such compulsory powers on grounds of mental disorder in any circumstances.

The United Nations High Commissioner for Human Rights' 2017 report to the General Assembly.⁴⁴ *Mental health and human rights* ('the High Commissioner's 2017 mental health report') sets out the grounds for prohibiting compulsory care. It endorses the approach adopted by the Committee on the Rights of Persons with Disabilities ('the CRPD Committee'), namely that deprivation of liberty and treatment without consent on grounds of a disability are discriminatory and contravenes the CRPD.⁴⁵ The report states that the UNCRPD 'establishes an absolute ban on deprivation on the basis of impairments, which precludes non-consensual commitment and treatment'.⁴⁶ These points are of equal relevance to adolescents as to adults given that Article 7 of the UNCRPD provides that children with disabilities should be able enjoy their rights and freedoms 'on an equal basis with other children'.

The 'absolute ban' on detention is derived from the interpretation of Article 14(1)(b) of the UNCRPD which states that 'the existence of a disability shall in no case justify a deprivation of liberty'.⁴⁷ While observing that this 'radically departs' from previous international human rights law given that 'the existence of a mental disability represented a lawful ground for deprivation of liberty', the Office of the High Commissioner for Human

⁴² Care Quality Commission, *Review of children and young people's mental health services, Phase One Report* October 2017, 19.

⁴³ Bartlett and Sandland (n 3) 239.

⁴⁴ Human Rights Council Mental Health and Human Rights – Report of the United Nations High Commissioner for Human Rights A/HRC/34/32 (2017)

⁴⁵ See Committee on the Rights of Person's with Disabilities *Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities* – the right to liberty and security of persons with disabilities (2015).

⁴⁶ UN Mental Health and Human Rights report (n 44) para 29.

⁴⁷ UNCRPD 14(1)(b).

Rights ('the OHCHR') states that 'the legal grounds upon which restriction of liberty is determined must be de-linked from disability and neutrally defined so as to apply to all persons on an equal basis',⁴⁸ a view reiterated by the High Commissioner's 2017 mental health report.⁴⁹

In relation to non-consensual medical treatment, although the UNCRPD does not explicitly prohibit treatment without consent, (a situation regarded by some to be a major gap⁵⁰) this is interpreted by the CRPD Committee and other UN bodies, such as the Special Rapporteur on Health,⁵¹ as outlawing compulsory treatment based on disability (whether this be for reasons of mental disorder or a lack of mental capacity). The CRPD Committee considers that 'forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law' (Article 12) as well as being 'an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16)'.⁵² The High Commissioner's 2017 mental health report endorses the CRPD Committee's call for 'the abolition of all involuntary treatment' and the adoption of measures to ensure that mental health services 'are based on the free and informed consent of the person concerned'.⁵³

In contrast, within the Council of Europe, the ECHR and other human rights standards permit in certain circumstances the detention and treatment without consent of

⁴⁸ Human Rights Council *Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities* (A/HRC/10/48 2009) paras. 48 and 49. Pointing out that proposals 'to limit the prohibition of detention to cases "solely" determined by disability were rejected' (para 48) the OHCHR concludes that even where additional conditions are required, if the detention is partly justified by the person's disability this will be considered to be discriminatory and therefore in contravention of UNCRPD art 14.

⁴⁹ UN Mental Health and Human Rights report (n 44) para 23

⁵⁰ See also R Kayess and P French, 'Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) *Human Rights Law Review* 8(1) 1, 30. See also T Minkowitz, 'Abolishing Mental Health Laws to Comply with CRPD' in B McSherry and P Weller *Rethinking Rights Based Mental Health Laws* (Hart Publishing 2010) 169 – 176 in which the author argues that in the light of the UNCRPD and the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) users and survivors 'can now begin to assert claims for traumatising forced interventions as a form of torture or ill-treatment'. P Bartlett 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75 (5) *MLR* 752.

⁵¹ Secretary General *Report of the Special Rapporteur on the right of everyone to the highest standard of physical and mental health* (A/64/272 2009) para 72 states that the UNCRPD '...reaffirms that the existence of a disability is not lawful justification for any deprivation of liberty, including denial of informed consent.' See also Human Rights Council *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment* (A/HRC/22/53) (2013) paras 35 and 85(e).

⁵² CRPD Committee General Comment No 1 (2014) *Article 12: Equal recognition before the law* para 42.

⁵³ UN Mental Health and Human Rights report (n 44) para 33.

individuals on grounds of mental disorder. The European Court of Human Rights (ECtHR) continues to refer to the (much criticised⁵⁴) 1991 *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* ('the Mental Illness Principles'),⁵⁵ which permit the detention and treatment without consent on the basis of 'mental illness',⁵⁶ whereas the High Commissioner's 2017 mental health report considers that they have been superseded by the UNCRPD.⁵⁷

Furthermore, not all UN bodies have adopted the CRPD Committee's view that detention and compulsory treatment on grounds of mental disorder are never permitted. For example, both the Human Rights Committee⁵⁸ and the Sub Committee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Sub Committee on Prevention of Torture)⁵⁹ envisage that detention on the grounds of mental disorder is permitted in some, albeit limited, circumstances. The Sub Committee on Prevention of Torture also sets out the circumstances treatment without consent may ('exceptionally') be justified.⁶⁰

Nonetheless, as Lady Hale remarked (extra-judicially⁶¹), despite the potential conflict with between the UNCRPD and the MHA 1983, 'for us the law is clear', in that the MHA 1983 permits such compulsory powers.⁶² However, there are indications that the UNCRPD has already influenced international and European human rights law. While falling far short of the CRPD Committee's objective of abolishing laws that detain and

⁵⁴ C Gendreau 'The Rights of Psychiatric Patients in the Light of the Principles Announced by the United Nations: A Recognition of the Right to Consent to Treatment?', (1997) *International Journal of Law and Psychiatry* 20(2), 259, 273. See also Secretary-General *Progress of efforts to ensure the full recognition and enjoyment of the human rights of persons with disabilities - A/58/181* para. 45; E Rosenthal and C Sundram 'International Human Rights and Mental Health Legislation', (2001-2002) 21 *NYLSchL Int'l & Comp L*, 469, 37.

⁵⁵ Adopted by the UN General Assembly resolution 46/119 of 17 December 1991. For the background to the development of these principles see Gendreau 1997 (n 48).

⁵⁶ See for example *MS v Croatia No 2* (App 75450/12) 19 February 2015[2015] MHLR 226.

⁵⁷ UN *Mental Health and Human Rights* report (n 44) para 22. See also *Report of the Special Rapporteur on torture* (n 51) para 58; the Thematic Study (n 48) para 48 and Kayess and French (n 50). Minkowitz (n 50) 153 states that they 'should be abandoned'.

⁵⁸ Human Rights Committee of the UN International Covenant on Civil and Political Rights (ICCPR) *General Comment No 35: Article 9 (Liberty and security of person)* (CCPR/C/GC/35) para 19.

⁵⁹ UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent CAT/OP/27/2 (2016) para. 8

⁶⁰ Approach of the Subcommittee (n 59) paras 12 – 19.

⁶¹ Lady Hale, Deputy President of the Supreme Court 'The other side of the Table?' Notes of talk given to the Mental Health Tribunal Members' Association 17 October 2014

⁶² Lady Hale was referring to detention, but her comments are equally applicable to treatment without consent.

treat individuals without their consent on grounds of their disability, as will be seen in the discussions below, the ECtHR has increased its scrutiny on the use of such compulsory powers. Similarly, at the UN level even though the Human Rights Committee and the Sub Committee on Prevention of Torture are not of the view that compulsory powers can never be applied on grounds of mental disorder, both bodies emphasise this is justified only in limited circumstances and must be subject to substantive and procedural safeguards.⁶³ Furthermore, they identify the need to revise laws ‘to avoid arbitrary detention’ and provide community-based alternatives to confinement.

1.5 Summary of Part 1

The key points arising from Part 1 are that the MHA 1983 will apply to adolescents if they need in-patient care for their mental disorder which cannot be provided on an informal basis and the criteria for detention under the Act are met. As such there is no overlap with the other potential legal routes for adolescent psychiatric care outlined in Chapter 1. It is not clear whether the numbers of under 18s detained under the MHA 1983 are increasing given that such information has only just started to be collected nationally but initial figures indicate an increase. Although there may be debates between children’s services and mental health services as to the appropriate intervention for an adolescent with conditions falling within the broad term of mental disorder, where an adolescent requires a period of in-patient psychiatric care, the CA 1989 is not a realistic alternative to the use of the MHA 1983. There is a conflict between the UNCRPD, which prohibits compulsory psychiatric care and the ECHR which permits it in certain circumstances. However, as discussed below, the ECHR has increased its scrutiny of compulsory powers.

⁶³ Human Rights Committee *General Comment No 35* (n 58) para 19. *Approach of the Subcommittee* (n 59) paras 7 – 11 and 12 – 19.

PART 2: COMPULSORY ADMISSION TO HOSPITAL UNDER THE MENTAL HEALTH ACT 1983

There 'are no age-related criteria for the use of the MHA 1983'.⁶⁴ Save for emergencies,⁶⁵ where adolescents require a period of in-patient psychiatric care that cannot be provided informally, they can be admitted compulsorily to hospital under the MHA 1983 if the criteria under sections 2 and 3 are met. Section 2 provides for assessment, or assessment followed by medical treatment, for up to 28 days.⁶⁶ Section 3 provides for detention in hospital for treatment for mental disorder for up to six months. Whereas detention under section 2 cannot be renewed,⁶⁷ detention under section 3 can be renewed for another six months and thereafter on an annual basis.⁶⁸

Although not the only right likely to be engaged,⁶⁹ reflecting that the main purpose of sections 2 and 3 is to authorise an individual's detention in hospital, the following analysis focuses on Article 5 of the ECHR and other human rights standards that govern 'detention' and 'deprivation of liberty' (these terms are used interchangeably) on the grounds of mental disorder. These standards apply to individuals of all ages, although (due to the paucity of cases relating to under 18s⁷⁰), the extensive jurisprudence of the ECtHR on 5(1)(e) has concerned adults.

The discussion below compares the provisions under the MHA 1983 with the ECHR and other human rights standards for detention on grounds of mental disorder, focusing on the thresholds they set for detention and the extent to which the views of the individual are taken into account. It also notes the confusion that can arise when practitioners seek to identify an adolescent's nearest relative' under the MHA 1983 given that there are additional rules for doing so for under 18s.

⁶⁴ CQC 2015/16 (n 30) 27. See also V Thomas and others, 'The application of mental health legislation in younger children' (2015) BJPsy Bulletin 39 302 in which the authors discuss a case in which an 8 year old boy was detained under the MHA 1983.

⁶⁵ Detention for shorter periods are provided for; see MHA 1983 ss 4, 5(2), 5(4), 135 and 136 MHA 1983. Part 3 of this Act, which provides for the admission to hospital of individuals involved in criminal proceedings is not considered.

⁶⁶ This 28 day limit is extended in two situations: where the person is absent without leave and where an application has been made to displace the nearest relative.

⁶⁷ For another 6 months, and thereafter on an annual basis, section 20.

⁶⁸ MHA 1983, s 20.

⁶⁹ The right to private and family life being another key right in this regard; see for example *B v Romania* (App 1285/03) 19 May 2013, [2015] MHLR 164.

⁷⁰ *Nielsen v Denmark* (1989) 11 EHRR 175 remains the only case concerning the deprivation of liberty connected to Article 5(1)(e) – this is discussed in Chapter 6.

2.1 Deprivation of Liberty under the ECHR: the *Winterwerp* criteria

Unlike its UN counterparts,⁷¹ the ECHR makes specific provision for ‘the lawful detention... of persons of unsound mind’ under Article 5(1)(e).⁷² In the past,⁷³ the MHA 1983 was considered to meet the requirement that national law provides ‘adequate legal protections and “fair and proper procedures”’,⁷⁴ as well as the ECtHR’s ‘three minimum conditions’ (save for emergency cases,) for the lawful detention under Article 5(1)(e). These conditions were established in *Winterwerp v the Netherlands* (1979)⁷⁵ (‘the *Winterwerp* criteria’).

The first two of the *Winterwerp* criteria will be relevant to an adolescent’s detention under sections 2 or 3 of the MHA 1983. First, the person ‘must reliably be shown to be of unsound mind, that is a true mental disorder must be established before a competent authority⁷⁶ on the basis of objective medical expertise’ (‘the ‘true mental disorder’ criterion’) and the second is that ‘the mental disorder must be of a kind or degree warranting compulsory confinement’ (‘mental disorder warranting compulsory confinement’ criterion). The third *Winterwerp* criterion is not considered below given that it is concerned with on-going detention, rather than the initial decision to detain. It states that ‘the validity of continued confinement must depend upon the persistence of such a disorder’ and is addressed by the requirement that individuals are discharged from detention if the grounds for such detention are no longer met.⁷⁷

⁷¹ See for example, ICCPR art 9; UNCRC art 37 and UNCRPD art 14. All these articles, save for UNCRC art 37 (which states that “[n]o child shall be deprived of his or her liberty...”) refer to “the right to liberty and security of person”, reflecting the terminology used in the Universal Declaration of Human Rights, which states (art 3): ‘Everyone has the right to...liberty and security of person’.

⁷² Article 5(1) lists the six cases in which detention may be justified (a) – (f) The ECtHR emphasises that this is ‘an exhaustive list which must be interpreted strictly’ (*Bouamar v Belgium* (1989) 11 EHRR 1 para 43) and ‘no deprivation of liberty will be lawful unless it falls within one of those grounds’ (*Saadi v United Kingdom* (2008) 47 EHRR 17 para 43).

⁷³ In *HL v United Kingdom* (2005) 40 EHRR 32 para 54 the ECtHR commented that the MHA 1983 provides ‘strict statutory criteria’ for detention.

⁷⁴ *Pleso v Hungary* (App 41242/08) 2 October 2012 para 59.

⁷⁵ *Winterwerp v. the Netherlands*, (1982) 4 EHRR 188.

⁷⁶ The ECtHR’s concern is that a fair and proper procedure has been followed; ‘namely that any measure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary’ (*Bik v Russia* (App 26321/03 22 October 2010 para 30) citing *Winterwerp* (n 69) para 45).

⁷⁷ Part V of the MHA 1983 (Mental Health Review Tribunals); MHA 1983 s 20 (Duration of Authority). The MHA Code 2015 (para. 32.18) states that responsible clinicians should discharge the patient if at any time they ‘conclude that the criteria which would justify renewing a patient’s detention...are not met’.

2.1.1 Establishing a 'true mental disorder'

Sections 2 and 3 MHA 1983 require that the Approved Mental Health Professional (AMHP), who makes the application for admission under the MHA 1983,⁷⁸ and the two doctors ('the MHA assessors') all agree that the person "is suffering from mental disorder",⁷⁹ that the criteria for detention under the MHA 1983 are met and that the application should be made.⁸⁰ The application is based on the recommendations of the two doctors. Both of the doctors must have 'personally examined the patient either together or separately',⁸¹ one of whom must be approved under section 12 of the MHA 1983 as having 'special experience in the diagnosis or treatment of mental disorder'.

This process meets the first *Winterwerp* criterion, ('the 'true mental disorder' criterion').⁸² The expansive definition of 'mental disorder' noted in Part 1 presents no difficulties given that Article 5(1)(e) refers to the 'potentially very wide and indeterminate'⁸³ term, 'unsound mind', which in the ECtHR's view 'does not lend itself to precise definition since its meaning is continually evolving as research in psychiatry progresses'.⁸⁴ The ECtHR's emphasis that individuals cannot be detained simply because their 'views or behaviour deviate from the norms prevailing in a particular society'⁸⁵ is reflected in the MHA Code 2015.⁸⁶

2.1.2 'The 'mental disorder must be of a nature or degree justifying the detention'

Although their terminology differs somewhat, both sections 2 and 3 include a requirement that reflects the second *Winterwerp* criterion (the 'mental disorder warranting compulsory confinement' criterion).

Section 2 requires that the person's mental disorder 'warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment)'⁸⁷ and

⁷⁸ MHA 1983 s 11(2). An application can also be made by the nearest relative (MHA 1983 s 11(1)).

⁷⁹ Section 2(2)(a), section 3(2)(a) MHA 1983.

⁸⁰ MHA 1983 ss 2(2), 2(3), 3(2), 3(3), 13 1(A) and 13(2).

⁸¹ MHA 1983 12(1).

⁸² *Pleso v Hungary* (n 74) para 60. *Mifobova v Russia* (App 5525/11) 5 February 2015 para 56 'the national authorities should reliably establish that the kind and degree of disorder warrant that person's detention (see *Winterwerp*, cited above, § 33)'. Fennell (2011) (n 3) para 2.16 notes that '[n]othing in Art 5 or the case-law requires admission to be authorised by a court or tribunal, so the current procedures are Convention compliant'.

⁸³ D Feldman, *Civil Liberties and Human Rights in England and Wales* (2nd ed OUP 2002) 455

⁸⁴ *Bergmann v. Germany* (2016) 63 EHHR 21 para 96.

⁸⁵ *Winterwerp* (n 69) para 37.

⁸⁶ MHA Code 2015 (n 1), 2.8.

⁸⁷ MHA 1983 s 2(2)(a)

that the person 'ought' to be detained 'in the interests of his own health or safety or with a view to the protection of other persons'.⁸⁸

It is likely that an adolescent's first compulsory admission to hospital will be under section 2 given that the pointers in the MHA Code 2015 on when to use this section refer to the need for in-patient assessments to formulate, or reformulate, a treatment plan. In contrast, the guidelines for using section 3 relate to matters such as having a clear treatment plan and the need to use compulsion to follow it.⁸⁹ Section 3 requires that the mental disorder 'makes it appropriate for him to receive medical treatment in a hospital',⁹⁰ that 'it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment' and that the treatment 'cannot be provided unless he is detained under this section'.⁹¹

Section 3 includes an additional requirement in that 'appropriate medical treatment is available'.⁹² However, this is an expansive and somewhat circular term given that it is defined as 'medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case',⁹³ while the purpose of 'medical treatment' is 'to alleviate, or prevent a worsening of, the mental disorder or one or more of its symptoms'.⁹⁴ Thus, although the requirement that the medical treatment is available and that 'its purpose must be to confer some benefit on the patient, if only to the extent of preventing the patient's condition getting worse',⁹⁵ should ensure that an adolescent's detention is directed at more than containment, its application is extremely wide.⁹⁶

⁸⁸ MHA 1983 s 2(2)(b). Whereas it might be thought that the legislators of the MHA 1983 borrowed the wording from the ECtHR's decision in *Winterwerp* (n 69) this is not the case. There is very little difference between section 2 MHA 1983 and the terminology used in its precursor (section 25 Mental Health Act 1958) and although significant changes have been made to section 3 since that time, its precursor, section 26 MHA 1959 refers to the mental disorder being of a "nature or degree" which warrants detention.

⁸⁹ See MHA Code 2015 (n 1) 14.27-14.28 (section 2 and 3 pointers).

⁹⁰ MHA s 3(2)(a).

⁹¹ MHA 1983 s 3(2)(c). As noted in Part 1 above, individuals with learning disabilities may only be admitted on the basis of their learning disability if "that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part" (MHA 1983 s 1(2A)).

⁹² MHA 1983 s3 (2)(d).

⁹³ MHA 1983 s 3(4). R Jones *Mental Health Act Manual* (19th edn Sweet and Maxwell 2016) 53 notes the "circularity" of this definition. See also Bartlett and Sandland (n 3) 254 who suggest that the outcome of the legislation is that 'appropriate treatment is appropriate if it is appropriate'.

⁹⁴ MHA 1983 s145(4).

⁹⁵ *H-L v Partnership in Care and Secretary of State for Justice* [2013] UKUT 500 (AAC) [2014] MHLR 241 [40].

⁹⁶ Jones 2016 (n 93) 53 1-071, states that there has been no reported case in which a '[Mental Health] Tribunal 'has found that a patient's treatment in hospital constituted mere containment'.

A comparison between sections 2 and 3 and international and European human rights standards shows a significant disparity in that these standards set a higher threshold for detention than the MHA 1983. Thus, the Council of Europe Recommendation (2004) 10 (CoE Rec (2004) 10) refers to 'a significant risk of serious harm' to the person's health or to other persons;⁹⁷ the Human Rights Committee refers to protecting the person 'from serious harm or preventing injury to others',⁹⁸ while the Sub Committee on Prevention of Torture states that those with 'serious mental disorders' may be detained 'to protect the detainee from discrimination, abuse and health risks stemming from illness'.⁹⁹ Both the Human Rights Committee and the Sub Committee on Prevention of Torture emphasise that the detention on grounds of mental must be 'necessary and proportionate'.¹⁰⁰ The issue of proportionality is also a significant factor in the approach now taken by the ECtHR, which is considered next.

2.2 Justifying a deprivation of liberty: the MHA 1983 and the ECHR

Although the essence of the 'Winterwerp criteria', has remained constant for nearly four decades, the evaluation of proportionality now forms part of the ECtHR's assessment of whether they have been met.¹⁰¹ Thus, the detention of individuals with mental disorder 'must be properly justified by the seriousness of the person's condition in the interest of ensuring his or her own protection or that of others'.¹⁰² This stems from the decision in *Witold Litwa v Poland* (2000), in which the ECtHR held that given the seriousness of such a measure, an individual's detention must be 'necessary in the circumstances'¹⁰³ and 'is only justified where other, less severe measures have been considered and found to be insufficient to safeguard the individual or the public interest which might require that person to be detained'.¹⁰⁴

The ECtHR has identified a wide range of reasons why 'the detention of a mentally disordered person may be necessary', which includes not just 'where the person needs

⁹⁷ Council of Europe Recommendation No (2004) 10 of the Committee of Ministers to member states concerning the human rights and dignity of persons with mental disorder and its Explanatory Memorandum (2004) (CoE Rec (2004) 10) art 17(1)(ii).

⁹⁸ Human Rights Committee *General Comment No 35* (n 58) para 19.

⁹⁹ Approach of the Subcommittee (n 59) para. 8

¹⁰⁰ Human Rights Committee *General Comment No 35* (n 58) para 19.

¹⁰¹ R Jones *Mental Health Act Manual* (15th edn Sweet and Maxwell 2012) 1013, 5-023 refers to this as a fourth condition to be added to the Winterwerp, namely 'that detention must be a proportionate response to the patient's situation'

¹⁰² *Atudorei v Romania* (2014) (App 50131/08) 16 September 2014 para 151.

¹⁰³ *Witold Litwa v. Poland*, (2001) 33 EHRR 53 para 78.

¹⁰⁴ *Witold Litwa v. Poland* (n 104) 78. See also *Varbanov v Bulgaria* (App 31365/96) 5 October 2000 para 46.

therapy, medication or other clinical treatment to cure or alleviate his condition’ but also ‘where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons’.¹⁰⁵ However, there are indications that in the post-UNCPRD era, the ECtHR is recalibrating the basis on which it considers detention to be justified. Whereas it has traditionally regarded Article 5(1)(e) as having a protective function, both for the protection of the public and because for those with a mental disorder ‘their own interests may necessitate their detention’,¹⁰⁶ this is beginning to change.

In determining whether the detention is justified on grounds of protecting the individual, the ECtHR now gives greater attention to the need for ‘weighty reasons’ to justify the detention, the extent to which the national authorities have taken into account the views of the person when determining that their deprivation of liberty was necessary and whether alternatives to detention had been considered. Although these points are closely linked, they merit separate attention.

2.2.1 Weighty reasons

The ECtHR has repeatedly stressed that people with mental disorder are a ‘particularly vulnerable group’ given the ‘considerable discrimination’ they have faced in the past’.¹⁰⁷ It requires a strict scrutiny of any interference with their rights, and ‘only “very weighty reasons” can justify a restriction of their rights’.¹⁰⁸ In *Pleso v Hungary* (2012),¹⁰⁹ a case concerning an applicant who had been detained on health grounds alone, the ECtHR considered that as the applicant ‘in no way represented imminent danger to others or to his own life or limb’ and the only concern was a deterioration in his health, ‘this should have warranted a more cautious approach’ by the authorities, given that encroachment of the rights of psychiatric patients ‘can be justified only by “very weighty reasons”’ and they ‘should not lose sight of the importance of fully respecting the physical and personal integrity of such persons, in conformity with Article 8 of the [ECHR]’.¹¹⁰ The ECtHR

¹⁰⁵ *Stanev v Bulgaria* (2012) 55 EHRR 22 para 146 citing *Hutchison Reid v. the United Kingdom*, (2003) 37 EHRR 9 but note this latter case was distinguished in *Pleso v Hungary* (n 74) para 67.

¹⁰⁶ See the early case of *Guzzardi v Italy* (1981) 3 EHRR 333 para 98 in which the ECtHR explained that the inclusion of Article 5(1)(e) was because it allows the ‘socially maladjusted’ individuals falling within its provision, to be deprived of their liberty not only because they were ‘dangerous for public safety’ but also because ‘their own interests may necessitate their detention’.

¹⁰⁷ *Alajos Kiss v Hungary* (2013) 56 EHRR 36 para 42.

¹⁰⁸ *Zagidulina v Russia* (App 11737/06) 2 May 2013 [2015] MHLR 246 para 53, citing *Alajos Kiss v Hungary* (n 101). See also *MS v Croatia No 2* (App 75450/12) 19 February 2015, [2015] MHLR 226 para 147.

¹⁰⁹ *Pleso v Hungary* (n 74).

¹¹⁰ *Pleso v Hungary* (n 74) para 65. See also *Mihailovs v Latvia* (App. No. 35939/10) 22 January 2013, para 149.

considered the Government's arguments that the mental disorder was of 'a kind or degree warranting compulsory confinement' to be 'unconvincing'.¹¹¹ In the subsequent case of *Mihailovs v Latvia* (2013) the ECtHR noted that it has not been established that 'at the material time the applicant posed any danger to himself or to others'.¹¹²

At first sight, such comments by the ECtHR call into question the MHA 1983's compatibility with the ECHR given that it permits individuals to be detained in hospital where the person's mental disorder on health grounds alone. However, the factors that the MHA Code 2015 states should be considered when deciding whether a person needs to be detained are far more limited than simply 'health'. In relation to the evidence suggesting that the patient should be at risk, it includes, 'suicide', 'self-harm' and 'self-neglect'.¹¹³ It also sets out pointers to consider such as 'whether other methods of managing the risk are available'.¹¹⁴ Furthermore, as noted below, the Code emphasises that the MHA 1983 should only be used as last resort.¹¹⁵

2.2.2 Relevance of the views of the person being assessed

In both *Pleso* and *Mihailovs*, the ECtHR highlighted the relevance of the applicants' views when assessing whether the detention was justified by the severity of the mental disorder. In *Pleso* the ECtHR highlighted the importance of balancing the views of the person against what others considered best for that person's health.¹¹⁶ The issue in *Pleso* was 'whether the medical treatment would improve his condition or the absence of such treatment would lead to a deterioration in that condition' rather than whether 'there is imminent danger to the person's health'. The ECtHR considered that in such cases, it is for the authorities to strike a fair balance between the competing interests involved, namely 'society's responsibilities to secure the best possible health care for those with diminished faculties' set against 'the individual's inalienable right to self-determination (including the right to refusal of hospitalisation or medical treatment, that is, his or her "right to be ill")' – in other words 'it is imperative to apply to the principal of proportionality'.¹¹⁷ In *Mihailovs* the ECtHR examined whether consideration has been given to the applicant's willingness to 'submit to treatment voluntarily' or to consider

¹¹¹ *Pleso v Hungary* (n 74) para 66.

¹¹² *Mihailovs v Latvia* (n 110) para 149.

¹¹³ MHA Code (n 1) 14.9.

¹¹⁴ MHA Code (n 1) 14.9.

¹¹⁵ MHA Code (n 1) 1.2.

¹¹⁶ *Stanev v Bulgaria* (n 38) para 153.

¹¹⁷ *Pleso v Hungary* (n 74) para 66. At para 67 the ECtHR distinguished *Hutchinson Reid v the United Kingdom* (in which the applicant was considered to present a danger to others).

alternatives to admission such as out-patient treatment 'or to other less restrictive means of social assistance and care'.¹¹⁸

The relevance of the views of the individual is highlighted by the CoE Rec 2004 (10) (Article 17 stating that 'the opinion of the person concerned has been taken into account') and the Human Rights Committee (which states that the procedures for detention 'should ensure respect for the views of the individual'¹¹⁹). In a similar vein to the comments made by the ECtHR in *Pleso*, the Explanatory note to the CoE Rec 2004 (10) states that the emphasis on considering the person's opinion on the issues relevant to the placement is because the 'balance between respecting self-determination and the need to protect a person with mental disorder can be difficult'.¹²⁰

In relation to the decision to detain a person in hospital under the MHA 1983, although the Act itself makes no specific reference to the views of the person the MHA Code 2015 highlights the importance of doing so. The MHA 1983 provides that the doctors must personally examine the patient¹²¹ and the AMHP must interview the person 'in a suitable manner'.¹²² The Code's guidance on the role of the AMHP, emphasises the importance of taking steps to address any communication needs the person has¹²³ as well as ensuring that the person is supported by a friend or advocate if the person so wishes,¹²⁴ which is also highlighted in the Code's 'empowerment and involvement' principle.¹²⁵ It also advises those assessing whether detention under the MHA 1983 is required that consideration should be given to the person's 'wishes and views of their own needs' in all cases¹²⁶ and 'whether there might be other effective forms of care and treatment which the patient would be willing to accept'.¹²⁷ In relation to adolescents, the Code highlights the need to provide age-appropriate information¹²⁸ and that their 'views, wishes and feelings should always be sought, their views taken seriously'.¹²⁹

¹¹⁸ *Mihailovs v Latvia* (n 110) 149. In contrast, in *Sabeva v Bulgaria* (App No. 44290/07) 10 June 2010 para 59 the ECtHR noted that the medical experts had 'considered that, in view of the nature of her disorder, she would not submit to treatment voluntarily, whereas, failing treatment, her situation was likely to worsen'.

¹¹⁹ Human Rights Committee *General Comment No 35* (n 58) para 19.

¹²⁰ CoE Rec 2004 (10) (n 97) para 136.

¹²¹ MHA 1983 s 12(1). If possible one of them should have a previous acquaintance of the patient MHA 1983 s 12(2).

¹²² MHA 1983 s 13(2).

¹²³ The MHA Code 2015 para 14.42.

¹²⁴ MHA Code 2015 (n 1) para 14.53.

¹²⁵ MHA Code 2015 (n 1) para 1.8.

¹²⁶ MHA Code 2015 (n 1) para 14.8.

¹²⁷ MHA Code 2015 (n 1) para 14.7.

¹²⁸ MHA Code 2015 (n 1) para 19.5.

¹²⁹ MHA Code 2015 (n 1) para 19.5.

2.2.3 Alternatives to admission

The MHA 1983 accords with international and European human rights standards¹³⁰ in that, as noted in Part 1, its compulsory powers are regarded as a measure of last resort. Thus, the MHA assessors must consider the provision of services in the community as an alternative to admission to hospital (whether informal or under the MHA 1983), such as the provision of crisis services;¹³¹ the AMHP can only make the application if satisfied ‘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 stands in need’¹³² and the medical recommendations (on which the application for admission under the MHA 1983 is based) must state ‘why informal treatment is not appropriate’.¹³³ For section 3, the doctors must also ‘say whether other methods of treatment or care (e.g. out-patient treatment or social services) are available and, if so, why they are not appropriate’.¹³⁴

Nonetheless, a significant flaw in the principle that the MHA 1983 is only used as a last resort is that it is predicated on the availability of community-based alternatives to hospital admission. It is of limited practical value if there is an inadequate level of such services. That there are insufficient mental health services generally and children and young people’s mental health services, in particular, has been acknowledged by the government which has committed to providing additional investment of £1 billion a year by 2020/21 to improve mental health services.¹³⁵ An example of the current deficiencies in this area is that whereas the MHA Code 2015 emphasises the importance of crisis services in providing alternatives to admission to hospital,¹³⁶ *The Five Year Forward View for Mental Health* (‘the Forward View report’) states that less than half (48 per cent) of children and young people’s services have a crisis intervention team.¹³⁷ The CQC referred to the gaps in provision of children and adolescent mental health service

¹³⁰ See for example UNCRC art 37(b); CoE Rec (2004) 10 (n 10) art 17; Human Rights Committee *General Comment No 35* (n 58) para 19.

¹³¹ MHA Code 2015 (n 1) paras 14.7 and 14.11.

¹³² MHA 1983 s13(2).

¹³³ See Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 (SI 2008/1184) reg 4(1)(b)(ii) and Sch 1 (forms A3, A4, A7 and A8).

¹³⁴ SI 2008/1184 (n 127) reg 4(1)(b)(ii) and Sch 1 (forms A7 and A8). This reflects MHA 1983 s 3(3)(b) which requires the medical recommendations to specify ‘whether other methods of dealing with the patient are available and, if so, why they are not appropriate’.

¹³⁵ HM Government, *The Government response to the Five Year Forward View for Mental Health*, (Department of Health 2017) 1 – 2 and 5 - 6. See also NHS England *Next Steps on the NHS Five Year Forward View* (NHS England 2017) 26 – 26, which sets out plans for the increased mental health funding, which include ‘150-180 new CAMHS Tier 4 specialist inpatient beds’.

¹³⁶ MHA Code 2015 (n 1) para 14.34.

¹³⁷ Mental Health Task Force, *The Five Year Forward View for Mental Health* (NHS England 2016) 30. Recommendation 17 states that community-based mental health crisis response services should be in place by 2020/21.

(CAMHS) in its last two reports on monitoring the MHA 1983.¹³⁸ This is of particular concern given that for adolescents who self-harm, admission to hospital may make their condition worse.¹³⁹ The question whether the positive duties under Article 5¹⁴⁰ and/or Article 8 of the ECHR¹⁴¹ might give rise to an obligation to develop community-based services as an alternative to detention in hospital is an underdeveloped area for the ECtHR. This is an area in which the UNCRPD may be of influence in the future given that it includes an obligation on states to develop a range of community-based services that supports disabled people's social inclusion.¹⁴²

2.3 The Nearest Relative and Adolescent Psychiatric Care

One of the safeguards built into the MHA 1983 is the involvement of the person's 'nearest relative',¹⁴³ who has a significant role in the admission process under the MHA 1983. Where an adolescent is to be detained in hospital under section 2, the AMHP must inform the adolescent's nearest relative of this. In contrast, prior to making an application for the adolescent's detention under section 3, the AMHP must consult the nearest relative¹⁴⁴ and if the nearest relative objects the compulsory admission cannot go ahead unless the nearest relative is displaced by the court.¹⁴⁵ In addition to the right to object to a section 3 admission, the nearest relative can seek to discharge the adolescent from hospital¹⁴⁶ (albeit the adolescent's 'responsible clinician' can prevent this by issuing a 'barring certificate'¹⁴⁷) and unless the adolescent requests otherwise, has the right to be

¹³⁸ CQC 2014-15 (n 34) 50 and CQC 2015/16 (n 31) 29-30, referring to NHS England *Tier 4 2014 report* (n 28) and *Future in Mind* (n 12).

¹³⁹ CQC 2014/15 (n 34) 50.

¹⁴⁰ *Kolanis v the United Kingdom* (2005) raised the question of the State's responsibility to put in place arrangements that would ensure the applicant's discharge from hospital. The ECtHR held that there was "no question of interpreting Article 5 § 1 (e)...as imposing an absolute obligation on the authorities to ensure that the conditions are fulfilled". It declined to consider what level of obligation might arise in such circumstances [71]

¹⁴¹ In relation to positive duties on states to consider alternatives to the separation of families, see for example *Saviny v Ukraine* (2010) 51 EHRR 33 and *Kutzner v Germany* (App 46544/99) 26 February 2002 ECHR 2002-1.

¹⁴² See for example Council of Europe Commissioner for Human Rights *The right of people with disabilities to live independently and be included in the community – Issue Paper* Council of Europe (2012) and C Parker and L Clements, *The UN Convention on the Rights of Persons with Disabilities: A New Right to Independent Living?* [2008] EHRLR Issue 4, 508-523

¹⁴³ *TW v Enfield LBC* [2014] EWCA Civ 362, [2014] 1 WLR 3665 [49].

¹⁴⁴ MHA 1983 11(4).

¹⁴⁵ MHA 1983 s 29 MHA s29(3)(c).

¹⁴⁶ MHA 1983 s 23.

¹⁴⁷ MHA 1983 s 25(stating that if discharged the patient 'would be likely to act in a manner dangerous to other persons or himself'.

given information about the adolescent's rights, such as the right to apply to the Mental Health Tribunal to be discharged from detention.¹⁴⁸

It will be for the AMHP to identify the nearest relative, in accordance with the Act.¹⁴⁹ AMHPs will be familiar with the list of relatives set out under section 26(1) of the MHA 1983 and how to identify which of one these is the nearest relative (for example, in many cases the nearest relative will be the elder of the adolescent's parents, but this will depend on the adolescent's personal circumstances at the time detention under the MHA 1983 is being considered, such as whether the adolescent is married¹⁵⁰). Furthermore, if the parents are unmarried, the AMHP will need to verify that the father has acquired parental responsibility¹⁵¹ given that the unmarried father can only be considered as 'father' on the MHA 1983's list of relatives if he has parental responsibility.¹⁵²

Two other rules will be of relevance to adolescents. First, if the adolescent is subject to a care order, the nearest relative will be the local authority (who shares parental responsibility with the parents) unless the adolescent is married or in a civil partnership.¹⁵³ Second, under section 28 of the MHA 1983 individuals who have been appointed as a guardian,¹⁵⁴ or 'special guardians'¹⁵⁵ for the adolescent, or are named in a child arrangement order as the person(s) with whom the adolescent is living (previously known as a 'residence order'), that person or persons will be the adolescent's nearest relative.

An anomaly that perhaps has been created by the cross-over between the CA 1989 and the MHA 1983 is that whereas the effect of the provisions in section 26 of the MHA 1983 is that there can only be one nearest relative of the patient at any one time, under 28 of the MHA 1983 two or more people can be the nearest relative. For example, if the adolescent is living with his grandparents in accordance with a child arrangement order, both being named on the order as the people with whom he is living, both will be his

¹⁴⁸ MHA 1983 s 132(4).

¹⁴⁹ MHA Code (n 1).

¹⁵⁰ MHA Code s 26.

¹⁵¹ CA 1989 s2 and s 4. This can be achieved by either: registering the birth of their child with the mother (but this only applies from 1st December 2003 onwards); enter into a parental responsibility agreement; or by means of a court order.

¹⁵² MHA 1983 section 26(2). He could become the nearest relative by other routes, e.g. the person who is the nearest relative delegates the function to him.

¹⁵³ MHA 1983 s27.

¹⁵⁴ CA 1989 s 5.

¹⁵⁵ CA 1989 s 14A.

nearest relative. In contrast, where an adolescent is living with her parents, both of whom have parental responsibility, only one (the eldest of the two) will be the nearest relative.

In relation to the involvement of parents, by way of analogy it is noteworthy that in cases concerning the state's decision to remove children from the care of their families, the ECtHR has required that the decision to separate the family is 'based on sufficient evidentiary basis' and that the parents have 'had sufficient opportunity to participate in the procedure in question'.¹⁵⁶ Although the MHA 1983 makes no specific provision for the involvement of parents in either the procedures for the admission to hospital, or for compulsory treatment, this is covered by the MHA Code 2015. In relation to admission, the Code advises AMHPs that when assessing under 18s, they should consider consulting with the adolescent's parents, whether or not they are the nearest relative. In relation to decisions about the adolescent's care and treatment, the Code advises that (subject to confidentiality), parents should be consulted in planning of the adolescent's care.¹⁵⁷

2.4 Summary of Part 2

Although the *Winterwerp* criteria set a lower threshold for detention than other human rights standards, the ECtHR has increased its scrutiny of the decisions to detain, requiring 'weighty reasons' for the decision. In this regard, although the MHA 1983 sets a low threshold by including a health criterion in the grounds for detention under sections 2 and 3, the guidance in the MHA Code 2015 sets a much higher threshold. The factors it advises should be considered when deciding if detention is necessary refer to situations where there are serious concerns about the person's own health or safety. Similarly, while the Act says very little about the wishes of the person, the Code places great emphasis on seeking the person's views and taking them into account.

Three key areas of concern in relation to adolescent psychiatric care have been identified. First, although the MHA 1983 and the Code make clear that the detention under the Act should be a last resort, consideration of alternatives to detention is limited due to the lack of CAMHS community-based services, such as crisis services. Secondly, there is a potential confusion on identifying the nearest relative. Thirdly, there are doubts

¹⁵⁶ *Saviny v Ukraine* (2010) 51 EHRR 33 para 51. See also UNCRC art. 9(1) 'States Parties shall ensure that a child shall not be separated from his or her parents against their will...'; Article 9(2) '...all interested parties shall be given an opportunity to participate in the proceedings and make their views known'.

¹⁵⁷ MHA Code (n 1) 24.52 and 19.38.

as to whether in-patient psychiatric care is beneficial for some adolescents, for example, those who self-harm.

PART 3: PLACEMENT FOR PSYCHIATRIC CARE

Part 3 considers two areas of concern in relation to adolescents in relation to the location and type of placement for adolescents in need of psychiatric care, namely the circumstances in which adolescents are admitted to adult psychiatric wards and the 'out of area' placement of adolescents. It highlights the lack of clarity on the basis on which such decisions are made, the lack of involvement of adolescents in the decision-making process and the potential human rights infringements that arise as a result. Consideration is first given to the placement of adolescents onto adult psychiatric wards; secondly, out of area placements; and third, the human rights implications of such placements.

3.1 Admissions to adult wards and the age-appropriate environment duty

Section 131A of MHA 1983 (the 'age-appropriate environment duty'), provides that where an under 18 year old is admitted to hospital (whether or not detained under the MHA 1983) the managers of that hospital must 'ensure that the patient's environment in the hospital is suitable having regard to his age (subject to his needs)'.¹⁵⁸ Its purpose is to address the long-standing concerns about under 18s being placed on adult psychiatric wards,¹⁵⁹ the government having been persuaded by a strong lobby of groups with an interest in children's rights (with the close involvement of young people who had experience of being placed on adult wards) that such a statutory duty was necessary. The Office of the Children's Commissioner's report, *Pushed into the Shadows: young people's experiences of adult mental health facilities*,¹⁶⁰ gave an insight into its impact on children and young people, revealing 'the truly scandalous quality' of their treatment.¹⁶¹ For some under 18s, it was not simply that they were being cared for in an environment that was unsuitable, by staff lacking the requisite skills, they also felt

¹⁵⁸ MHA 1983 131A(2). The duties of the hospital managers are detailed in C Parker *A Briefing on the Responsibilities of NHS Trust Boards under Section 131A of the Mental Health Act 1983*, 131A of the Mental Health Act 1983, YoungMinds, 2010.

¹⁵⁹ Mental Health Bill, Minister for Health, Rosie Winterton, HC Deb 18 June 2007, vol 461 col 1144.

¹⁶⁰ Office of the Children's Commissioner, *Pushed into the Shadows: young people's experiences of adult mental health facilities*, 2007.

¹⁶¹ R Sandland 'Children, Mental Disorder, and the Law' in (Gostin L, Bartlett P, Fennell P, McHale J and MacKay R (eds)), *Principles of Mental Health Law and Policy* (OUP 2010) para 18.45.

extremely unsafe, for example because they were subject to verbal and/or sexual harassment by other patients and/or threatened and intimidated by staff.¹⁶²

3.1.1. Incidents of adolescent admissions to adult psychiatric wards

Admissions to adult wards are not prohibited outright. Although sporadic and inconsistent, the available information shows that under 18s continue to be admitted to adult wards.¹⁶³ For example information included in the Department of Health's report *Equality for all: Mental Health Act 1983: Code of Practice 2015: Equality Analysis* indicates that 178 under 18s were detained on adult psychiatric wards during the financial year 2013/14, and 183 in 2012/13.¹⁶⁴ However, it is not clear how many adolescents are admitted, for how long or for what reason.

The CQC was notified of 240 adolescents being placed on adult wards for the period 2015/16, as compared to 235, for the period 2014/15 and 193 for the period 2013/2014.¹⁶⁵ However, as emphasised by the CQC,¹⁶⁶ the requirement to notify the CQC is only triggered if an adolescent remains on an adult ward (whether or not they are detained under the MHA 1983) for more than 48 hours.¹⁶⁷ Therefore, the numbers of under 18s placed on adults wards are likely to be higher given that the CQC will not be told of those adolescents transferred from adult wards within the 48 hour period.¹⁶⁸

3.1.2 Circumstances giving rise to admissions to adult wards

Although the default position for under 18s is that they are admitted to a CAMHS in-patient facility,¹⁶⁹ the question of whether an adolescent can be admitted to an adult

¹⁶² *Pushed into the Shadows* (n 160) 66-73.

¹⁶³ Information is provided by NHS Digital in monthly bulletins in (Mental Health Services Monthly Statistics) in form of 'bed days': <<http://content.digital.nhs.uk/mentalhealth>>.

¹⁶⁴ Department of Health 2015, 68. The report states that this is the total number of under 18s detained under the MHA 1983 but the link to the reference cited is that of statistics collected from adult mental health services, thereby indicating that the numbers in fact refer to those under 18s detained under the MHA 1983 in adult mental health services. The collation of data on CAMHS only started in January 2016 – see <<http://content.digital.nhs.uk/mentalhealth>>. See also Health and Social Care Information Centre *Monthly MHMDS Report – A special feature on people under 18 admitted to adult mental health wards* (HSCIC March 2014) 4, which provided figures for the number of under 18 year olds admitted to adult wards in 2011/12 (357 16 or 17 years and 47 under 16s) and 2012/13 (219 16 or 17 year olds and 23 under 16s).

¹⁶⁵ CQC 2015/16 (n 31) 30.

¹⁶⁶ Care Quality Commission *Monitoring the Mental Health Act in 2013/14* (CQC 2013/14) 52.

¹⁶⁷ Care Quality Commission (Registration) Regulations 2009, SI 2009/3112 reg. 18(2)(h). The CQC would welcome a review on whether this notification requirement should be triggered in a shorter timeframe (CQC 2013/14 (n 166) 52.

¹⁶⁸ CQC 2013/14 (n 166) 52.

¹⁶⁹ A raft of measures and guidance were issued to support this objective. See National Mental Health Development Unit *Working Together to Provide Age-Appropriate Environments and Services for Mental Health Patients Aged under 18*, June 2009, Royal College of Psychiatrists CCQI, *Safe and Appropriate Care for Young People on Adult Mental Health Wards Pilot*

psychiatric ward turns upon the question of whether the in-patient environment is 'suitable having regard to his age (subject to his needs)'. This term is not defined in the MHA 1983. The MHA Code 2015 considers that such admissions will only be permissible in 'exceptional circumstances',¹⁷⁰ which it envisaged will fall into one of two categories.¹⁷¹ The first, is the 'atypical' case (thought likely to be rare) in which despite being under 18, the adult ward is considered more appropriate, such as the admission of a young mother to a mother and baby unit thereby allowing her child to remain with her.¹⁷² The second scenario covers emergency situations such as a crisis in which 'the first imperative is to ensure that the child or young person is in a safe place'.¹⁷³ Where such an admission is made, the reasons for this should be recorded, 'including an explanation as to why this is considered to be suitable having regard to their age and why other options were not available and/or suitable'.¹⁷⁴

The CQC's MHA 1983 monitoring report of 2013/14, refers to the types of reasons given for an adolescent's admission to an adult ward. These fell into two categories. The first category (admissions being 'clinically and socially the most appropriate environment') covered 'older adolescents presenting unacceptable levels of risk for CAMHS services'.¹⁷⁵ Such statements raise the question whether the reason for the admission to the adult ward falls within the case that the MHA Code 2015 warns against, namely that 'the needs of other children and young people should not override the need to provide accommodation in an environment that is suitable' for that patient.¹⁷⁶ The Code adds that 'the detrimental impact on other young persons is not an acceptable reason for

Programme Report, July 2009 and Royal College of Psychiatrists CCQI, Safe and Appropriate Care for Young People on Adult Mental Health Wards (AIMS-SC4Y) (2009).

¹⁷⁰ MHA Code 2015 (n 1) 19.94-19.95

¹⁷¹ CQC 2013/14 (n 166) 68 notes that in some parts of the country the age appropriate environment duty was interpreted to mean that a 'place of safety' connected to adult wards could not be used for those aged under 18, with the result that police stations were being used instead. The use of police cells for under 18s was also highlighted in the media – see N Beckford 'Hundreds of children "detained in police cells"' (BBC Radio 4, the World This Weekend 26 January 2014) < www.bbc.co.uk/news/uk-25900085>. This has now been addressed by the MHA Code 2015 (n 1) para 19.105 which states that the place of safety being attached to an adult ward does not preclude its use for under 18s and that the use of police stations should be not acceptable save for exceptional circumstances. This latter point has been reinforced by the Policing and Crime Act 2017 s 81(6) which will amend the MHA 1983. When in force, MHA s 136A will prohibit the use of police stations as a place of safety for under 18s.

¹⁷² MHA Code 2015 (n 1) para 19.100

¹⁷³ MHA Code 2015 (n 1) para 19.99

¹⁷⁴ MHA Code 2015 (n 1) para 19.96, which goes on to state: 'Details of whether action will be necessary to rectify the situation, and what action taken by whom, and when, should also be recorded.'

¹⁷⁵ CQC 2013/14 (n 166) 52 stated that they had been notified of 175 adolescents admitted to adult wards.

¹⁷⁶ MHA Code 2015 (n 1) para 19.102.

transferring a child or young person to an adult ward',¹⁷⁷ the implication being that other ways of addressing the risk need to be found. The reasons recorded under the CQC's second category (immediate admission being 'urgently need to protect the person or others, and there were no specialist resources available') included 'lack of beds on adolescent wards in an area' and 'emergency – not other service available'.¹⁷⁸

Whereas adolescents and generally their parents would have to be involved in decisions about their informal admission¹⁷⁹ to an adult ward, neither the MHA 1983, nor the MHA Code 2015, refer to the need to seek their views, nor to explain why such an admission is necessary if they are being detained under the MHA 1983.

3.2 Location: out of area placements

Another concern in relation to adolescent psychiatric care is that high numbers of children and young people are being have been placed in CAMHS units long-distances away from their families.¹⁸⁰ The numbers of under 18s affected is not clear. However, the Centre Forum Commission on Children and Young People's Mental Health notes that freedom of information requests have shown that 'of 18 trusts that provided out-of-area placement data, 10 had sent children more than 150 miles away for care. The furthest distance was from Sussex to Bury, Greater Manchester, a distance of 275 miles'. The report also states (on the basis of a Minister's answer to a parliamentary question) that 'nearly 1000 under 18s (979) were treated outside of their own local NHS area in 2014/15'.¹⁸¹

Save for section 140 of the MHA 1983 which places a duty on clinical commissioning groups to provide details of hospitals in their area that provide for under 18s (so in reality requires a list of such hospitals), the MHA 1983 says nothing about the location of the hospital in which the person is to be detained. The MHA Code 2015 states that the hospital setting should be 'as close as reasonably possible' to the patient's home or family member or carer, if that is what the person wishes¹⁸² and that the reasons for the

¹⁷⁷ MHA Code 2015 (n 1) 19.102

¹⁷⁸ CQC 2013/14 (n 166) 52.

¹⁷⁹ MHA 1983 s 131.

¹⁸⁰ S Marsh and D Campbell 'NHS England Sending Anorexic Patients to Scotland for Treatment' 11 December 2016 <www.theguardian.com/society/2016/dec/11/nhs-england-anorexic-patients-scotland-mental-health> accessed 11 August 2017; E Forde 'We've travelled 8,000 miles to see our anorexic daughter' 27 November 2016 <www.bbc.co.uk/news/health-38121799> accessed 11 August 2017.

¹⁸¹ E Frith *Centre Forum Commission on Children and Young People's Mental Health: State of the Nation* (Centre Forum 2016) 24.

¹⁸² MHA Code 2015 (n 1) paras 1.4 and 14.81.

location of the placement 'should be monitored and reviewed regularly'.¹⁸³ The MHA Code 2015 provides no specific guidance on how these decisions are made, save that it states that local policies should be in place for 'the safe and appropriate admission of people in their local area'¹⁸⁴ and that "[c]ommissioners should have in place a policy so that the patient and/or the patient's carers are able to challenge a decision" concerning the location of the hospital to which the patient is admitted.¹⁸⁵

3.3 Human Rights Implications of Placements for Adolescent Psychiatric Care

As noted above, *Pushed into the Shadows* raised concerns that adolescents are at risk of serious human rights violations if placed on adult psychiatric wards.¹⁸⁶ However, even if no such concerns arise during an adolescent's confinement there, the decision to admit an adolescent to an adult psychiatric ward requires consideration of the human rights implications. So too does the decision to place an adolescent in a CAMHS in-patient unit that is a long distance from the adolescent's home. In its report of June 2016, the CRC noted that adolescents are 'often treated far away from home...do not receive adequate child-specific attention and support, are placed in adult facilities...'.¹⁸⁷ Two areas in which human rights standards are of particular relevance are considered below.

First, the decision to admit an adolescent to a psychiatric unit will engage rights that seek to protect family life. Articles 9(1) of the UNCRC and Article 23(4) of the UNCRPD both provide that parents and their children should not be separated against their will 'except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such a separation is necessary for the best interests of the child'. The CRPD adds that '[i]n no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents'. Such decisions will also engage Article 8 of the ECHR, so the placement will need to be justified under Article 8(2). In relation to out of area placements, the long distance between adolescents and their homes will restrict their contact with family and friends (with their family's Article

¹⁸³ MHA Code 2015 (n 1) para 14.81.

¹⁸⁴ MHA Code 2015 (n 1) para 14.80.

¹⁸⁵ MHA Code 2015 (n 1) para 14. 84.

¹⁸⁶ *Pushed into the Shadows* (n 160). Sandland (n 161) points to a range of rights under the UNCRC that are likely to be relevant (paras 18.45 –18.46) and also observes (at para 18.46) that the case histories outlined in *Pushed into the Shadows* suggest that 'situations which could give rise to breaches of Articles 3 and 8 of the [ECHR] may not be uncommon'.

¹⁸⁷ CRC Advanced unedited version Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland CRC/C/GBR/CO/5 2016 para 59(c). See also CRC Concluding observations of United Kingdom of Great Britain and Northern Ireland CRC/C/GBR/CO/4 2008, para 56 in which the CRC raised concerns that 'children may still be treated in adult psychiatric wards'.

8 rights also being engaged). Although the Prime Minister has committed to ensuring 'no child will be sent away from their local area to be treated for a general mental condition' the target date for this goal is 2021.¹⁸⁸

The question whether the adolescent's placement is justified under Article 8(2) will depend upon the facts of the case. By analogy with the approach the ECtHR has taken in respect of complaints by parents whose children have been taken into state custody, the question whether the placement amounts to a breach of Article 8 is likely to include consideration of whether the measures taken to implement the decision are 'supported by "sufficient" reasons justifying them as proportionate to the legitimate aim pursued'.¹⁸⁹ For placements on adult psychiatric wards, a relevant consideration might be whether the placement falls within the exceptional circumstances outlined by the MHA Code 2015 noted above. The age of the adolescent may also be relevant given the Government's policy that under 16s should not be admitted to an adult ward.¹⁹⁰ However, it should be noted that in general, the ECtHR is reluctant to require States to provide a certain level, or specific type, of services or support and considers that States should be given a wide margin of appreciation in deciding how limited public resources are to be allocated 'in issues of general policy, including social, economic and health-care policies'.¹⁹¹

Secondly, Article 5 of the ECHR may also be relevant given that the age appropriate environment duty is underpinned by Article 37(c) of the UNCRC which states that 'every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so'. Although the ECtHR considers that Article 5 is not 'concerned with suitable treatment or conditions',¹⁹² it might accept that concerns about an adolescent's detention on an adult psychiatric ward falls within the remit of Article 5(1)(e) given its decision in *Nart v Turkey* (2008).¹⁹³ In that case, having referred to Article 37(c) of the UNCRC, the ECtHR held that a 17 year old's remand in a prison for adults amounted to a breach of Article 5(3).¹⁹⁴

¹⁸⁸ Included in Theresa May PM's speech 'The Shared Society' delivered 9th January 2017 <www.gov.uk/government/speeches/the-shared-society-prime-ministers-speech-at-the-charity-commission-annual-meeting> accessed 11 August 2017.

¹⁸⁹ *Olsson v Sweden* (App 10465/83) 24 March 1988, para 83.

¹⁹⁰ MHA Code 2015 (n 1) para 19.97.

¹⁹¹ *McDonald v UK* (2015) 60 EHRR 1, para 54.

¹⁹² *Ashingdane v the United Kingdom* Application (1985) 5 EHRR 528 para. 44; *Stanev v Bulgaria* (2012) 55 EHRR 22 para. 147; *Aerts v Belgium* (2000) 29 EHRR 50 para. 46

¹⁹³ (App 20817/07) 6 May 2008 para 31.

¹⁹⁴ ECHR art 5(3) concerns the rights of individuals subject to pre-trial detention.

3.4 Summary of Part 3

Despite the introduction of section 131A (the age appropriate environment duty), adolescents continue to be placed on adult psychiatric wards. It is not clear to what extent adolescents are consulted about such admissions. Albeit such matters are untested thus far, the decision to place adolescents on adult wards may give rise to infringements of their rights under Articles 5 and 8 of the ECHR. There are no statutory provisions concerning out of area placements, while the MHA Code 2015 gives little guidance on this area. Out of area placements may give rise to infringements of adolescents' rights under Article 8 of the ECHR as well as rights under the UNCRC and UNCRPD that seek to protect families from being separated arbitrarily. In relation to both types of placement there is little or no information on how many adolescents are affected, how long the placements last, or why they were necessary.

PART 4 TREATMENT IN HOSPITAL UNDER THE MENTAL HEALTH ACT 1983

Adolescents admitted to hospital under sections 2 and 3 of the MHA 1983 can be treated for mental disorder without their consent in accordance with Part IV of the MHA 1983. In theory, the provisions under Part IV set out a range of safeguards that are commensurate with the invasiveness of the treatment proposed,¹⁹⁵ but in practice invasive treatments can be given under section 63 (treatment not requiring consent), which requires none of the safeguards provided for in sections 58 (treatment requiring consent or a second opinion) or 58A (the administration of electro-convulsive therapy (ECT)).¹⁹⁶ Section 57, which covers treatments such as psychosurgery is not considered in the discussions below since such treatments cannot be given without the person's consent and are rarely proposed, even for adults.¹⁹⁷

¹⁹⁵ *R (Wilkinson) v Broadmoor Hospital Authority* [2001] EWCA Civ 1545; [2002] 1 WLR 419 [9] (Simon Brown LJ).

¹⁹⁶ MHA 1983 s 57, which covers treatments such as psychosurgery and applies to all patients, whether or not detained under the MHA 1983, can only be given with the person's consent. MHA 1983 s 62 (urgent treatment) provides for the circumstances in which the procedures set out in sections 57, 58 and 58A do not apply.

¹⁹⁷ CQC 2015/16 (n 31) 47 notes that in 2015/16 four proposals for treatments under s 57 were considered and agreed.

Save where ECT is proposed (which on the information available is rare for this age group¹⁹⁸) there are no specific provisions for the treatment of children and young people.¹⁹⁹ Adolescents, like adult patients, can seek the assistance of an Independent Mental Health Advocate (IMHA) in relation to their treatment under the MHA 1983, but neither the IMHA, nor the adolescent's parent or nearest relative has a statutory role in the process of determining whether the treatment should be given. However, the MHA Code 2015 emphasises that parents should be involved.²⁰⁰

The discussion is divided into three main parts. First, the provisions under Part IV of the MHA 1983 that are relevant to the non-consensual psychiatric treatment of adolescents are outlined. Secondly, general concerns in relation to these compulsory treatment provisions are highlighted, and thirdly, two points specific to adolescents are raised.

4.1 Treatment without consent under the MHA 1983: Overview

The following five areas are considered: a) sections 63, 58 and 58A; b) the role of the SOAD; c) questions about the efficacy of the SOAD safeguard; d) the relevance of decisional capacity; and e) MHA Code 2015 and the ECHR.

4.1.1 Treatment for mental disorder: sections 63, 58 and 58A

Like adults, provided that the treatment 'is given by, or under the direction of the approved clinician in charge of the treatment', adolescents detained under the MHA 1983 can be given a range of treatments under section 63, without their consent and irrespective of their decisional capacity. It states:

The consent of a patient shall not be required for any medical treatment given to him for mental disorder from which he suffering, not being a form of treatment to which section 57, 58 or 58A applies if the treatment is given by or under the direction of the approved clinician in charge of the treatment.

¹⁹⁸ Care Quality Commission *Monitoring the Mental Health Act in 2009/10* (CQC 2009/10), 90 notes that of the two requests for authorisation by a SOAD of ECT for an under 18 year old, only one was granted. CQC 2015/16 (n 31) notes that only two requests for authorisation were received, 30.

¹⁹⁹ Although Part 4A includes specific provisions for under 16s who are subject to community treatment orders (CTOs).

²⁰⁰ MHA Code 2015 (n 1) paras 19.6, 19.21 and 24.52.

Whereas section 63's purpose was intended to authorise 'perfectly routine, sensible treatment',²⁰¹ given that the definition of 'medical treatment', includes 'medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations', its scope is far wider than this. It permits treatments ranging from treatment for 'wounds self-inflicted as part of, or ancillary to mental disorder',²⁰² to naso-gastric tube feeding.²⁰³

Furthermore, for an initial period of three months,²⁰⁴ section 63 authorises the administration of psychiatric medication. Save where urgent treatment is required,²⁰⁵ section 58 applies to the administration of psychiatric medication beyond this period, so that if an adolescent is not willing, or is unable, to give consent to such medication, the treatment cannot be given unless it is authorised by an independent doctor ('second opinion appointed doctor' (SOAD)).²⁰⁶ There is no 'three month' rule for the administration of ECT. This is governed by section 58A, which is discussed below.

4.1.2. *The Role of the SOAD*

The SOAD must certify, in writing, first, that the adolescent is either 'not capable of understanding the nature, purpose and likely effects' of the proposed treatment or 'being so capable has not consented to it'; and second, 'that it is appropriate for the treatment to be given'. In the rare cases in which ECT is proposed for an adolescent, section 58A will apply, which provides that (save where urgent treatment is required²⁰⁷) such treatment cannot be given to patients who are 'capable of understanding the nature, purpose and likely effects of the treatment' unless they consent to it. Patients who are not so capable, cannot be given ECT unless a SOAD has certified in writing that 'it is appropriate for the treatment to be given'.²⁰⁸ In relation to under 18s, the Act provides that a SOAD must authorise its administration, whether or not they are detained under the MHA 1983 and even if they are able and willing to consent.²⁰⁹

²⁰¹ Lord Elton Hansard HL vol 426, col 107, cited in Jones (n 93) 370, 1-795.

²⁰² MHA Code 2015 (n 1) para 24.5.

²⁰³ *B v Croydon Health Authority* [1995] Fam 133; [1995] 1 All ER 683.

²⁰⁴ This starts to run from the date on which the patient first received the treatment under the Act.

²⁰⁵ MHA 1983 s 62.

²⁰⁶ The role of the SOAD is explained in MHA Code 2015 (n 1) chp 25.

²⁰⁷ MHA 1983 s 62.

²⁰⁸ The only aspect of MHA 1983 s 58A(5)(c) that is relevant to an adolescent is if a deputy appointed by the Court of Protection to act on behalf of the adolescent in accordance with the MCA 2005 has the authority to do so, and does, object to ECT being given.

²⁰⁹ MHA 1983 s 58A(4).

4.1.3 Questions about the efficacy of the SOAD safeguard

While the MHA Code 2015 describes the SOAD's role as providing 'an additional safeguard to protect the patient's rights, primarily by deciding whether certain treatments are appropriate',²¹⁰ commentators have raised significant concerns about the efficacy of this 'statutory watchdog' function²¹¹ in achieving this objective.²¹² While two procedural improvements to the SOAD procedure have been introduced in the light of case-law (now reflected in the MHA Code 2015, in that SOADs are required to 'reach their own judgement about whether the proposed treatment is appropriate'²¹³ and give written reasons for their decision²¹⁴) significant shortcomings in the SOAD procedure remain.

One major concern is that this safeguard is not engaged in relation to medication during the initial three-month period. Since 'most detentions last less than three months'²¹⁵ it may be concluded that this important safeguard does not apply to the majority of detained patients who are given medication without their consent. Another is that the engagement of a SOAD is dependent on the recognition that the patient is not able or willing to agree to the treatment. In this regard, the CQC has expressed concerns that the SOAD system is undermined by the failure of clinicians to recognise that the patient is not giving consent, or lacks the decisional capacity to do so.²¹⁶

4.1.4 The Relevance of decisional capacity

Although the wording of sections 58 and 58A differ from them, the MHA Code 2015 and the CQC advise that the usual tests for assessing the patient's decisional capacity (incapacity under sections 2 and 3 MCA 2005 for 16 and over and 'Gillick competence' for under 16s) should be applied. Support for this approach can be found in judicial comments in the post-HRA cases, which implied that the then common law test for mental capacity was a more apt test.²¹⁷

²¹⁰ MHA Code 2015 (n 1) para 25.60.

²¹¹ *R (Wilkinson) v Broadmoor Hospital Authority* [2001] EWCA Civ 1545; [2002] 1 WLR 419 [60] (Hale LJ).

²¹² Bartlett and Sandland (n 3) 411. The authors provide a detailed analysis of the provisions of Part IV generally (see 409 – 431). See also P Fennell, *Treatment without Consent, Law, Psychiatry and the Treatment of the Mentally Ill since 1845*, (Routledge 1996) chp 12.

²¹³ MHA Code 2015 (n 1) para 25.60 reflecting *R (B) v S (Responsible Medical Officer, Broadmoor Hospital)* [2006] EWCA Civ 28, [2006] 1 WLR 810 [68].

²¹⁴ MHA Code 2015 paras 25.63 – 25.66 reflecting the decision in *R (Wooder) v Feggetter* 2002 EWCA Civ 554 (Fam), [2003] QB 219, 3 WLR 591 [25] and [32] – [33].

²¹⁵ Jones (n 87) 345 (1-745). See also Bartlett and Sandland (n 3) 411.

²¹⁶ Care Quality Commission *Monitoring the Mental Health Act in 2012/13* (CQC 2012/13), 59.

²¹⁷ *Wilkinson* (n 211) [66] Hale LJ (as she then was) remarked that the common law test for capacity 'would be equally suitable for assessing capacity for the purpose of section 58(3)(b) of the Mental Health Act'. Hale LJ's comments were referred to in *R (B) v S* (n 207) by Phillips LCJ

That the MHA 1983 permits the treatment of individuals irrespective of their decisional capacity was one of the issues raised in the spate of cases taken soon after the introduction of the HRA 1998 ('the post-HRA cases') which sought (unsuccessfully) to challenge the compulsory treatment provisions under the MHA 1983.²¹⁸ Despite acknowledging that compulsory treatment under the MHA is capable of interfering with the individual's ECHR rights, in particular Article 8 and Article 3, the proposition that 'detained patients who have the capacity to decide for themselves can never be treated against their will' was rejected by the courts.²¹⁹

While acknowledging that the 'indications that the issue of capacity is assuming greater importance in the context of psychiatric treatment', in the 2001 case of *R (Wilkinson) v Broadmoor Hospital*, Hale LJ (as she then was) was of the view that the point at which the 'accepted norm' was that detained patients with decisional capacity 'can only be treated against their will for the protection of others or for their own safety' had not been reached.²²⁰ Citing her comments, in the 2006 case of *R (B) v S (Responsible Medical Officer, Broadmoor Hospital) (R(B) v S)*,²²¹ Lord Phillips CJ, took the view that irrespective of the approach taken in other human rights standards, the court's concern was whether the MHA 1983 was compatible with the ECHR. The court concluded that no such incompatibility arose given that in *Nevmerzhitsky v Ukraine*²²² the ECtHR had been referred to international materials that advocated this position, and it had rejected the argument that those with capacity could not be subject to compulsory treatment.²²³ A capacitous refusal is however an important factor to be taken into account when deciding whether compulsory treatment is justified.²²⁴

at [33] when he questioned whether the words of MHA 1983 s 58(3)(b) 'go far enough to define capacity.

²¹⁸ Thus far challenges that the MHA 1983 represents a breach of individuals' rights under ECHR art. 8 ECHR together with ECHR art 14 on the basis that it allows their capacitous refusal to be overridden on grounds of mental disorder have not been successful. See for example *R (B) v Dr SS* [2005] EWHC 86 (Admin) [190] – [217] (Silber J). See comment on ECHR art 14 and treatment without consent the MHA 1983 Part IV see Bartlett and Sandland (n 3) 418.

²¹⁹ *Wilkinson* (n 211) [80] (Hale LJ). See also *R (B) v S* *R (B) v S* (n 207) [58]; *R (B) v Haddock* [2006] EWCA Civ 961, (2007) BMLR 52, [2006] MHLR 306 [12] and *R (B) v S* [2005] EWHC 86 (Admin) [148]- [189] (Silber J). Whereas in *Wilkinson* (n 205) Simon Brown LJ (at [30]) stated that if 'this claimant has capacity to refuse consent to the treatment proposed here, it is difficult to suppose that he should nevertheless be forcibly subjected to it', Silber J (at [27]) in *R (B) v S* [2005] EWHC 86 (Admin) considered that the Lord Justice's observation was directed to the specific facts of the case.

²²⁰ *Wilkinson* (n 211) [80] (Hale LJ).

²²¹ *R (B) v S* (n 213) [52] – [56].

²²² *Nevmerzhitsky v Ukraine* (2006) 43 EHRR 32.

²²³ *R (B) v S* (n 213) [58].

²²⁴ In *R (B) v S* [2005] EWCA 86 (Admin) Silber J considered (at [189]) 'the refusal of a capable patient is a very important consideration'. It should be noted however that the national courts have recognised that the views of the patient are important even if they lack capacity to decide

4.1.5 The MHA Code 2015 and the ECHR

The national courts' response to the post-HRA cases along with the unsuccessful challenge to the treatment provisions of the MHA 1983 before the ECtHR,²²⁵ may explain the MHA Code 2015's advice to clinicians on their duties to comply with the HRA 1998. Highlighting Articles 8 and 3 of the ECHR as being of particular relevance to compulsory treatment,²²⁶ it states that '[s]crupulous adherence to the requirements of the legislation and good clinical practice should ensure that there is no such incompatibility'.²²⁷ However, given the developments in human rights law since the post-HRA cases, the MHA Code 2015 assertion that the MHA 1983's compulsory treatment provisions are compatible with the ECHR is questionable. As Bartlett and Sandland observe, whereas in the past its jurisprudence in this area has been of 'minimal assistance', the ECtHR is beginning to take such matters more seriously.²²⁸

4.2 Treatment without consent under the MHA 1983: Human Rights Implications

The following points are considered: a) low threshold for compulsory treatment; b) increased scrutiny of the ECtHR; c) procedural requirements under the ECtHR; and d) relevance of the views of the detained patient.

4.2.1 Low threshold for compulsory treatment

The threshold for compulsory treatment to be justified under sections 63, 58 and 58A is low. Save that clinicians must abide by their 'ordinary duties of care',²²⁹ and the purpose of the treatment must be to 'alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations',²³⁰ section 63 requires only that the treatment is 'given by, or under the direction of' the 'approved clinician in charge of the treatment'.

For treatments under sections 58 and 58A, the SOAD must consider that 'it is appropriate for the treatment to be given'. The MHA Code 2015 sets out a range of factors that the SOAD should consider, which include the patient's objection, appropriateness of alternative forms of treatment and to 'balance the potential therapeutic efficacy of the

about their medical treatment. See *R (B) v Dr SS* [2005] EWHC 1936 (Admin) [2005] MHLR 347 [94] – [102]; *R (B) v S* (n 213) [50] and *Wilkinson* (n 211) [64] (Hale LJ).

²²⁵ *Wilkinson v the United Kingdom* (App 14659/02) 28 February 2006. The applicant's complaint was accordingly found to be manifestly unfounded.

²²⁶ MHA Code 2015 (n 1) para 24.42.

²²⁷ MHA Code 2015 (n 1) para 24.44. No reference is made to ECHR art. 14.

²²⁸ Bartlett and Sandland (n 3) 417.

²²⁹ *Wilkinson* (n 211) [68] (Hale LJ).

²³⁰ MHA 1983 s145(4).

proposed side effects and any other potential disadvantage to the patient'.²³¹ These points resonate with the points made in the post-HRA case of *(R(B) v S)*,²³² when considering the pre-MHA 2007 requirements on the SOAD to consider whether the treatment should be given 'having regard to the likelihood of its alleviating or preventing a deterioration of [the patient's] condition'.²³³ The Court of Appeal highlighted the need for the SOAD to consider 'whether an alternative and less invasive treatment will achieve the same result' and '[t]he distress that will be caused to the patient if the treatment has to be imposed by force' (commenting that it could not see how a SOAD could authorise the treatment 'unless satisfied that the treatment is the best interests of the patient').²³⁴

Although more restrictive than the powers under section 63, the circumstances in which compulsory treatment is permitted under sections 58 and 58A, are still wider than relevant human rights standards. First, both Council of Europe (CoE) and UN human rights standards that permit compulsory treatment do so in more limited circumstances than the MHA 1983. Within the CoE, standards relating to psychiatric facilities of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment ('the CPT Standards) provide that even where individuals are detained in psychiatric institutions, this 'should not be construed as authorising treatment without his consent'; that 'every competent patient, whether voluntary or involuntary should be given the opportunity to refuse treatment, or other medical intervention' and '[a]ny derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances'.²³⁵

No information is provided on the anticipated nature of the exceptional circumstances, but this raises the question whether the requirement under sections 58 and 58A of the MHA 1983 that it is 'appropriate for the treatment to be given' is sufficient, let alone the open-ended section 63 of the MHA 1983, which simply requires the treatment to be given under the direction of the approved clinician. Noting that for the first three months psychiatric medication can be given without the patient's consent, the MHA Code 2015 states that during the time 'the patient's consent should still be sought' for such medication 'wherever practicable' and if the patient has capacity to consent but does not

²³¹ MHA Code 2015 (n 1) para 25.62.

²³² *R (B) v S* (n 213).

²³³ MHA 1983 s 58(3)(b) (prior to its amendment by MHA 2007).

²³⁴ *R (B) v S* (n 213) [62]

²³⁵ European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT Standards) *Involuntary placement in psychiatric establishments (extract from the 8th General Report of the CPT published in 1998 CPT/Inf(98)12-part ('the CPT Standards'))* para 41.

do so, clinicians ‘must consider carefully whether to proceed in the absence of consent, to give alternative treatment or stop treatment’.²³⁶ However, as noted below, the CQC has highlighted concerns as to whether this guidance is being followed in practice.

Furthermore, Article 18 of the CoE Rec (2004) 10 restricts involuntary treatment to cases where individuals have a mental disorder and their condition ‘represents a significant risk of serious harm’ to their health or to other persons; that ‘no less intrusive means of providing appropriate care are available’ and ‘the opinion of the person concerned has been taken into consideration’. The CoE *Convention on Human Rights and Biomedicine* also states that individuals who have a mental disorder of a ‘serious nature’ can be treated without their consent only where, without such treatment, serious harm is likely to result to his or her health.²³⁷ At the UN level, the Subcommittee on Prevention of Torture limits treatment without consent to circumstances in which the person lacks decisional capacity,²³⁸ stating that the measure ‘must be a last resort to avoid irreparable damage to the life, integrity of health of the person concerned’ and subject to procedural safeguards.

The MHA Code 2015 reminds clinicians that when they are authorising or administering treatment without consent under the MHA 1983 they must do so in compliance with the HRA 1998. The Code refers to two ECHR rights. In relation to Article 8, it notes that this is likely to be engaged but its interference will be justified if it is given in compliance with the procedures under the Act and is proportionate to the legitimate aim of ‘the reduction of the risk posed by a person’s mental disorder and the improvement of their health’.²³⁹ In relation to Article 3, the Code notes that compulsory treatment is capable of being inhuman treatment or torture, but that ‘a measure which is convincingly shown to be of medical necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman or degrading’.²⁴⁰ For the reasons noted below, the compatibility of section 63 with Article 8 ECHR is questionable.

²³⁶ MHA Code 2015 (n 1) para 24.41

²³⁷ Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (ETS No. 164) art 7.

²³⁸ *Approach of the Subcommittee* (n 58). Para 14 sets out the points to be considered when deciding if a person is not able to consent to the proposed treatment.

²³⁹ MHA Code 2015 (n 1) para 24.43.

²⁴⁰ MHA Code 2015 (n 1) para 24.43.

4.2.2 Increased scrutiny of the ECtHR

When examining complaints concerning non-consensual interventions, the ECtHR has intensified its scrutiny of the purported justification for such action. This is marked in relation to its approach to assessing whether complaints about compulsory treatment amount to a human and degrading treatment under Article 3 even though its starting point is still the much criticised,²⁴¹ but ‘fundamental Strasbourg case on psychiatric treatment’,²⁴² *Herczegfalvy v Austria* (1992).²⁴³ In that case the ECtHR rejected the applicant’s complaint that his psychiatric treatment (“forcibly administered food and neuroleptics, isolated and attached with handcuffs to a security bed”) amounted to a violation of Article 3 because there was insufficient evidence “to disprove the Government’s argument that according to the psychiatric principles generally accepted at the time, medical necessity justified the treatment in issue”.²⁴⁴

The ECtHR now adopts a more exacting approach,²⁴⁵ as illustrated by its decision in *MS v Croatia* (No 2) (2015).²⁴⁶ It upheld the applicant’s complaint that the physical restraints she was subjected to during her compulsory admission to a psychiatric hospital amounted to a violation of Article 3 because the government had failed to show that the use of such restraints was ‘necessary and proportionate in the circumstances’.²⁴⁷

While maintaining its view that ‘as a general rule, a measure which is of therapeutic necessity cannot be regarded as inhuman or degrading’ the ECtHR emphasised that ‘the assessment of whether involuntary treatment of patients with disabilities in the hospital setting was justified needed to be examined against the question of medical necessity, which must convincingly be shown to exist’. Significantly, it added ‘...taking into account

²⁴¹ Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (n 51) para 35: ‘The doctrine of medical necessity continues to be an obstacle to protection from arbitrary abuses in health-care settings’.

²⁴² P Bartlett ‘The Necessity Must Be Convincingly Shown to Exist’: Standards for Compulsory Treatment for Mental Disorder under the Mental Health Act 1983’ (2011) *Med LR* 19(4) 514, 524.

²⁴³ (1993) 14 EHRR 437. As P Bartlett notes in ‘A Matter of Necessity? Enforced Treatment under the Mental Health Act’ (2007) *Med LRev* 15(1) 86, 94, this case was decided in 1992 and therefore pre-dates the CPT Standards noted above (n 230).

²⁴⁴ *Herczegfalvy* (n 243) para 83. Although the ECtHR considered that some of the applicant’s allegations were not supported by the evidence, the Austrian government accepted that ‘staff had used coercive measures including the intramuscular injection of sedatives and the use of handcuffs and the security bed’ (see para. 81).

²⁴⁵ See also *Bureš v the Czech Republic* (App 37679/08) 18 October 2012 [2013] MHLR 126; *Nevmerzhitsky v Ukraine* (2006) 43 EHRR 32 para 94; *Fyodorov and Fyodorova v. Ukraine* (App 39229/03) 7 July 2011, para. 62; *Gorobet v Moldova* (App 30951/10) 11 October 2011, para 51.

²⁴⁶ (App 75450/12) 19 February 2015, [2015] MHLR 226.

²⁴⁷ *MS v Croatia No 2* (n 108) para 110.

the current legal and medical standards on the issue'.²⁴⁸ The ECtHR then referred to a range of human rights standards and reports (including the UN Mental Illness Principles, the CoE Rec (20014)10, the CPT report of its visit to Croatia (which *inter alia* referred to restraint being used as a last resort) and the report of the Special Rapporteur on Torture).²⁴⁹ In the ECtHR's view 'the developments in contemporary legal standards on seclusion and other forms of coercive and non-consensual measures' in relation to individuals with mental disorders who are deprived of their liberty 'require that such measures be employed as a matter of last resort and when their application is the only means available to prevent immediate or imminent harm to the patient or others'.²⁵⁰ Furthermore, there must be adequate safeguards from abuse that demonstrate that the measures are necessary and proportionate, 'that all other reasonable options failed to satisfactorily contain the risk of harm to the patient or others' and the measures were used for no longer than strictly necessary'.²⁵¹

One of the outcomes of the post-HRA cases is that the *Herczegfalvy* test of 'medical necessity' (also described as 'therapeutically necessary') is considered to be relevant to assessing whether the use of compulsory powers comply with Article 8(2) ECHR.²⁵² Fennell explains this connection when he observes that such medical interventions 'must be in accordance with law and *therapeutically necessary* in a democratic society (i.e. proportionate) for protection of public safety, prevention of disorder and crime, the protection of health or the rights and freedoms of others'.²⁵³ Thus, while compulsory treatment is justified under the MHA 1983 'because it is necessary for the health or safety of the patient, or for the protection of others',²⁵⁴ it must also comply with the ECHR's standard as to whether it is a proportionate response. The evaluation of such a response will require an assessment of the medical necessity test in the light of the ECtHR's

²⁴⁸ *MS v Croatia No 2* (n 108) para 103.

²⁴⁹ *MS v Croatia No 2* (n 108) para 104, referring to para 36.

²⁵⁰ *MS v Croatia No 2* (n 108) para 104.

²⁵¹ *MS v Croatia No 2* (n 108) para 105.

²⁵² *R (B) v Haddock* [2006] EWCA Civ 961 (2007) 93 BMLR 52, [2006] MHLR 306 [12]. In relation to ECHR art 3, the courts have tended to proceed on the basis that the imposition of treatment without consent was of a sufficient level of severity to engage Article 3 ECHR; see for example, *R(N) v M* [2002] EWCA Civ 1789, 1 WLR 562 [15] and *R (B) v Dr SS 2005* EWHC 1936 [61]. For a discussion of the '*Herczegfalvy* test' see *Haddock* [29] – [49], in particular [39] in which Auld LJ states that the requirement is 'for the court to be satisfied that medical necessity has been established'. See also N Munro 'Treatment in Hospital' in L Gostin, P Bartlett, P Fennell, J McHale and R MacKay (eds), *Principles of Mental Health Law and Policy* (OUP 2010) paras 13.64 – 13.65 and Bartlett 'The Necessity Must be Convincingly Shown to Exist' (n 238).

²⁵³ Fennell (n 3) para 10.12.

²⁵⁴ *R (B) v S* (n 213) [43]

contemporary interpretation, which as illustrated below is no longer as deferential to medical opinion as it (or the national courts) have been in the past.

4.2.3 Procedural Requirements under the ECtHR

Given the ECtHR's decision in *X v Finland*²⁵⁵, the absence of any independent review of the clinician's decision to treat under section 63 appears to be incompatible with the requirements of Article 8 of the ECHR. As noted in Chapter 1, this right is engaged where treatment is given without consent.²⁵⁶ Nonetheless, while the ECtHR considers that that the 'freedom to accept or refuse specific medical treatment, or to select an alternative form of treatment' is 'vital to the principles of self-determination and personal autonomy'²⁵⁷ under Article 8, it does not rule out compulsory medical treatment on the grounds of mental disorder.²⁵⁸ Thus, as the MHA Code 2015 notes, no violation will be found if the non-consensual treatment can be justified under the broad set out circumstances (which includes 'the protection of health') set out in Article 8(2).²⁵⁹ Nonetheless, the interference must be lawful under both national and ECHR law, the significance of *X v Finland* being that the ECtHR expects certain procedural safeguards to be in place when compulsory treatment is proposed, which are absent under section 63.

Although the applicant's detention and compulsory treatment accorded with domestic law in *X v Finland*, the ECtHR held her compulsory treatment under the Finnish mental health legislation to be a violation of Article 8 of the ECHR because the decision to detain included 'an automatic authorisation to treat the patient, even against his or her will', without any judicial scrutiny of the doctor's decision.²⁶⁰ The ECtHR concluded that the forced medication by the treating doctors was implemented without any proper safeguards, which 'deprived the applicant of the minimum degree of protection to which

²⁵⁵ *X v Finland* (App 34806/04) 3 July 2012, ECHR 2012 (extracts) [2012] MHLR 318. That this raises concerns about the compatibility of the MHA 1983 with the ECHR was noted by the CQC in its 2012-2013 monitoring report, 53.

²⁵⁶ *YF v Turkey* (2004) 39 EHRR 34 para 33.

²⁵⁷ *Jehovah's Witnesses of Moscow and Others v Russia*, (2011) 53 EHRR 4 para 136. See also *Pretty v the United Kingdom* (2002) 35 EHRR 1.

²⁵⁸ *Herczegfalvy v. Austria* (1993) 14 EHRR 437 para 86.

²⁵⁹ MHA Code 2015 (n 1) para 24.43. *Juhnke v Turkey* (2009) 49 EHRR 24 para. 76 states that where treatment is given without consent a breach of ECHR art 8 will arise unless it can be justified under ECHR art 8(2). In *Schneiter v Switzerland* (App 63062/00) 31 March 2005 (judgment only available in French, summary in European Court of Human Rights Press Unit, *Factsheet – Mental Health* (May 2013), 5) the applicant's complaint was held to be ill-founded 'because the forced medication had a legal basis and pursued a legitimate aim (protection of the rights and freedoms of others). The applicant, who was being treated in a psychiatric hospital for various manic-delusional disorders and multiple drug addiction, had struck a nurse on the face'.

²⁶⁰ *X v Finland* (n 255) [220].

she was entitled under the rule of law in a democratic society'.²⁶¹ This approach accords with the views of both the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)²⁶² and the UN Sub Committee on Prevention of Torture),²⁶³ which state that a person's confinement should not include the authorisation of treatment without consent.²⁶⁴

4.2.4 Relevance of the views of the detained patient

In relation to medical treatment under section 58, the patient's decisional capacity is relevant only to the extent that if the patient is not able and willing to agree to the treatment proposed, it cannot be given (save where urgent treatment is needed²⁶⁵) without the SOAD authorising it.

In relation to section 63, although the MHA Code 2015 states that clinicians should seek the patient's consent and record patients' views about their treatment,²⁶⁶ in all seven of its MHA monitoring reports since 2009, the CQC has noted the lack of recording of consent and the assessment of patients' capacity to agree to their treatment.²⁶⁷ Furthermore, the CQC has raised concerns about the 'reality of consent', for example, in relation to the failure to either review the treatment when a patient expresses unhappiness with its side effects²⁶⁸ or to undertake and record an assessment of capacity in certain cases such as where patients have 'complex or high-dose medication regimes'.²⁶⁹ While acknowledging that there is a presumption of capacity under the MCA 2005, the CQC is of the view that where patients are subject to the compulsory powers under the MHA 1983 this should be 'backed up by an evidenced record', noting that an

²⁶¹ *X v Finland* (n 255) [221]. *Storck v Germany* (2006) 43 EHRR 6 held that this right was breached because the applicant's confinement had not been authorised by a court order, which was required by domestic law. See also *Shopov v Bulgaria* (App 11373/04) 2 September 2010, judgment in French and Bulgarian) European Court of Human Rights Press Release, 2 September 2010.

²⁶² CPT Standards (n 235), para 41. The CPT Standards and the CPT's recommendation on the need for legislative reform following its visit to Finland were noted in *X v Finland* (n 249) paras 132- 134.

²⁶³ Approach of the Subcommittee (n 58) para 7.

²⁶⁴ *Bartlett and Sandland* (n 3) 417-418, question whether, in the light of international and European standards 'the blanket removal of consent' under the MHA 1983 meets the requirement under Article 8(2) that the intervention is 'necessary in a democratic society'.

²⁶⁵ MHA 1983 s 62.

²⁶⁶ CQC 200910 (n 198) 80 and CQC 2015-2016 (n 31) 31.

²⁶⁷ CQC 2014/15 (n 34) 57.

²⁶⁸ CQC 2012/13 (n 216) 59.

²⁶⁹ CQC 2014/2015 (n 34) 57.

incorrect assumption that a patient has capacity may deprive that patient of the SOAD safeguard.²⁷⁰

In relation to SOADs, the MHA Code 2015, states that they should seek to understand the patient's views on the proposed treatment, and the reasons for them as well as giving 'due weight to the patient's views, including any objections to the proposed treatment and any preference for an alternative'.²⁷¹ The MHA Code 2015 also anticipates that the SOAD will ask the 'statutory consultees' (two professionals concerned with the patient's care)²⁷² about 'the implications of imposing treatment on a patient who does not want it and the reasons why the patient is refusing treatment'.²⁷³

This is another area in which the development of ECHR jurisprudence is relevant. The ECtHR has placed an increasing emphasis on ensuring that the views of the person concerned are taken into account where interferences with a person's right to private and family life under Article 8 arises. In this regard *Pleso v Hungary* (2012) is noteworthy. Although (as noted in Part 2 above), this decision concerned detention in hospital under Article 5(1)(e), its comments on the importance of seeking the views of the person concerned are pertinent to decisions on compulsory treatment powers under the MHA 1983 and their impact on Article 8, particularly given the ECtHR's express reference to the connection between, detention, compulsory treatment and Article 8 ECHR.²⁷⁴ The ECtHR commented that the only concern about the applicant was a deterioration of his health, which therefore warranted a more cautious approach. In relation to the failure of the national authorities to strike a balance between the competing interests of society and the 'individual's inalienable right to self-determination' in reaching its decision to detain, the ECtHR noted the lack of consideration as to the rational or irrational character of the applicant's choice (to refuse hospitalisation) and the failure to give any weight to his 'non-consent'. This emphasis on taking into account the views of the person concerned resonates with CoE Re 2004(10) which requires the opinion of the person to be taken into consideration.²⁷⁵

²⁷⁰ Care Quality Commission *Monitoring the Mental Health Act in 2011/12* (CQC 2011/12), 69-70.

²⁷¹ MHA Code 2015 (n 1) para 25.62

²⁷² One of whom must be a nurse and the other must be neither a nurse or a medical doctor MHA 1983 s 58(4). See also MHA Code 2015 (n 1) paras 25.53 – 25.69.

²⁷³ MHA Code 2015 (n 1) para 25.56 – stating that they should be prepared to answer questions on such matters.

²⁷⁴ *Pleso v Hungary* (n 74) para 65.

²⁷⁵ CoE Rec 2004 (10) (n 97) Article 18 (iv) and Article 19(2)(i).

The ECtHR's comments suggest that a greater justification should be required to override an individual's objections to treatment if the purpose of the treatment is to address concerns about the person's health, than if the purpose was to address the risks the person presents to others.

4.3 Adolescents and treatment under the MHA 1983: Specific concerns

In addition to the general concerns discussed above, two points concerning adolescents are pertinent to the analysis of Part IV of the MHA 1983.

First, the provision of ECT to adolescents who are informal patients is an area of potential confusion given that the SOAD's authorisation is not sufficient for the treatment to be given. This means that where the adolescent lacks decisional capacity, those wishing to give ECT must ascertain whether this can be given on the basis of parental consent or in accordance with the MCA 2005.²⁷⁶

Secondly, and of major concern, is that the CQC's monitoring report of 2014-2015 notes that it had found 'some problems relating to assessment and understanding of consent to treatment and care for children'.²⁷⁷ Furthermore, the CQC saw 'examples of patients being treated under "parental responsibility" without assessment of Gillick competence'.²⁷⁸ This indicates a poor understanding of the 'scope of parental responsibility'.

4.4 Summary of Part 4

The provisions of Part IV of the MHA 1983, described as having 'limited safeguards, minimal procedures, and near-unfettered discretion',²⁷⁹ raise significant concerns. The justification for compulsory treatment under Part IV of the MHA 1983 are expressed in broad terms and require little, or no, regard to the views of the person concerned, irrespective of that person's decisional capacity. While the provisions under sections 58 and 58A include an independent review, section 63 includes none. The efficacy of the SOAD procedure is questionable, particularly as it does not apply in the first three months and is dependent on the need for a SOAD to be recognised, this latter point linking to the CQC's concern about assessments of decisional capacity. As a result, these provisions give rise to significant human rights concerns. First, the MHA 1983 has a lower

²⁷⁶ MHA Code 2015 (n 1) paras 19.84 – 19. 85.

²⁷⁷ CQC 2014/15 (n 34) 51.

²⁷⁸ CQC 2014/15 (n 34) 51.

²⁷⁹ Bartlett and Sandland (n 3) 417.

threshold for compulsory treatment than articulated in human rights standards, (including the ECHR given its increased scrutiny when considering whether the medical necessity for a non-consensual intervention has been convincingly shown). Secondly, there is a disconnect between the expansive powers of the treating clinician under section 63 and the procedural requirements required in the light of *X v Finland*. Another area highlighted by human rights standards, including the ECtHR, is the importance of taking the views of the individual into account.

CONCLUSION

This chapter has examined the provisions of the MHA 1983, together with the MHA Code 2015, in relation to adolescents in need of in-patient psychiatric care, focusing on the provisions for their detention in hospital, their placement in hospital and treatment for mental disorder. It has raised significant concerns in all these areas, as set out in the summaries of Parts 1 – 4. This conclusion focuses on the findings that address the two points noted in Chapter 1, namely areas of which might give rise to confusion and the human rights implications of compulsory care under the MHA 1983.

(1) Potential areas of confusion

- i) *Complexity of the law*: As Jones observes, the MHA 1983 ‘has become a very complex piece of legislation which is often poorly understood’.²⁸⁰ Nonetheless, there is no overlap with the other potential routes to psychiatric care given that the MHA 1983 will only apply to adolescents if they need in-patient psychiatric care which cannot be provided on an informal basis and the criteria for detention under the Act are met. In such cases, the CA Act 1989 is not a realistic alternative.
- ii) *Confusion about key concepts*: Three key concepts are relevant to the compulsory powers under the MHA 1983. First, the expansive term ‘mental disorder’ is the gateway to the MHA 1983, albeit adolescents can only be detained under the Act if the other criteria under sections 2 and 3 are met. Secondly, the tests for decisional capacity are relevant given that the MHA Code 2015 and the CQC advise that they should be applied when medical treatment is provided under Part IV of the MHA 1983. However, the CQC has raised significant concerns about the failure to assess patients’ decisional capacity and willingness to consent to

²⁸⁰ Jones (n 93) Preface.

treatment generally. Furthermore, the CQC has raised concerns about the lack of understanding as to how to assess adolescents' decisional capacity. Thirdly, comments made by the CQC in relation to the medical treatment of children on the basis of parental consent, suggests that there remain misunderstandings about the 'scope of parental responsibility' and the role of parents in making decisions on behalf of their child in relation to mental health care (this point is discussed in the next chapter).

- iii) *Gaps in the legislation and other areas of concern:* Three areas of concern fall under this category. First, there are potential areas of confusion in relation to identifying an adolescent's nearest relative, given that additional rules apply to them in certain circumstances. Secondly, there are no provisions under the MHA 1983 concerning the placement of adolescents (or adults) out of area. Thirdly, given the ECtHR's decision in *X v Finland*, a major gap is the lack of procedural safeguards in relation to treatment under section 63.

(2) Human rights implications of compulsory care under the MHA 1983

The points raised in this analysis give rise to the following comments.

- i) As noted above, *X v Finland* suggests that the MHA 1983 is incompatible with the ECHR and therefore requires amendment so as to provide ECHR compatible safeguards.
- ii) The principle of proportionality, which as noted in Chapter 1 is a 'defining characteristic', plays a significant role in the ECtHR's approach to the protection of individuals' ECHR rights. The ECtHR's enhanced scrutiny of the national authorities' interventions on grounds of disability, including mental disorder, is particularly noticeable in the post-UNCRC era.²⁸¹
- iii) The MHA Code 2015 plays a significant role in ensuring that the MHA 1983 is applied compatibly with the ECHR. While the procedures for both detention and compulsory treatment under the Act set lower thresholds for intervention than indicated by recent ECtHR jurisprudence, the Code's emphasis on using that the compulsory powers under the Act are applied

²⁸¹ *Glor v Switzerland* (App 13444/04) 30 April 2009, ECHR 2009.

only when necessary and taking the person's views into account is more in line with the approach adopted by the ECtHR.

- iv) Notwithstanding the clear guidance in the MHA Code 2015 on the importance of involving patients in the planning of their care and treatment, the CQC's monitoring reports indicate that in many cases this is not happening in practice.
- v) There are additional worrying aspects in relation to adolescent psychiatric care in that they continue to be placed in adult psychiatric wards, or many miles from home, with very little information on the reasons for this, or the duration of their stay.

Despite the concerns raised in relation to the application of the MHA 1983 identified in this chapter, in particular the limitations of the safeguards for compulsory treatment, it provides important safeguards. These include the right to have help from an IMHA and to apply to a Mental Health Tribunal, with legal advice and representation in doing so. None of these safeguards apply to adolescents who lack decisional capacity in relation to their psychiatric care and are admitted informally on the basis of their parents' consent. This is the topic of the next chapter.

CHAPTER 6: INFORMAL ADMISSION TO HOSPITAL: DEPRIVATION OF LIBERTY AND THE ‘SCOPE OF PARENTAL RESPONSIBILITY’ – *NIELSEN V DENMARK* REVISITED¹

INTRODUCTION

Adolescents who lack decisional capacity can be admitted to hospital informally on the basis of parental consent, if this is within the ‘scope of parental responsibility’, or where adolescents aged 16 or 17 lack capacity under the Mental Capacity Act (MCA) 2005, they can be admitted under that Act, provided this does not amount to a deprivation of liberty. Although parental consent and the MCA 2005 provide different legal routes to non-consensual adolescent psychiatric care, they are connected in that recent cases have held that the role of parental consent is a key factor when determining whether a deprivation of liberty has arisen.

In *Trust A v X and Others (Trust A v X)*² the court held that the parents of a 15 year old, D, could consent to their son’s placement in a locked psychiatric ward (over 15 months by the time of the decision), because this fell within the ‘zone of parental responsibility’³ (referred to in the *Mental Health Act 1983 Code of Practice 2015* (the MHA Code 2015) as the ‘scope of parental responsibility’⁴). Keehan J remarked when giving judgment that ‘for the avoidance of doubt, I have not had regard to the “controversial” majority judgment in *Nielsen* in coming to my decision in this case’. The irony is that his decision assumed that parents had far greater powers over their child than envisaged by the European Court of Human Rights (ECtHR) in *Nielsen v Denmark* (1988) (*Nielsen*).

Nielsen concerned the placement of Jon Nielsen, a 12 year old boy, by his mother and against his wishes, in a children’s psychiatric unit for 5½ months. The ECtHR concluded that this did not amount to a deprivation of liberty under Article 5 (the right to liberty and

¹ Parts of this chapter are based on: C Parker ‘*Trust A v X and Others: The Ghost of Nielsen Returns?*’ (2016) *MedLRev* 24(2) 268.

² *Trust A v X (A Child)* [2015] EWHC 922 (Fam), [2016] 3 WLR 1401.

³ *Trust A v X* (n 2).

⁴ Department of Health *Mental Health Act 1983: Code of Practice* (TSO 2015) (the MHA Code 2015) paras. 19.38-19.43.

security of person) of the European Convention on Human Rights (ECHR), because it 'was a responsible exercise by his mother of her custodial rights in the interest of the child'.⁵ *Nielsen* was – and remains - controversial.⁶ Two of the dissenting judges in *Nielsen* not only considered that the boy's placement fell outside 'the normal exercise of parental authority or the normal practice of psychiatry', but also that 'it represented an abuse of both'.⁷ One commentator describes the decision as narrowing 'the responsibilities of the state, and the protection of the rights of children, almost to a vanishing point'.⁸

Notwithstanding Keehan J's desire to distance his decision in *Trust A v X* from that of the ECtHR's in *Nielsen*, Keehan J's conclusion that D's confinement did not amount to a deprivation of liberty because his parents consented to the restrictions placed on him had the same outcome. In both cases, the consent of the boys' parents meant that they were not deprived of their liberty and therefore Article 5 of the ECHR was not engaged. As noted in Chapter 5, this right protects everyone, including children,⁹ from arbitrary detention. Individuals can only be deprived of their liberty in certain specified circumstances and this must be 'in accordance with a procedure prescribed by law'.¹⁰ Article 5 also requires certain procedural safeguards to be in place if individuals are deprived of their liberty such as the right to seek an independent review of the detention,¹¹ which are incorporated into the Mental Health Act (MHA) 1983. Crucially though, such safeguards only apply when individuals have been deprived of their liberty.

Furthermore, there is a significant difference in approach for 16 and 17 year olds given that in *Birmingham City Council v D and others ('BCC v D')*,¹² the court held that parents cannot 'consent to the confinement of a child who has attained the age of 16' as such decisions fall outside the scope of parental responsibility.¹³ In relation to adolescent psychiatric care this is likely to mean that such adolescents will be admitted and treated under the MHA 1983 in accordance with the provisions discussed in Chapter 5.

⁵ *Nielsen v Denmark* (1989) 11 EHRR 175 para 73.

⁶ See for example G Van Bueren, *International Law on the Rights of the Child* (Save the Children, Marinus Nijhoff Publishers 1995) 212 – 213; A MacDonald *The Rights of the Child, Law and Practice* (Jordan Publishing Ltd 2011) para 14.67; and J Fortin *Children's Rights and the Developing Law* (3rd edn Cambridge University Press 2009) 101-102.

⁷ *Nielsen* (n 5), Joint Dissenting Opinion of Judges Pettiti and De Meyer.

⁸ D Feldman, *Civil Liberties and Human Rights in England and Wales*, (2nd ed. OUP) 459.

⁹ *Nielsen* (n 5) para 58.

¹⁰ ECHR art 5(1).

¹¹ ECHR art 5(4).

¹² [2016] EWCOP 8; [2016] COPLR 198.

¹³ *BCC v D* (n 12) [142]. Judgment from the Court of Appeal is pending.

The relationship between the 'scope of parental responsibility' and a 'deprivation of liberty' is therefore crucial given that it determines whether parents can consent to their child's confinement in hospitals or other placements.

Whilst not condoning its outcome, this chapter argues that an analysis of *Nielsen* identifies that there are limits to parental consent in relation to the psychiatric care of adolescents. Furthermore, an examination of ECtHR jurisprudence provides important insights into the concepts of 'the scope of parental responsibility' and 'deprivation of liberty' and how they relate to each other, which is an area of significant confusion under national law.

Given the implications of *Trust A v X* – that parents may be able to authorise their child's admission to hospital in circumstances where, if the adolescent was aged 16 and over, a deprivation of liberty would arise - this is the most controversial, difficult and troubling of the three scenarios of non-consensual adolescent psychiatric care considered in this thesis.

Analysis and structure of this chapter

Part 1 provides an overview of the legal and policy context of informal admission to hospital, exploring why the concepts of deprivation of liberty and the scope of parental responsibility are of such importance to decisions about adolescents' admission to hospital, but also give rise to such uncertainty.

Part 2 considers the approach taken by the ECtHR in determining whether a deprivation of liberty has arisen under Article 5 ECHR, in relation to adults. This is followed by an analysis of *Nielsen*, revisiting that decision in the light of the ECtHR's more recent jurisprudence, to ascertain what are likely to be the key points when considering the relevance of parental consent to the determination of a deprivation of liberty.

Part 3 analyses the judgment in *Trust A v X* and then compares this approach taken in this case with the subsequent decision of *BCC v D* which concerned the scope of parental responsibility in relation to adolescents aged 16 and 17.

The Conclusion sets out the key points arising from the discussions in Parts 1 – 3 of this chapter.

PART 1: CONTEXT

Part 1 considers the relevance of the scope of parental responsibility and deprivation of liberty to the question whether an adolescent who lacks decisional capacity can be admitted to hospital informally. It considers the following areas: first, why there is a lack of clarity on the meaning of these two concepts; secondly, the impact of the Supreme Court's decision in *P v Cheshire West and Chester Council; P and Q v Surrey County Council (Cheshire West)*,¹⁴ on the legal framework for informal admission; thirdly, the requirements for a deprivation of liberty and uncertainty as to how parental consent impacts on the determination of a deprivation of liberty; fourthly, the factors falling within the concept of the scope of parental responsibility. This is followed by a summary of the key points.

1.1 Scope of parental responsibility and deprivation of liberty: lack of clarity

That there is uncertainty and confusion in relation to the meaning and application of the two concepts of 'the scope of parental responsibility' and 'deprivation of liberty, as well as how these concepts relate to one another is illustrated by the Law Commission's comments in its consultation paper *Mental Capacity and Deprivation of Liberty* 'Law Commission Consultation Paper No. 222'); which stated that it is:

...a matter of concern that judicial confidence is being placed in the "zone of parental control" which remains a poorly understood and ill-defined concept. It is a concept introduced in the 2008 version of the Mental Health Act Code of Practice and was renamed the "scope of parental responsibility" in the current version...

...The implication of the case law is that a young person who lacks capacity may be left without the protections guaranteed by article 5 as a result of this concept.¹⁵

The Law Commission's reference to the protections under Article 5 highlights the importance of this right. Whereas the jurisprudence of the ECtHR has established a clear process for assessing whether a placement in a mental health setting has given rise to a deprivation of liberty under Article 5(1)(e) (which permits 'the lawful detention...of persons of unsound mind'), to date these cases have concerned only adults. Nearly thirty

¹⁴ [2014] UKSC 19; [2014] AC 896, 2 All ER 585.

¹⁵ Law Commission, *Mental Capacity and Deprivation of Liberty A Consultation Paper* CP No 222, (Law Com CP No. 222 2015) para 15.10. See also A Ruck Keen '*Baby Bournemouth*'? <<http://www.mentalcapacitylawandpolicy.org.uk/baby-bournemouth/>> accessed 2 April 2015.

years on, *Nielsen* remains the leading case in relation to the deprivation of liberty of minors on grounds of 'unsound mind',¹⁶ (the few cases post-*Nielsen* relate to the detention of children for 'educational supervision'¹⁷). There has also been a paucity of analysis at the national level. While 'deprivation of liberty' has been the subject of extensive scrutiny by the national courts in recent years, most particularly the Supreme Court's decision in *Cheshire West*,¹⁸ for the most part this has been in the context of the MCA 2005 and not concerned with the role of parental consent.

One question that arose in the aftermath of *Cheshire West*, is how the Supreme Court's judgment impacts on those aged under 18, specifically, how a minor's deprivation of liberty is determined and the circumstances in which parents can make decisions on behalf of their child. While this is a question that the courts are beginning to address, the approach adopted in *Trust A v X*,¹⁹ the first significant case on this issue has caused concern. Having observed that 'judicial confidence is being placed in the "zone of parental control"' (a reference to the case of *Trust A v X*), the Law Commission 2015 consultation paper noted that in this case '[i]t was held that a child's parents are capable of authorising what would otherwise be a deprivation of liberty where this is within the "zone of parental responsibility"'.²⁰ In addition to *Trust A v X* and *BCC v D*, the courts have also ruled that where children and young people are subject to a care order or interim care order under the Children Act (CA) 1989,²¹ the relevant local authority (which shares parental responsibility with the parents) cannot authorise what would otherwise be a deprivation of liberty (the Judge also considered it unlikely that the parents would be able to do so in such circumstances).²²

The contrasting approaches between *Trust A v X*²³ and *BCC v D*²⁴ and this clear demarcation between children aged under 16 and young people aged 16 and 17 are discussed in Part 3.

¹⁶ Although in *Storck v Germany* (2006) 43 EHRR 6 the applicant had been placed in a psychiatric clinic by her father when she was 16, her complaint to the ECtHR concerned subsequent admissions when she was 18 and had therefore reached the age of majority.

¹⁷ See for example *Bouamar v Belgium* (1989) 11 EHRR 1 and *Koniarska v United Kingdom* (App 33670/96) 12 October 2000.

¹⁸ *Cheshire West* (n 14).

¹⁹ *Trust A v X* (n 2).

²⁰ Law Com CP No 222, 2015 (n 15) para 15.4, referring to *Trust A v X* (n 3) [55]

²¹ Children Act (CA) 1989, ss 31 and 38.

²² *A Local Authority v D and Others* [2015] EWHC 3125 (Fam) [26]- [29]

²³ (n 2).

²⁴ (n 12).

1.2 Limitations on informal admission

Section 131(1) MHA 1983 originates from a recommendation made by the *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954 – 1957* ('the Percy Commission')²⁵ prior to the Mental Health Act (MHA) 1959.²⁶ The Percy Commission had concluded that rather than requiring the use of compulsory powers 'unless the patient can express a positive desire for treatment' (which was the position prior to the MHA 1959), mental health legislation should provide for 'the offer of care, without deprivation of liberty, to all who need it and are not unwilling to receive it'.²⁷

Despite such policy intentions, subsequent events have curtailed the use of informal admission for 'incapacitated but compliant' individuals significantly, so that '[i]n a sense the wheel has turned full circle'.²⁸ The main driver for the near return to pre-MHA 1959 times is Article 5 of the ECHR. In *HL v the United Kingdom (2004)* the ECtHR held that the informal admission of a man with learning disabilities (HL), who was unable to consent to his admission to hospital, breached his rights under Article 5. Having found that despite his apparent compliance with this decision, HL's admission to hospital amounted to a deprivation of his liberty, the ECtHR then considered whether his detention complied with the requirements under Article 5. Although accepting that HL's detention was on the basis of his 'unsound mind' (one of the cases in which detention may be permitted under Article 5(1)(e) of the ECHR), it was not 'in accordance with a procedure prescribed by law'. The ECtHR considered that the common law doctrine of necessity (the legal basis for HL's admission to hospital under domestic law) lacked sufficient procedural safeguards to protect individuals from arbitrary detention.²⁹

To address the breach of Article 5 ECHR identified in *HL v the United Kingdom*, the government amended the MCA 2005 'to introduce some machinery for the many thousands of mentally incapacitated people who are deprived of their liberty in hospitals, care homes and elsewhere'.³⁰ Thus, the Act now prohibits the deprivation of liberty of individuals aged 16 and above unless authorised by the Court of Protection or, in the

²⁵ Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957 *Report* (Cmnd. 169 1956-57) ('Percy Commission').

²⁶ Mental Health Act (MHA) 1959 s 5(1) implemented this recommendation, which was 're-enacted verbatim' by MHA 1983 s 131(1)

²⁷ Percy Commission (n 26) 289-291.

²⁸ *Cheshire West* (n 14) [2].

²⁹ *HL v the United Kingdom* (2005) 40 EHRR 32.

³⁰ *Cheshire West* (n 14) [8].

case of adults, under a scheme known as the 'Deprivation of Liberty Safeguards (DoLS)'.³¹

The Supreme Court's decision in *Cheshire West*,³² has further narrowed the remit of informal admission given that the concise test formulated by Lady Hale in her leading judgment has lowered what was previously thought to be the threshold for what constitutes a deprivation of liberty under the MCA 2005.³³ Commonly referred to as 'the acid test',³⁴ the focus is on whether the person concerned is 'under continuous supervision and control' and 'not free to leave'.³⁵ Where that test is met the individual cannot be admitted to hospital informally under the MCA 2005. The consequence (for adults) is explained in Chapter 13 of the MHA Code 2015, which states that where a deprivation of liberty has arisen it 'must be specifically authorised under the MCA by a DoLS authorisation or a Court of Protection order, or otherwise made lawful by way of detention under the [MHA 1983]'.³⁶ Given that DoLS only apply to adults, the options for under 18s are either compulsory admission under the MHA 1983 or an application to the court. For young people who lack capacity to make the relevant decisions under the MCA 2005 this could be to the Court of Protection, otherwise for those aged under 18, an application would need to be made to the High Court to authorise a deprivation of liberty under its inherent jurisdiction.³⁷

Cheshire West therefore clarified the limitations of the MCA 2005 for adults, specifically that it cannot authorise the informal admission to hospital of a person if that admission amounts to a deprivation of liberty and the 'acid test' is to be applied when determining if a deprivation of liberty has arisen. However, for the reasons explained below, the situation for children and young people post-*Cheshire West* was less clear.

³¹ MCA 2005 s 4B also allows individuals who lack capacity to make decisions about such matters to be deprived of their liberty in order to give that person life-sustaining treatment or to prevent a serious deterioration in the person's condition while a decision is being sought from the Court of Protection.

³² *Cheshire West* (n 14).

³³ Law Com CP No. 222, 2015 (n 15) para 7.25.

³⁴ Derived from Lady Hale's reference to 'the acid test' in *Cheshire West* (n 14) [48]-[49] as well as [54] in which lady Hale refers to a person being 'under the complete supervision of those caring for her and is not free to leave the place that she lives'.

³⁵ *Cheshire West* (n 14) [49] (Lady Hale), [63] Lord Neuberger.

³⁶ MHA Code 2015 (n 4) para 13.35.

³⁷ MHA Code 2015 (n 4) para 19.52

1.3 Cheshire West and Deprivation of Liberty

How to determine whether individuals are deprived of their liberty was central to the decision in *Cheshire West*.³⁸ The issue before the Supreme Court was whether the living arrangements for three individuals with learning disabilities amounted to a deprivation of liberty.³⁹ All three were considered to lack capacity to agree to their care and treatment, which was being provided in their best interests (and without evidence of their objection) in accordance with the MCA 2005 'in a small group or domestic setting which is as close as possible to "normal" home life'.⁴⁰ Given that the MCA 2005 specifies that the meaning of a deprivation of liberty is the same as Article 5(1) ECHR,⁴¹ it was necessary to review the ECtHR's jurisprudence to 'find out what is meant by a deprivation of liberty in this context'. Having done so, the Supreme Court confirmed that that ECHR case-law has established that there are three core requirements for a deprivation of liberty to have arisen. A deprivation of liberty consists of two parts – the objective element (the restrictions imposed on the person concerned – the 'acid test') and the subjective element (the lack of valid consent to those restrictions) with the third requirement being that the deprivation of liberty engages the responsibility of the State.⁴²

The 'subjective' element of deprivation of liberty focuses on whether or not the person has 'validly consented to the confinement in question'.⁴³ Thus, even if a person is subject to restrictions that are severe enough to give rise to an objective deprivation of liberty, if that person has agreed to such restrictions, there is no deprivation for the purpose of Article 5 ECHR. This is because the person can withdraw his or her consent, at which point the restrictions will be withdrawn and the person can walk away. Thus, in *David v Moldova* (2008), the ECtHR held that the applicant, who had agreed to go into hospital but had then changed his mind, was deprived of his liberty 'from the moment he expressed his wish to leave the hospital'.⁴⁴

³⁸ *Cheshire West* (n 14).

³⁹ This case amalgamated two Court of Appeal decisions, the first concerning two sisters, known as MIG and MEG, both of whom had learning disabilities and the second concerning a man with physical and learning disabilities.

⁴⁰ *Cheshire West* (n 14) [32]

⁴¹ Mental Capacity Act (MCA) 2005, s64(5).

⁴² *Cheshire West* (n 14) [37].

⁴³ *Storck* (n 16) para 74. *Stanev v Bulgaria* (2012) 55 EHRR 22 para 117 states that this is one of the 'general principles' for determining if a deprivation has arisen.

⁴⁴ *David v Moldova* (App 41578/05) 27 February (2008) para 35. The ECtHR stated 'that the fact that a person initially agreed to enter an institution does not prevent him or her from relying on Article 5 if he or she subsequently wishes to leave' basing this on its judgment in *De Wilde, Ooms and Versyp v Belgium* (No 1) (1979-1980) 1 EHRR 373.

Given that neither was in dispute in *Cheshire West*, little attention was given to either the subjective element or State imputability. Apart from noting that these to be core requirements for a deprivation of liberty to have arisen under Article 5, little attention was given to either the subjective element or State imputability in the Justices' judgments. The question of State responsibility was not in dispute. Nor was the subjective element in issue given that all three individuals lacked capacity (within the definition of the MCA 2005⁴⁵) to consent to the restrictions placed upon them as part of their care regimes. This perhaps explains why discussions within the national legal and policy context have tended to focus on the objective element of a deprivation of liberty. Like *Cheshire West*, the majority of cases since the ECtHR's identification of the subjective element,⁴⁶ have concerned MCA 2005 cases in which young people and adults lack the capacity to decide about their living arrangements and care. The subjective element is met because they have been assessed as unable to consent to such arrangements.⁴⁷ Accordingly, the courts' only consideration when determining whether a deprivation of liberty has arisen, for the purpose of the MCA 2005, is whether such individuals are objectively deprived of their liberty.⁴⁸

Although, the *Cheshire West* acid test established a means for determining whether an adult's admission to hospital amounts to a deprivation of liberty, it was not concerned with (and therefore did not address),⁴⁹ the relevance of parental consent. Thus, it was not clear whether, and if so, how, the subjective element might apply in relation to decisions made by parents on behalf of their child who is unable to make such decisions for him or herself. The uncertainty as to whether parental consent is relevant to determining a deprivation of liberty is highlighted by the 2015 Mental Health Act 1983 Code of Practice ('2015 MHA Code'), which notes that *Cheshire West*:

...did not expressly decide whether a person with parental responsibility could, and if so in what circumstances, consent to restrictions that would, without their consent, amount to a deprivation of liberty.⁵⁰

⁴⁵ See s 2 MCA 2005. Discussed in Chapter 2.

⁴⁶ *Storck* (n 16). The relevance of the subjective element was noted in *JE v Surrey County Council*; *DE v Surrey County Council* [2006] EWHC 3459 (Fam) [2007] 2 FLR 1150.

⁴⁷ See for example the Court of Appeal's decisions in *P* (otherwise known as *MIG*) and *Q* (otherwise known as *MEG*) v *Surrey County Council* [2011] EWCA Civ 190 [18], [2011] All ER (D) 286 (Feb) and *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257 [2011] All ER (D) 150 (Nov) [17].

⁴⁸ MCA 2005 s 64(6) excludes State responsibility from the determination of deprivation of liberty for the purpose of this Act.

⁴⁹ Compare with [77] – [79] (Lord Kerr).

⁵⁰ MHA Code 2015 (n 4) para 19.48.

The point being made here is that it is not clear whether parental consent might affect whether the subjective element of a deprivation of liberty is met. An adolescent, who lacks decisional capacity in relation to his admission to hospital would be deprived of his liberty if the objective element of a deprivation of liberty was met as he would not be able to agree to it. However, if his parents can consent to this on his behalf, the adolescent is not deprived of his liberty because the subjective element (lack of valid consent) is not met. This question was considered by Keehan J in *Trust A v X* (in relation to under 16s) and *BCC v D* (in relation to 16 and 17 year olds) and the key points arising from these cases are explored in Part 3 below. The meaning of the scope of parental responsibility is considered next.

1.4 The Scope of Parental Responsibility

The scope of parental responsibility is relevant to adolescent psychiatric care as it is a key consideration when considering if an adolescent can be admitted to hospital informally.

In its first incarnation, the 'scope of parental responsibility' was called 'the zone of parental control'. As Fennell notes, the 'zone of parental control' is not a term derived from family law.⁵¹ Rather, it was a concept introduced by the Mental Health Act 1983 Code of Practice 2008 (the MHA Code 2008) and renamed the 'scope of parental responsibility' in the MHA Code 2015. Both are simply terms ascribed to the process of deciding whether the parent's consent provides the requisite legal authority for the action proposed, for example admission to hospital or medical treatment (and is considered by the Department of Health to be of broader application than mental health care).⁵² Unless it is considered that parents can agree to anything – or nothing – in relation to their child's healthcare, some means of determining whether the particular decision is one that the parent(s) can make is required. Thus, 'the principle upon which the 'zone of parental control' is based, is of fundamental importance, namely that there are limits to the kind of decisions that parents can make in relation to their child'.⁵³

The following points are considered below: some general concerns about the zone of parental control/ scope of parental responsibility; the legal context for this concept; an

⁵¹ P Fennell *Mental Health: Law and Practice* (2nd edn, Jordans 2011) para 11.42.

⁵² Department of Health, *Reference guide to consent for examination or treatment* (Department of Health 2nd edn 2009) p 35, para 19 refers to the 'zone of parental responsibility' in relation to the treatment of children who are not *Gillick* competent.

⁵³ Department of Health, *Stronger Code: Better Care, consultation on the proposed changes to the Code of Practice: Mental Health Act 1983* (Department of Health 2014)

outline of the factors that form part of the determination as to whether a particular decision falls within the scope of parental responsibility and the relevance of this concept to articles 5 and 8 of the ECHR.

1.4.1 General concerns

The term ‘the zone of parental control’, was criticised by legal commentators and practitioners alike as being vague and unhelpful,⁵⁴ one problem being its suggestion that there is ‘a demarcated zone with observable boundaries’,⁵⁵ which there is not. In response to such criticism, the term has been renamed as the ‘scope of parental responsibility’ and additional guidance provided as part of the revisions to the MHA Code 2015.⁵⁶ The following points therefore consider first, principles on which it is based and, second, factors that are integral to this concept itself.

1.4.2 Legal context

The only reference given in the MHA Code 2008 in support of the ‘zone of parental control’ was that of *Nielsen*, stating that ‘the zone of parental control derives largely from case law from the European Court of Human Rights in Strasbourg’.⁵⁷ This may be one reason for confusion on this concept. While the ECtHR stated in *Nielsen* that ‘the rights of the holder of parental authority cannot be unlimited’,⁵⁸ as noted above, this decision is not generally regarded as an illustration of the principle that there are limits to parental power, given that far from limiting parental authority recognized that it extended to allowing a 12-year-old-child to be locked up for several months in a closed psychiatric ward’.⁵⁹

In any event, as commentators have pointed out, the courts have long recognised there are limits to the scope of parents’ control.⁶⁰ For example, Fennell notes that the zone of

⁵⁴ See for example, J Watts and R Mackenzie ‘The Zone of Parental Control: a reasonable idea or an unusable concept’ 18(1) *Tizard Learning Review* 38; R Sandland ‘Children, Mental Disorder, and the Law’ in *Principles of Mental Health Law and Policy* L Gostin, P Bartlett, P Fennell, J McHale and R MacKay (eds) (OUP 2010) para, 18.96 – 18.100. This concern was noted in *Consultation on the proposed changes to the Code of Practice* (n 54) para 7.2.

⁵⁵ B Dolan and S Simlock ‘When is a DOL not a DOL? When parents of a 15 year old agree’, (Serjeants’ Inn Chambers, CoP team, undated) <<https://www.serjeantsinn.com/wp-content/uploads/2016/06/SIC-DOLS-casenote.pdf>> accessed 30 October 2017.

⁵⁶ MHA Code 2015 (n 4), chp 19.

⁵⁷ MHA Code 2008 para 36.09.

⁵⁸ *Nielsen* (n 5) para 72.

⁵⁹ B Hale, *Mental Health Law* (5th ed Sweet & Maxwell 2010), 92. Sandland (n 55) makes a similar comment, noting that in *Nielsen* (n 5) ‘the European Court took an expansive approach to the extent of parental responsibility/control’ para 18.98.

⁶⁰ In addition to the cases referred to in the text, see also *F v Wirral Metropolitan Borough Council* [1991] Fam 69 (Purchas LJ), which noted (at 87) that the need for interference with

parental control is said to be ‘an attempt to encapsulate the idea enunciated by Lord Denning in *Hewer v Bryant*’,⁶¹ where he referred to the parent’s right to the legal right custody of the child as ‘...a dwindling right...It starts with a right of control and ends with little more than advice’ (a view endorsed by the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority (Gillick)*).⁶² Sandland suggests (citing *Gillick*), that it ‘merely states in new form the truism that parental rights “exist for the benefit of the child and they are justified only in so far as they enable the parent to perform [his or her] duties] towards the child”’.⁶³ The MHA Code 2015 reflects such views, stating that ‘court decisions relating to parental consent have emphasised that there are limits to both the types of decisions that can be made by those on behalf of their child and the circumstances in which these decisions can be made’ and noting that ‘parents must act in the best interests of their child’.⁶⁴ The cases cited in support include both *Hewer v Bryant*’ and *Gillick*.

1.4.3 Factors relevant to the scope of parental responsibility

The following factors are derived from guidance in the MHA Code 2015 concerning the role of parents, including the specific guidance on the scope of parental responsibility. Each factor is relevant to the question whether parental consent can be relied upon to authorise the proposed intervention(s), such as the adolescent’s admission to hospital and/or treatment.

First, as noted in Chapter 2, the scope of parental responsibility can only be engaged if the adolescent lacks decisional capacity in relation to the particular intervention. The question whether the parent can consent to a particular decision ‘will need to be assessed in the light of the particular circumstances of the case’.⁶⁵

parental rights (and therefore the existence of such rights) was recognised as early as 1601, with the Poor Relief Act 1601 providing that children of parents thought unable to ‘keep and maintain their children’ could be set to work. *Re KD (a minor) (ward: termination of access)* [1988] 1 AC 806, [1988]1 All ER 577 HL Lord Oliver, at 825, referred to parenthood as being a privilege that is ‘circumscribed by many limitations imposed both by the general law and, where the circumstances demand, by the courts or by the authorities on whom the legislature has imposed on supervising the welfare of children and young persons’.

⁶¹ Fennell (n 52) para 11.42 referring to *Hewer v Bryant* [1970] 1 QB 357, 369. For a discussion on the importance of this case, see A Bainham, ‘Lord Denning as a champion of children’s rights: the legacy of *Hewer v Bryant*’ (1999) Denning LJ 14(1), 81.

⁶² *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 [1985] 3 WLR 830 HL.

⁶³ Sandland (n 55) para 18.98 citing *Gillick* (n 63) at 170 (Lord Fraser).

⁶⁴ MHA Code 2015 (n 4) para 19.40. See also *Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, CA, at 178 (Ward LJ): ‘parental rights and powers...must be exercised in the best interests of the child’.

⁶⁵ MHA Code 2015 (n 4) para 19.41.

Secondly, the person whose consent is being sought must have parental responsibility for the adolescent.⁶⁶

Thirdly, consideration of the nature of the decision is required. The MHA Code 2015 highlights the need to consider whether it is 'a decision that a parent should reasonably be expected to make'. It notes that if the decision in question 'goes beyond the kind of decisions parents routinely make in relation to the medical care of their child, clear reasons as to why it is acceptable to rely on parental consent to authorise this particular decision will be required'.⁶⁷ Factors to consider in this regard include the type and invasiveness of the proposed intervention and the extent to which the adolescent may resist this intervention.

Fourthly, the wishes of the adolescent are central to the decision-making process. The MHA Code 2015 states that the age maturity and understanding of the adolescent is relevant. First, it notes that the parents decision-making role 'should diminish as their child develops greater independence, with accordingly greater weight given to the views of the child or young person'. This reflects the 'dwindling right' of parents referred to in *Hewer v Bryant*⁶⁸ and the ECtHR's comment in *Nielsen* that parents do not have unlimited rights. The second consideration is the extent to which the decision accords with adolescent's wishes and whether the adolescent is resisting the decision. The third consideration is whether the adolescent had expressed any views about the proposed intervention when the adolescent had decisional capacity, the suggestion being that if the adolescent had stated a willingness to receive one form of treatment but not another 'it might not be appropriate to rely on parental consent to give the treatment that they had previously refused'. Thus, even though under 18s cannot make legally binding advance refusals under the MCA 2005, this guidance highlights the importance of taking the adolescent's previously stated wishes into account. These three points reflect concepts that are core principles of the UNCRC, namely the evolving capacities of the child (Article 5 recognising that the role of parents in decision-making recede as their child becomes older and more mature); the right of the child to be heard under Article 12 and the principle of the best interests of the child under Article 3(1), which takes in account Article 5 and Article 12.

⁶⁶ Children Act (CA) 1989 s.3, *Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, 178; MHA Code 2015 (n 4) paras 19.6 – 19.8.

⁶⁷ MHA Code 2015 (n 4) para 19.41.

⁶⁸ [1970] 1 QB 357, 369.

Fifthly, the MHA Code 2015 highlights the need to consider whether ‘there are any factors that might undermine the validity of parental consent’.⁶⁹ This covers points such as whether the parent(s) lacks the mental capacity to make the decision or is unable to focus on what course of action is in the best interests of their child and whether there is a disagreement between the parents (one parent agreeing with the proposed decision but the other objecting to it).⁷⁰

1.5 Summary of Part 1

The discussion in Part 1 has highlighted why the concept of deprivation of liberty is so important in relation to informal admission, that the core requirements for a deprivation of liberty to arise were identified by *Cheshire West* but did not explain how they related to parental consent. It is for this reason that the cases of *Trust A v X* and *BCC v D* are so significant and merit analysis. The importance of the scope of parental responsibility has also been highlighted and the factors that would need to be considered when determining if parental consent can be relied upon to authorise the proposed intervention.

Part 2 considers the development of the ECtHR’s jurisprudence on the meaning of deprivation of liberty.

PART 2: DEPRIVATION OF LIBERTY: THE EUROPEAN COURT OF HUMAN RIGHTS’ APPROACH

Part 2 focuses on the following four areas. First, brief consideration is given to the three conditions that must exist for a deprivation of liberty to arise under Article 5 of the ECHR, namely, the imputability of the state, together with the objective and subjective elements. Second, the development of the ECtHR’s case-law in relation to the subjective element, is considered. Third, the decision in *Nielsen* is re-examined in the light of the ECtHR’s more recent jurisprudence. Fourth, the key points are summarised and the differences in determining a deprivation of liberty as between adults and adolescents highlighted.

⁶⁹ MHA Code 2015 (n 4) para 19.41.

⁷⁰ MHA Code 2015 (n 4) paras 19.40 – 19.41.

2.1 The three core requirements of a deprivation of liberty

For almost forty years, the ECtHR's starting point for determining whether a deprivation of liberty has arisen has been 'the concrete situation'.⁷¹ However, over the last decade or so, the ECtHR has highlighted the importance of a second dimension when considering cases concerning the placements of individuals in mental health settings. In *Storck v Germany (2005)* the ECtHR stated that deprivation of liberty 'does not only comprise the objective element of a person's confinement in a particular restricted space for a not negligible length of time' but there is also an additional 'subjective element', namely that the person 'has not validly consented to the confinement in question'.⁷²

2.1.1 State responsibility

The ECtHR has held that even where the decision to admit the applicant to the hospital or social care home is taken by a private individual (the guardian), State responsibility is engaged if the placement is then implemented by the State.⁷³ This is likely to be the situation for most admissions to hospital of children and young people, certainly in the UK, in that they will be admitted to NHS hospitals⁷⁴ or private hospitals funded by the NHS.

2.1.2 The objective element of a deprivation of liberty

As noted in Part 1, Lady Hale concluded in *Cheshire West* that since *H.L. v the United Kingdom (2004)*, the ECtHR has focused on two key features when assessing the 'concrete situation' of individuals confined in mental health settings, namely whether 'the person concerned was "under continuous supervision and control and was not free to leave"'.⁷⁵ In their minority judgment, Lords Carnwath and Hodge provide an alternative analysis of the objective element when explaining why they were unconvinced by this 'acid test'. They observe that the ECtHR 'has remained wedded to a case-specific test' and continues to apply its 'standard Engel formula' (that 'account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation

⁷¹ *Engel v Netherlands* (1979 -80) 1 EHRR 647 para 59.

⁷² *Storck* (n 16) para 74.

⁷³ *Shtukurov v Russia* (2012) 54 EHRR 27.

⁷⁴ *Glass v the United Kingdom* (2004) 39 EHRR 341 para 71, the ECtHR noted that 'it has not been contested that the hospital was a public institution and that the acts and omissions of its medical staff were capable of engaging the responsibility of the respondent State under the Convention'. See also *MS v Croatia* ((App 75450/12) 19 February 2015, [2015] MHLR 226 para 99; *P and S v Poland* (App 57375/08 30 October 2010) [2013] 1 FCR 476 para 129.

⁷⁵ *Cheshire West* (n 14) [49].

of the measure in question').⁷⁶ While acknowledging the weight that the ECtHR attaches to the two factors identified by the 'acid test' they considered that this 'was only one of a number of factors leading to the overall assessment'.⁷⁷

Whether or not the 'acid test' embraces the decisive features for a finding by the ECtHR that the applicant's placement in a mental health setting amounts to a deprivation of liberty, the ECtHR also refers to factors, such as restrictions being placed on the applicant's contact with carers⁷⁸ and ability to maintain regular social contact with the outside world.⁷⁹ Furthermore, given that the Supreme Court's decision in *Cheshire West* concerned individuals who lacked capacity to consent to their care and treatment in a home-like setting, but who did not object to their placement, other factors may be relevant in different circumstances. For example, the duration of the confinement is likely to be relevant, albeit not decisive.⁸⁰ Even short periods of confinement may give rise to a deprivation of liberty,⁸¹ although this is usually combined with an element of coercion, 'which in the Court's view is indicative of a deprivation of liberty within the meaning of Article 5(1)';⁸² such as the use of force to take a person to the police station.⁸³ The ECtHR also notes that 'each case has to be decided on its own particular "range of factors"' and 'distinguishing features'.⁸⁴ Furthermore, although Article 5 of the ECHR is concerned with deprivation of liberty, not a restriction on a person's liberty, the ECtHR considers that the distinction between the two 'is merely one of degree or intensity and not one of nature or

⁷⁶ *Cheshire West* (n 14) [96]. Their Lordships were referring to the fact that similar wording has been used by the ECtHR since *Engel and Others* (n 72) (see para 22). See, for example, *Guzzardi v Italy* (1981) 3 EHRR 333 para 92 and *Storck* (n 16) para 70.

⁷⁷ Referring to *Stanev v Bulgaria* (n 44) para 96(c).

⁷⁸ *HL v United Kingdom* (n 30).

⁷⁹ *Shtukurov v Russia* (2012) 54 EHRR 27 para 107. See also *Akopyan v Ukraine* (App 12317/06) 5 June 2014 para 68: 'applicant was confined within the hospital for a considerable period of time, she was not free to leave it, and her contact with the outside world was seriously restricted'.

⁸⁰ See *Cheshire West* (n 14) [63] (Lord Neuberger) although agreeing with the two features of Lady Hale's acid test, Lord Neuberger added in parenthesis 'in addition to the area and period of confinement'.

⁸¹ *Krupko and Others v Russia* (App 26587/07 26 June 2014) para 35 noted that ECHR art 5(1) 'applies to deprivation of liberty of any duration, however short it may have been'.

⁸² *MA v Cyprus* (App 41872/10) 23 July 2013, ECHR 2013, para 193, *Krupko v Russia* (n 81) para 36.

⁸³ *Foka v Turkey* (App 28940/95 24 June 2008) paras 74 - 79. See also *Gillan and Quinton v United Kingdom* (App 4158/05) 12 January 2010 ECHR 2010 (extracts), para 57, the ECtHR considering that element of coercion arising from the threat of being 'liable to arrest, detention in a police station and criminal charges' was indicative of a deprivation of liberty under Article 5 (although, having found a violation of Article 8, it made no final determination on this point).

⁸⁴ *HL v United Kingdom* (n 30) para 93, *Atudorei v Romania* (App 50131/08) 16 September 2014 para 133.

substance',⁸⁵ acknowledging that in that some borderline cases this will be 'a matter of pure opinion'.⁸⁶

2.1.3 *The subjective element of deprivation of liberty*

Despite its relatively recent arrival, the 'subjective' element of deprivation of liberty is now a well-established part of the ECtHR's 'notion of deprivation of liberty', when considering 'the placement of mentally disordered persons in an institution'.⁸⁷

The subjective element is the absence of valid consent⁸⁸ (the person 'has not validly consented to the confinement in question'⁸⁹). From this perspective, the subjective element of Article 5 is a reflection of the libertarian values of the ECHR, specifically 'the notions of self-determination and personal autonomy' that the ECtHR has highlighted when considering matters such as medical treatment decisions under Article 8 (right to private and family life) ECHR.⁹⁰ While there may be reasons for the State intervening in its citizens' lives, the starting point (for adults) is that the 'ability to conduct one's life in a manner of one's own choosing includes the opportunity to pursue activities perceived to be physically harmful or dangerous nature for the individual concerned'.⁹¹

Accordingly, individuals who are subject to restrictions that meet the objective element are not deprived of their liberty for the purpose of Article 5 ECHR if they have consented to those restrictions. However, they are free to change their minds and as noted in Part 1(2) above, the ECtHR made clear in *David v Moldova* (2008) that once the person decides he wishes to leave any continued detention will amount to a 'deprivation of liberty' under Article 5 ECHR.

⁸⁵ A comment made repeatedly by the ECtHR. See for example, *Guzzardi v Italy* (n 76) para 93; *Ashingdane v the United Kingdom* (1985) 5 EHRR 528 para 4; *HL v United Kingdom* (n 30) para 89; *HM v Switzerland* (2004) 38 EHRR 17 para 42 and *Lazariu v Romania* (App 31973/03) 13 November 2014 para 96.

⁸⁶ *Guzzardi v Italy* (n 76) para 93; *Stanev v Bulgaria* (n 44) para 115; *Blokhin v Russia* (App 47152/06) 14 November 2013 para 106 (the finding that the applicant was deprived of his liberty was upheld by the Grand Chamber in its judgment of 23 March 2016 (ECHR 2016 GC)); *Shimovolov v Russia* (App 30194/09) 21 June 2011 para 49.

⁸⁷ This is one of the 'general principles' for determining if a deprivation has arisen *Stanev v Bulgaria* (n 44) para 117. See also *Mihailovs v Latvia* (App 35939/10) 22 January 2013 para 128. The relevance of the subjective element was reiterated in *Akopyan v Ukraine* (App 12317/06, 5 June 2014) para 67.

⁸⁸ B Rainey, E Wicks, and C Ovey, *Jacobs White & Ovey: The European Convention on Human Rights* (6th edn OUP 2014) 215: 'There is no deprivation of liberty if the applicant consents to the detention'.

⁸⁹ *Storck* (n 16) para 74.

⁹⁰ *Jehovah's Witnesses of Moscow and others v Russia* (2011) 53 EHRR 4 para 135; *Pretty v United Kingdom* (2002) 35 EHRR 1 paras 61 and 65.

⁹¹ *Jehovah's Witnesses* (n 90) para 135.

2.2 Subjective Element: Background and Application

The development of ECtHR jurisprudence in relation to the subjective element of a deprivation of liberty is considered below.

2.2.1 Genesis of the Subjective Element

As noted above the ECtHR first articulated its view that a deprivation of liberty comprises of these two objective and subjective elements in *Storck v Germany* (2005) (*Storck*). Although the ECtHR identifies *HM v Switzerland* (2002)⁹² (which concerned the placement of an elderly woman (HM) in a foster home 'to ensure the necessary medical care') as the source for requiring that the person 'has not validly consented to the confinement in question', that judgment made no mention of the 'subjective element'.⁹³ The details of this case are noted first, followed by *Storck*.

2.2.1.1 *HM v Switzerland* (2002)

On the face of the judgment, HM's agreement to her continued stay in the home was not the decisive factor in the ECtHR's conclusion that HM was not deprived of her liberty.⁹⁴ The ECtHR placed greater emphasis on the reasons for her placement (to provide her with care and treatment), concluding that the placement did not amount to a deprivation of liberty as it was 'a responsible measure taken by the competent authorities in the applicant's interests'. The reason why the ECtHR makes the connection between HM's case and that of *Storck* may be due to its comments in *HL v United Kingdom* (2004). In that case, the UK government argued that the situation of HL, who lacked capacity to consent to his admission to hospital but did not object to being in hospital, was comparable to *HM v Switzerland*, HM being 'unable to express clearly whether or not they wished to be in relevant institution'. The ECtHR disagreed with this analysis, responding that one of the distinguishing features between the two cases was that it had not been established that HM 'was legally incapable of expressing a view on her position, she had often stated that she was willing to enter the nursing home and, within weeks of being there, she had agreed to stay'.⁹⁵

⁹² *HM v Switzerland* (2004) 38 EHRR 17.

⁹³ *Storck* (n16) para 73; *Shtukurov v Russia* (2012) 54 EHRR 27 para 106; *D.D. v Lithuania* (App 13469/06) 14 February 2012, para 145.

⁹⁴ *HM* (n 92). See also the summary of *HM* in *Cheshire West* (n 14) [97 iii] (Lord Carnwath and Lord Hodge).

⁹⁵ *HL v the United Kingdom* (n 30) para 93. When analysing *HM* (n 92) in *JE v DE* [2006] EWHC 3459 (Fam), [2007] 2 FLR 1150 at [34] – [50] (Munby J (as he then was)) referred to the ECtHR's change of emphasis as a 'retreat' from an otherwise puzzling judgment [48]-[49]. That the ECtHR has subsequently concluded that the fact that the measure in question is aimed at

2.2.1.2 *Storck v Germany (2005)*

In *Storck*, the applicant's complaint that she had been deprived of her liberty in a private psychiatric clinic during two periods of admission (the first for twenty months, the second for three months) was disputed by the German government on the basis that she had consented to these admissions and her continued stay in the clinic. The ECtHR approached this argument by reviewing both the applicant's 'factual situation' (the objective element) and whether she had consented to her stay in the clinic (the subjective element).

In relation to the first admission, having found that the applicant was 'objectively' deprived of her liberty, the ECtHR assessed whether she had consented to her confinement. Although the applicant had the capacity to consent or object to her admission and treatment in hospital (she had reached the age of majority and had not been placed under guardianship) she had not signed the clinic's admission form prepared on the day of her arrival. The fact that she had gone to the clinic, accompanied by her father (who had admitted her to a children's psychiatric unit in the past) was not relevant in the light of the well-established principle that individuals do not lose the benefit of Article 5 ECHR safeguards just because they have given themselves up to detention.⁹⁶

With regard to her continued stay in the clinic, 'the key factor' was that she had tried to escape a number of times (the ECtHR noting that she had to be 'shackled in order to prevent her from absconding' and she was returned to the clinic by the police when she had escaped). Accordingly, the ECtHR was 'unable to discern any factual basis for the assumption that the applicant... agreed to her stay in the clinic'. Noting that her treatment involved 'strong medication', the ECtHR also suggested that if, as a result, the applicant was no longer capable of consenting, 'she cannot in any event be considered to have validly agreed'.⁹⁷

2.2.2 *Subjective element and 'guardianship'*

Since *Storck*, a series of complaints against Central and Eastern Europe States have illustrated the significance of the subjective element. Many countries in this region maintain a system of guardianship in which individuals are appointed to make decisions

protecting the person is not relevant to whether it amounts to a deprivation of liberty (see *Austin v United Kingdom* (2012) 55 EHRR 14 and *Creanga v Romania* (2013) 56 EHRR 11 [GC] may be the reason for relying on HM's consent as the retrospective justification for its finding that there was no deprivation of liberty.

⁹⁶ *De Wilde, Ooms and Versyp v Belgium* (n 45).

⁹⁷ *Storck* (n16) para 75.

on behalf of adults deemed to lack the legal capacity to make decisions for themselves. In some countries guardians are able to authorise admission to psychiatric hospitals and social care homes, on behalf of a person who lacks capacity. On the basis of the guardian's consent the person is deemed to be admitted voluntarily, even if that person has not consented. Such a practice, which has been the subject of severe criticism from international and European organisations,⁹⁸ was first considered by the ECtHR in *Shtukaturov v Russia* (2008).⁹⁹

In *BCC v D* the court accepted the submissions of the Official Solicitor that there was no authority for the principle for 'substituted consent' arising from the jurisprudence of the ECtHR and therefore that parents of adolescents 'cannot give substituted consent on behalf their child to his confinement which absent a valid consent would be in breach of Art 5(1)'.¹⁰⁰ For the reasons set out below, it is suggested that an alternative interpretation can be given to the ECtHR's approach. As noted in *BCC v D*,¹⁰¹ the ECtHR made the following comment in *Stanev v Bulgaria*, but gave no further consideration to this point:

The Court observes in this connection that there are situations where the wishes of a person with impaired mental faculties may validly be replaced by those of another person acting in the context of a protective measure and that it is sometimes difficult to ascertain the true wishes or preferences of the person concerned.¹⁰²

As Keehan J describes, this comment has 'the character of a chance passing comment'. However, the ECtHR repeats this phrase in *Mihailovs v Latvia* (2013), citing *Stanev* in support.¹⁰³ The ECtHR then goes on to state in *Mihailovs* that this did not apply in the applicant's case because he 'subjectively perceived his compulsory admission' to be a deprivation of liberty.¹⁰⁴ This indicates that the ECtHR is open to the possibility of someone else consenting on the person's behalf, but that this is subject to two important provisos; the first is that the person purporting to authorise the person's confinement has

⁹⁸ For a discussion on the human rights implications of the system of guardianship see: *Progress of efforts to ensure the full recognition and enjoyment of the human rights of persons with disabilities*, Report of the United Nations Secretary General, A/58/181, paras 14-22.

⁹⁹ (n 74).

¹⁰⁰ (n 12) para 122.

¹⁰¹ (n 12) [54] and [117].

¹⁰² *Stanev* (n 44) para 130.

¹⁰³ *Mihailovs v Latvia* (n 87) para 134.

¹⁰⁴ *Mihailovs v Latvia* (n 87) para 134.

the authority to do so, and the second is that the person being confined has not expressly, or otherwise, shown that he objects to his placement. These points are explored further below.

2.2.2.1 Guardianship – subject to the person’s objection

In *Shtukaturv*, the applicant had been admitted to a psychiatric hospital at the request of his guardian. The ECtHR was not prepared to accept the Government’s position that there was no deprivation of liberty on the basis that under domestic law the admission was considered to be voluntary, having been authorised by the applicant’s guardian. Noting that the factual situation was ‘largely undisputed’, the ECtHR focused on the ‘subjective’ element. It noted that even though the applicant ‘lacked *de jure* legal capacity to decide for himself’, his actions (requesting his discharge and attempting to escape from the hospital) demonstrated that he was *de facto* able to understand his situation.¹⁰⁵ Although the applicant was legally incapable of expressing his wishes, the ECtHR ‘was unable to accept’ that he had agreed to his continued stay in hospital and concluded that he was deprived of his liberty within the meaning of Article 5(1) ECHR.¹⁰⁶

The ECtHR has taken a similar approach in subsequent cases in which the applicant’s confinement in a mental health institution¹⁰⁷ was at the request of his or her guardian. In such cases the ECtHR has made clear that it is concerned with whether the applicant ‘subjectively perceives’ the confinement to be a deprivation of liberty,¹⁰⁸ reiterating that ‘the fact that a person lacks legal capacity does not necessarily mean that he is unable to comprehend his situation’.¹⁰⁹ Thus statements objecting to their admission,¹¹⁰ expressing a desire to leave, requesting discharge from hospital,¹¹¹ trying to escape,¹¹² making ‘complaints to the courts, asking for help to leave and stating that he was there

¹⁰⁵ (n 74). The ECtHR also questioned the domestic courts findings on the applicant’s mental condition and the decision to deprive him of his legal capacity (holding that this was in breach of ECHR art 8, para 96).

¹⁰⁶ (n 74) paras 107 -109.

¹⁰⁷ The ECtHR has considered this issue in relation to psychiatric hospitals (e.g. *Shtukaturv v Russia* (n 74) and social care institutions (e.g. *Stanev v Bulgaria* (n 44)).

¹⁰⁸ *D.D. v Lithuania* (n 93); *Kedzior v Poland* (App 45026/07) 16 October 2013; *Mihailovs v Latvia* (n 87).

¹⁰⁹ *Stanev* (n 44) para 130.

¹¹⁰ *D.D. v Lithuania* (n 93); *Mihailovs v Latvia* (n 87). See also *Sykora v Czech Republic* (App 23419/07) 22 November 2012 (although in its conclusions the ECtHR did not explain why it had held that the applicant had not consented, the summary of the facts of the case note that he had objected to his detention (para 23) and that his lawyer requested his release 5 days after his admission (para 26).

¹¹¹ *D.D. v Lithuania* (n 93) para 150.

¹¹² *D.D. v Lithuania* (n 93) para 150.

against his will',¹¹³ have all been considered by the ECtHR as evidence that the applicant has not consented to the placement.

2.2.2.2 Why objection is relevant in guardianship cases: distinguishing *HL v United Kingdom*

There is a significant, albeit subtle, difference between the manner in which the ECtHR has approached the guardianship cases and that of cases, such as *HL v United Kingdom*. HL's lack of objection (he 'was compliant and never attempted, or expressed the wish, to leave')¹¹⁴ was not relevant because he could not consent to the placement given that he lacked the capacity to do so (and no one else had authority to consent on his behalf).¹¹⁵

Accordingly, (if HL's case had been discussed in such terms) the subjective element (the lack of valid consent) was met. In contrast, the applicant's objections are relevant in the guardianship cases because under domestic law the guardian has authority to agree to the admission on the applicant's behalf. Thus, potentially the subjective element might not be met. However, although acknowledging that there may be cases in which 'due to the severity of his or her incapacity, an individual may be wholly incapable of expressing consent or objection' to the placement,¹¹⁶ the ECtHR is not prepared to accept that the applicant's views can be overridden. It will examine the circumstance of the case to ascertain whether the applicant has said or done anything that demonstrates consent or objection to the confinement. In cases where applicants have expressed their objection to their placement, the ECtHR has concluded that notwithstanding the guardian's consent, the subjective element is met and the applicant is being deprived of his or her liberty. In essence, therefore, it seems that the ECtHR seeks to ascertain whether the applicant's actions rebut the purported consent of the guardian.

From this perspective, it can be seen why in *Mihailovs v Latvia* the applicant's 'tacit acceptance' of his confinement was sufficient to hold that he was not deprived of his liberty, whereas it was not in the case of MIG and MEG in *Cheshire West* (Lady Hale having noted this to be 'the most difficult aspect of the case'¹¹⁷). In *Mihailovs* a guardian had consented to the placement on behalf of the applicant, so the question was whether

¹¹³ *Kedzior v Poland* (n 108).

¹¹⁴ *HL v United Kingdom* (n 30) para 90.

¹¹⁵ *HL v United Kingdom* (n 30). The ECtHR notes (para 93) that the 'hospital did not have authority to act on the applicant's behalf'.

¹¹⁶ *Stanev* (n 44) para 130; *DD v Lithuania* (n 93), *Kedzior v Poland* (n 108) para 58 and *Mihailovs v Latvia* (n 87).

¹¹⁷ *Cheshire West* (n 14) [55]

the applicant's actions rebutted his guardian's consent. In relation to his second placement, the ECtHR concluded that they had not. Whereas he had opposed his placement in the first institution (which the ECtHR held to be a deprivation of liberty) the applicant had refused to move from the second institution, stating that he was satisfied with his stay there, nor had he applied to any domestic authority for his release from the institution. On that basis, the ECtHR concluded that he had 'tacitly agreed to stay' in the institution.¹¹⁸

2.2.2.3 The person consenting to the placement must have the authority to do so

That it is necessary to consider the authority of the person said to be making decisions on the applicant's behalf as well as the views of the applicant is demonstrated in *Atudorei v Romania* (2014),¹¹⁹ in which the applicant had been admitted to hospital on the basis of her mother's consent. The ECtHR first notes that 'at the time of her hospitalisation the applicant was of full age and that there is no evidence in the file that she lacked capacity to decide matters for herself'.¹²⁰ Given that the applicant's mother was said to have signed the informed consent form for the admission on behalf of her daughter, 'on account of the applicant's clinical condition', the ECtHR considered it 'reasonable to assume that the applicant did not directly consent to her hospitalisation and treatment'.¹²¹ The ECtHR then considered the role of the applicant's mother. It noted that there was no evidence to show that the mother had been appointed to act as the applicant's legal representative. Furthermore, given the circumstances of the case, including the conflict between the applicant and her parents, the ECtHR was not convinced that the mother had acted as the applicant's personal representative. On this basis, the ECtHR concluded that the applicant had neither directly, nor indirectly, consented to her hospitalisation and treatment.¹²²

2.2.2.4 Importance of the views of the person being confined

The importance of the person's views was also highlighted in *Atudorei*.¹²³ The ECtHR noted the medical evidence on file regarding the applicant's views about her admission, which stated that 'during her hospitalisation the applicant lacked insight and therefore did not have the ability to recognise the need for her hospitalisation and treatment'.¹²⁴

¹¹⁸ *Mihailovs v Latvia* (n 87) paras 138 – 140.

¹¹⁹ *Atudorei v Romania* (2014) (App 50131/08) 16 September 2014

¹²⁰ *Atudorei* (n 119) para 135.

¹²¹ *Atudorei* (n 119) para 135.

¹²² *Atudorei* (n 119) paras 137 and 138.

¹²³ *Atudorei* (n 119).

¹²⁴ *Atudorei* (n 119) para 137.

On that basis, even though the applicant had not lodged a complaint or attempted to escape, the ECtHR concluded that she had never regarded her admission or treatment as consensual.¹²⁵

2.3 Parental Consent and Deprivation of Liberty: Nielsen Revisited

As previously noted, despite the doubts raised by the national courts¹²⁶ about *Nielsen v Denmark (1988)*,¹²⁷ remains the leading case in relation to deprivation of under 18s in relation to admission to hospital for mental health care. Two points are relevant when considering this judgment.

First is that *Nielsen* was one of the early cases on deprivation of liberty under Article 5 ECHR, being only 8 years after *Guzzardi v Italy (1980)*. Since *Nielsen*, as highlighted in Part 2(2) above, the ECtHR has developed extensive case law in this area. Significantly, it pre-dated the *Storck v Germany* distinction between the objective and subjective elements of a deprivation of liberty.

Second, an obvious feature that distinguishes *Nielsen* from other cases concerning the deprivation of liberty and the admission to psychiatric hospitals or other mental health settings, is the age of the applicant, which meant that his mother was recognised as having the authority to make decisions about the care and upbringing of her child. As Lady Hale notes in *Cheshire West*, it would appear that *Nielsen* ‘turns upon the proper limits of parental authority in relation to a child’.¹²⁸

Accordingly, the decision is considered below with the aim of understanding the ECtHR’s approach in *Nielsen* while also examining whether, in the light of post-*Nielsen* ECHR jurisprudence, there are areas in which the approach would differ today. It does so by considering three areas. First, the role of parents, second, state responsibility and third, the factors which are referred to in the *Nielsen* judgment.

2.3.1 The role of parents

Three key points are relevant when considering the role of parents.

¹²⁵ *Atudorei* (n 119) para 137.

¹²⁶ See for example *Re A and C (Equality and Human Rights Commission intervening)* [2010] EWHC 978 (Fam) [161] ‘*Nielsen*...is widely perceived today as being questionable’.

¹²⁷ *Nielsen* (n 5).

¹²⁸ *Cheshire West* (n 14) [30]. See also *JE v DE* [2006] EWHC 3459 (Fam) (Munby J (as he then was) stated that ‘properly understood’ *Nielsen* ‘is a case about the proper ambit of parental authority’ [30].

First, is the recognition of their authority to act on behalf of their children. That there is a difference between the situation of adults who lack capacity and that of children and young people was highlighted in *HL v the United Kingdom* when the ECtHR rejected the UK government's argument that HL's situation was comparable to *Nielsen*. The ECtHR pointed out that the government's need to first rely on the doctrine of necessity, and subsequently the MHA 1983, as authority for HL's admission and stay on the ward meant that 'the hospital did not have the legal authority to act on the applicant's behalf in the same way as Mr Nielsen's mother'.¹²⁹

Second, is the acknowledgement that parents have rights in relation to the upbringing of their children. Given that Jon Nielsen was 12 years old at the time of his admission to hospital, the ECtHR considered that his mother's rights under Article 8 ECHR were also relevant. Notably, before commencing its analysis of the applicant's complaint, the ECtHR emphasised that the exercise of parental rights constitutes a fundamental element of family life' under Article 8 ECHR, a view it has since reiterated.¹³⁰ Moreover, the ECtHR stated (which again, it has recently reiterated¹³¹) that family life 'encompasses a broad range of parental rights and responsibilities in regard to the care and custody of minor children' and that this 'normally and necessarily' requires that parents 'impose, or authorize others to impose, various restrictions on the child's liberty'. Furthermore:

'Thus the children in a school or other educational or recreational institution must abide by certain rules which limit their freedom of movement and their liberty in other respects. Likewise a child may have to be hospitalised for medical treatment.'¹³²

In *Glass v United Kingdom (2004)* the ECtHR recognised the authority of parents to make treatment decisions on behalf of their children, referring to the mother of a 'severely handicapped child' as acting as her son's 'legal proxy'.¹³³

Third, notwithstanding the recognition of such parental rights, ECtHR stated in *Nielsen* that 'the rights of the holder of parental authority cannot be unlimited'¹³⁴ (albeit it did not elaborate on this point) and that the protection afforded by Article 5 'clearly also covers

¹²⁹ *HL v the United Kingdom* (n 30) para 93.

¹³⁰ *Glass v UK* (2004) 39 EHRR 341, para 70.

¹³¹ *Diamante and Pelliccioni v San Marino*, (App 3225/08) 8 March 2012 para 170.

¹³² *Diamante* (n 126) para 61, referring to *R v the United Kingdom* (1987) 10 EHRR 74 para 64: 'The exercise of parental rights and the mutual enjoyment by parent and child of each other's company constitute fundamental elements of family life'.

¹³³ *Glass v UK* (n 129) para 70.

¹³⁴ *Nielsen* (n 5) para 72.

minors'.¹³⁵ It has since emphasised that a parent cannot be entitled under Article 8 to have such measures taken as would harm the child's health and development'.¹³⁶ It has also emphasised that 'in respecting parental rights, the authorities cannot ignore the child's interests, including its own right to respect for private and family life'.¹³⁷

2.3.2 State responsibility for the intervention

The ECtHR's finding that the Danish government was not responsible for the applicant's confinement in a State-run Child Psychiatric Ward¹³⁸ is perhaps the issue that most depends upon the peculiar facts of *Nielsen*.

The ECtHR considered that as the applicant's mother was the 'sole person with power to decide on her son's hospitalisation or on his removal from hospital' under Danish law, 'the assistance rendered by the authorities was of limited and subsidiary nature'.¹³⁹ It would appear that there were two reasons for this. First, the applicant's father did not have parental responsibility and therefore his views were not relevant (the applicant's complaint was part of a more complex and long-standing custodial dispute between his unmarried parents). Secondly, the applicant had a 'nervous condition' rather than a 'psychotic disorder', which meant that the Danish mental health legislation did not apply to the applicant (and therefore he could not be detained compulsorily).¹⁴⁰

The ECtHR considered that the involvement of the police in bringing the applicant back to the unit was not sufficient to incur State liability for the placement because this would have been something the police would have done in relation to a boy of his age (bringing him back home). On this basis it can be distinguished from *Storck* in which (as discussed above) the ECtHR considered that the fact that the police brought the applicant back to the clinic was evidence of State involvement, although given the development of ECHR case-law on this point (noted above) if considered today, the ECtHR may well take a different view.

¹³⁵ *Nielsen* (n 5) para 58.

¹³⁶ *Neulinger and Shuruk v Switzerland* (2012) 52 EHRR 11 para 136.

¹³⁷ *Osman v Denmark* (2015) 61 EHRR 10 para 73.

¹³⁸ The Danish government argued both that Article 5 was not applicable because Jon Nielsen's hospitalisation was the responsibility of his mother and not the State and that in any event it did not give rise to a deprivation of liberty within the meaning of Article 5 *Nielsen* (n 5) para 60.

¹³⁹ *Nielsen* (n 5) para 63.

¹⁴⁰ *Nielsen* (n 5). The Mentally Ill Persons Act 1938 did not apply to individuals with 'a mental disorder of a non-psychotic nature' – see paras 47– 52, whereas Jon Nielsen had a 'nervous condition' (para 70).

2.3.3 Key factors in determining if a deprivation of liberty has arisen

Having held that the decision to hospitalise her son was made by the applicant's mother, the ECtHR went on to assess three areas; first whether the mother was acting lawfully and appropriately, second Jon Nielsen's actual situation and third his views on the situation (albeit little weight was given to this latter point). Each of these are considered below.

2.3.3.1 Whether the parent is acting lawfully and appropriately

Although the ECtHR started its assessment of whether a deprivation had arisen by stating that it must consider Jon Nielsen's 'actual situation' while in hospital, 'taking into account 'such factors as the type, duration, effects and manner of implementation of the measures in question' (the objective element),¹⁴¹ this was not its first consideration. Rather, the ECtHR focused on the basis for the mother's decision to admit her son to a psychiatric hospital. It found that the decision of the applicant's mother to do so was considered by the domestic authorities to be lawful and 'well-founded',¹⁴² that she had acted on medical advice and 'had as her objective the protection of the applicant's health' which the ECtHR commented was 'certainly a proper purpose for the exercise of parental rights'.¹⁴³ This concern resonates with its post-UNCRC emphasis that 'the child's best interests must be the primary consideration'.¹⁴⁴

2.3.3.2 Assessing the restrictions placed on the adolescent: 'reasonable parenting restrictions'

The ECtHR stated that there 'is also no reason to find' that the treatment given to Jon Nielsen at the hospital and the 'conditions under which it was administered...were inappropriate in the circumstances'. It noted that the applicant was in need of treatment for 'his nervous condition' and that the treatment, which was 'curative', 'did not involve medication, but consisted of regular talks and environmental therapy'.¹⁴⁵ In relation to the applicant's 'freedom of movements and contacts with the outside world, the ECtHR considered that these were not much different from restrictions which might be imposed on a child in an ordinary hospital' and that 'in general, conditions on the Ward were said to be "as similar as possible to a real home"'. It also noted that while the duration of his treatment was 5½ months, which the ECtHR conceded 'may be a long time for a boy of

¹⁴¹ *Nielsen* (n 5) para 67, referring to *Guzzardi* (n 76) and *Ashingdane v United Kingdom* (1985) ECHR 528.

¹⁴² *Nielsen* (n 5) para 68.

¹⁴³ *Nielsen* (n 5) para 69.

¹⁴⁴ *Neulinger and Shuruk v Switzerland* (n 131) para 134.

¹⁴⁵ *Nielsen* (n 5) para 70.

12 years of age' this was no more than the average period of therapy on the ward and that 'the restrictions imposed were relaxed as treatment progressed'.

The restrictions imposed on Jon Nielsen (which included being on a locked ward, from which he could only leave with permission¹⁴⁶) are similar to those imposed on the applicant in *Stanev v Bulgaria*, during his confinement in a social care home, which the ECtHR found to have met the objective element of a deprivation of liberty.¹⁴⁷ In addition, Jon Nielsen stated (which does not appear to have been disputed by the Government) that he needed permission to receive visitors and make contact with people outside the hospital and that he was 'under almost constant surveillance'.¹⁴⁸ However, having concluded that Jon Nielsen's mother was acting lawfully and her authorisation of his care and treatment in hospital fell within the type of decisions appropriate for his mother to make, the ECtHR held that applicant's hospitalisation 'was a responsible exercise by his mother of her custodial rights in the interest of the child'.¹⁴⁹

One possible interpretation of the ECtHR's approach is that when considering the restrictions that can be authorised by a parent, a different standard is applied when considering the applicant's 'concrete situation' (what the ECtHR now refers to as the 'objective element'). This can be compared to *Engel and others v The Netherlands* (1976) in which the ECtHR recognised that members of the armed forces might be subject to restrictions that would not be acceptable for citizens. It considered that 'rather wide limitations on the freedom of movement of the members of the armed forces are entailed by reason of the specific demands of the military service so that normal restrictions accompanying it do not come within the ambit of Article 5'. Thus:

A disciplinary penalty or measure which on analysis would unquestionably be deemed a deprivation of liberty were it to be applied to a civilian may not possess this characteristic when imposed upon a serviceman.¹⁵⁰

¹⁴⁶ *Nielsen* (n 5) para 70 (although by the end of his period in hospital, he was visiting his parents regularly and going to school).

¹⁴⁷ *Stanev* (n 44) para 124 notes that although allowed to leave the social care home, Mr Stanev, needed express permission to do so 'and the time he spent away from the home and the places where he could go were always subject to controls and restrictions'.

¹⁴⁸ *Nielsen* (n 5) para 65.

¹⁴⁹ *Nielsen* (n 5) para 72.

¹⁵⁰ *Engel* (n 72) para 59.

However, Article 5 ECHR is engaged if the restrictions ‘clearly deviate from the normal conditions of life within the armed forces of the Contracting States’.¹⁵¹

Another similarity between *Engel* and *Nielsen* is that in both the ECtHR was seeking to assess what was acceptable within the context of the applicant’s situation. In *Engel* the ECtHR’s distinction between the disciplinary measures that amounted to a deprivation of liberty and those that did not, focused on not just where and for how long the soldiers were confined, but also whether they were ‘excluded from the performance of their normal duties’.¹⁵² In *Nielsen* the ECtHR made the comparison between the restrictions placed on him on the children’s psychiatric ward and the restrictions that would have been placed on a boy of his age during period of admission on a non-psychiatric hospital ward. It concluded that the restrictions placed on the applicant ‘were no more than the normal requirements for the care of a child of 12 years of age’ receiving treatment in hospital’ and the conditions on the ward ‘did not, in principle, differ from those obtaining in many hospital wards where children with physical disorders are treated’.¹⁵³

This suggests that in the ECtHR’s view the kind of restrictions that would normally be placed on a child of that age (12 years) receiving treatment in a general children’s ward fall within the types of restrictions that a parent can consent to – these might be termed ‘reasonable parenting restrictions’. The restrictions that are placed on patients in a psychiatric ward would not fall within such a category. This seems to be the point being made by the ECtHR in its otherwise rather odd comment that ‘he was not detained as a person of unsound mind so as to bring the case within [Article 5(1)(e)]’. Seemingly, a significant factor in reaching this conclusion was that the ward was not used for patients detained under Danish mental health legislation or ‘of patients otherwise suffering from mental illnesses of a psychotic nature’.¹⁵⁴ Significantly, in subsequent cases the ECtHR has highlighted the fact that he was not given medication as one of the features that

¹⁵¹ *Engel* (n 72) paras 57 - 59. The ECtHR went on to add (para 59), what has become, with slight variation, the standard approach taken by the ECtHR when assessing whether a deprivation of liberty has arisen; namely that ‘account should be taken of a whole range of factors such as the nature, duration, effects and manner of execution of the penalty or measure in question’.

¹⁵² *Engel* (n 72) para 60.

¹⁵³ *Nielsen* (n 5) para 72. A similar observation was made by the Court of Appeal in its 2017 decision *R (Ferreria) v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31 [93] when stating that in *Nielsen* ‘[t]he majority held that there was no deprivation of liberty because the treatment would have been the same if the applicant had been treated on another ward for his physical illness’.

¹⁵⁴ *Nielsen* (n 5) para 72. Indeed, in subsequent cases the ECtHR has highlighted the fact that he was not given medication as one of the features that distinguishes Jon Nielsen’s case from other applicants who were given medication for mental disorder, without their consent.

distinguishes Jon Nielsen's case from other applicants who were given medication for mental disorder, without their consent.¹⁵⁵

2.3.3.3 Views of the child

In *Stanev*, the ECtHR referred to Jon Nielsen being 'a child who was not capable of expressing a valid opinion'.¹⁵⁶ This observation might be on the basis that in *Nielsen* the ECtHR concluded that 'he was still of an age at which it would be normal for a decision to be made by the parent even against the wishes of the child'.¹⁵⁷

Although the ECtHR took little account of Jon Nielsen's views due to his age, the decision pre-dated the UNCRC, (it came into force in 1990), and as discussed in Chapter 1, Article 12 provides for the right of children who are capable of forming their view 'to express those views freely' in all matters affecting them with their views 'being given due weight in accordance with their age and maturity'.¹⁵⁸ The ECtHR has adopted this approach, noting that children's opinions on the relevant subject should be taken into account 'once they had attained the necessary maturity to express them'.¹⁵⁹

Another potential influence is that of the ECHR jurisprudence on the guardianship cases. The ECtHR's finding in *Nielsen* that the applicant's hospitalisation was his mother's decision, 'in her capacity as holder of parental rights' (with the sole powers to admit the applicant to, and discharge him from, hospital) is analogous to the 'guardianship cases' considered above. These cases not only emphasise the importance of the views of adults, irrespective of their legal capacity but make clear that the applicant's views are determinative. Where applicants have expressed their objection to their placement, for example expressing a desire to leave or trying to escape, the ECtHR has concluded that notwithstanding the guardian's consent, the subjective element is met so that the applicant is being deprived of his or her liberty.¹⁶⁰ Given the emphasis on taking children

¹⁵⁵ *Atudorei v Romania* (n 119) para 181; *DD v Lithuania* (n 93) para 149.

¹⁵⁶ *Stanev* (n 44) para 122.

¹⁵⁷ *Nielsen* (n 5) para 72.

¹⁵⁸ The Committee on the CRC's general comment on Article 12 states that children do not have to have 'comprehensive knowledge of all aspects of the matter affecting [them]', rather that they have 'sufficient understanding to be able to capable of appropriately forming [their] own views on the matter'. This right requires recognition of and respect for non-verbal forms of communication such as body language and facial expressions. Furthermore, 'children with disabilities should be equipped with, and enabled to use, any mode of communication necessary to facilitate the expression of their views' CRC/C/GC/12 [21]

¹⁵⁹ See for example, *Pini v Romania* (2005) 40 EHRR 13 para 164.

¹⁶⁰ See for example *Shtukaturov v Russia* (n 74) para 110 and *Mihailovs v Latvia* (n 87).

and young people's views into account, the ECtHR may well adopt a similar approach to adolescents' psychiatric placements.

2.4 Deprivation of Liberty: Summary of Relevant Factors

Set out below is a summary of the key issue relevant to determining whether a deprivation of liberty has arisen; dividing the discussion between adults and adolescents and in each identifying any differences between the approach taken by the ECtHR and that adopted by the national courts.

2.4.1 Adults and deprivation of liberty

As confirmed by *Cheshire West*, the national courts approach to ascertaining whether a deprivation of liberty has arisen for the purpose of Article 5 ECHR is the same as that of the ECtHR. For there to be a deprivation of liberty the objective and subjective elements must be met, and this must be imputable to the state. There are two key areas of difference.

First, under English law, the objective element is assessed against the 'acid test' (whether the person is a) under continuous care and supervision and b) not free to leave) whereas the ECtHR has not formulated such a concise test.

Second, whereas under English law, as noted by Lady Hale in *Cheshire West*, 'there is no equivalent in English law to parental authority over a mentally incapacitated adult', the position is not so clear cut under ECHR jurisprudence. For the reasons outlined under Part 2 (2) above, it is suggested (contrary to the points made in *BCC v D*) there are indications that the ECtHR does not exclude the possibility of a person authorised to act on behalf of the applicant being able to consent to the confinement with the result that the subjective element is not met. However, this is subject to that person acting lawfully and moreover, is rebutted if the applicant objects to the confinement, whether expressly or otherwise.

2.4.1 Adolescents and deprivation of liberty

The approach that the ECtHR takes to determining the deprivation of liberty of adolescents is less clear than that of adults for the simple reason that it has not considered this issue since *Nielsen*. Not only is *Nielsen* controversial, it is also over thirty years old. In the meantime, the ECtHR has developed extensive jurisprudence in this area, including identifying the objective and subjective elements of a deprivation of

liberty. In relation to state responsibility, given its more recent case-law, it is possible that the ECtHR would hold a *Nielsen*-type confinement to be imputable to the state (the approach taken by the national courts is considered in Part 3 below). In relation to the assessment for whether a deprivation of liberty has arisen, the question is whether the ECtHR would adopt the *Storck* test (whether the objective and subjective elements are present) for determining if an adolescent's confinement amounts to a deprivation of liberty, and if it did, whether it would view parental consent as being relevant to determining whether the subjective element was met. This gives rise to the following observations.

First, in *Nielsen* the ECtHR considered three key areas, namely whether the parent was acting lawfully and appropriately; whether the restrictions were what might be described as 'reasonable parenting restrictions' and views of the adolescent. As noted above, given its more recent jurisprudence, it is likely that today greater weight would be given to the adolescent's view than the ECtHR gave to Jon Nielsen's wishes. It is possible that, as in the guardianship cases, the ECtHR would regard the adolescent's wishes to be determinative, in other words even if the parent was acting lawfully and appropriately and the confinement fell within reasonable parenting restrictions, the adolescent's objection would rebut the parent's consent, thereby giving rise to a deprivation of liberty has arisen. As noted in the guardianship cases, the ECtHR is not concerned with the person's legal or mental capacity, but whether they have indicated any objection to their confinement.

Secondly, whereas an adult can agree to significant restrictions being placed on them and the fact that they have consented to such restrictions means that they are not deprived of their liberty (because the subjective element is not met), this is not the case for parents. As noted in Part 1 when considering the scope of parental responsibility, both the ECtHR and national law recognise that there are limits to what parents can agree to on behalf of their child, even if the parents are willing and able to do so, and irrespective of the adolescent's compliance.

Thirdly, in the aftermath of *Cheshire West* questions were raised as to how the 'acid test' should be applied to under 18s. In *Deprivation of liberty: a practical guide*, the Law Society proposes that a 'nuanced acid test' should be applied.¹⁶¹ Referring to comments in *Nielsen* and in *Cheshire West*, the Law Society argues that for under 18s 'the acid test should be considered in the context of the liberty-restricting measures that are universally

¹⁶¹ (Law Society, April 2015) para 9.8.

applied to those of the same age and maturity who are free from disability'.¹⁶² Support for such an approach can be gleaned from *Cheshire West*. For example, Lord Kerr commented (albeit *obiter*), that '[a]ll children are (or should be) subject to some level of restraint' which 'adjusts with their maturation and change of circumstances' so when assessing if a deprivation of liberty had arisen, the relevant comparator is a child or young person of the same age.¹⁶³ Lady Hale did not address this question specifically, but having rejected the 'relative normality' approach (comparing the life of a person with disabilities 'with the life which another person with his disabilities might be leading'), she commented that she had 'much more sympathy' with a comparison 'with the ordinary lives which young people of their ages might live at home with their families'.¹⁶⁴

Fourthly, recognition that the role of parents and the level of restrictions parents place on their child as part of 'normal parenting' is integral to the UNCRC in its concept of the evolving capacities of the child, which refers 'to the process of maturation and learning whereby children progressively acquire knowledge, competencies and understanding, including acquiring understanding about their rights and about how they can best be realized'.¹⁶⁵ As the child increases in his or her knowledge, experience and understanding the more the parent has 'to transform direction and guidance into reminders and advice and later to an exchange on an equal footing'.¹⁶⁶ This is reflected in the MHA Code 2015 which states that practitioners 'will need to determine whether the care regime for, and restrictions on, the child accord with the degree of parenting control and supervision that would be expected for a child or young person of that age'¹⁶⁷ and that the parent's role in decision-making 'should diminish as their child develops greater independence with accordingly greater weight given to the views of the child or young person'.¹⁶⁸

Fifth, when considering whether the confinement of an adolescent gives rise to a deprivation of liberty in the post-*Cheshire West* era, the national courts consider both the objective element (applying the acid test, without modification) and the relevance of parental consent.

¹⁶² Law Society, April 2015 (n 161) para 9.9.

¹⁶³ *Cheshire West* (n 14) [77]–[79].

¹⁶⁴ *Cheshire West* (n 14) [47].

¹⁶⁵ CRC General Comment No. 7 (2005) *Implementing child rights in early childhood* para 17.

¹⁶⁶ General comment no. 12 *The right of the child to be heard* (CRC/C/GC/12) para 84.

¹⁶⁷ MHA Code 2015 para 19.47.

¹⁶⁸ MHA Code 2015 para 19.41.

It is argued that there has been a failure to identify and distinguish between a) the elements that give rise to a deprivation of liberty and b) the factors relevant to whether a decision falls within the scope of parental responsibility. This has added to the confusion and uncertainty in this area of law, as well as leading to an inconsistent approach between adolescents aged under 16 years and those aged 16 and 17 years when determining whether an adolescent's confinement gives rise to a deprivation of liberty. This is discussed in Part 3.

PART 3: PARENTAL CONSENT AND ADMISSION TO HOSPITAL

Part 3 considers issues arising from two cases, *Trust A v X* and *BCC v D*, both of which crucial to the question whether an adolescent who lacks decisional capacity can be admitted and treated in hospital on an informal basis.

The decision of *Trust A v X* is analysed first by considering the three 'human rights decision-making questions' set out in Chapter 1. It therefore focuses on the legal authority for D's placement (the justification question); the extent to which this took into account D's wishes (the wishes versus welfare question); and how this compares to human rights standards (the human rights comparison question). This is followed by consideration of the inconsistencies that arise between the decisions of *BCC v D* and *Trust A v X*.

3.1 Adolescents under 16

Trust A v X concerned the placement of 15 year old ('D') in a psychiatric unit and whether it amounted to a deprivation of liberty under Article 5 of the ECHR. D was considered to lack *Gillick* competence 'to consent to his residence and care arrangement or to any deprivation of liberty'¹⁶⁹ and his parents had consented to his admission and continued stay in hospital on his behalf. However, the Trust submitted that D's parents could not consent to D's placement in hospital because such a decision 'falls outside the "zone of parental responsibility"'. Accordingly, it sought 'the court's approval of D's placement under the inherent jurisdiction of the High Court',¹⁷⁰ (D's treating psychiatrist being of the view that the use of the MHA 1983 would be 'inappropriate'¹⁷¹). The local authority

¹⁶⁹ *Trust A v X* (2) [20].

¹⁷⁰ *Trust A v X* (n 2) [6]–[8].

¹⁷¹ *Trust A v X* (n 2) [20]. The reason given for this was that 'It is not necessary to detain D in order to treat him'. It is not clear what this means. Nonetheless, this view seems to have been accepted by the court and the parties involved without seeking any further information or explanation.

argued that the placement did not amount to a deprivation of liberty, the parents could consent to the placement as this was a 'proper exercise of their parental responsibility' and the State was not responsible for D's placement.¹⁷²

3.1.1 The Scope of Parental Responsibility

The justification for authorising D's placement in a locked ward (where he had been placed for the previous 15 months) was that the court held this to be 'in the proper exercise of parental responsibility'. However, although using the term, 'the zone of parental responsibility' when referring to decisions that fall within the 'proper exercise of parental responsibility'¹⁷³ no reference is made to the guidance provided on this concept in either the MHA Code 2008 or MHA Code 2015 (which at the time of the judgment had been published but was not in force) on what factors need to be considered in making this determination. The guidance in both Codes identify factors relevant to whether parental consent can authorise the proposed intervention.¹⁷⁴

The effect of relying on parent consent in this case was that D was not deprived of his liberty because his parents were able to consent to D's placement, thereby meaning that the subjective element of a deprivation of liberty was not satisfied.¹⁷⁵ Although the Judge emphasised that such cases have to be decided on their own facts, this case suggests that significant and prolonged restrictions could be authorised by parental consent. Furthermore, although the children's guardian was noted to have observed that D was well placed in the hospital and was progressing, D's views on his placement do not seem to have been sought.

Keehan J seemed to consider that as D's parents were acting on the advice of the treating clinicians and were acting in his best interests, this was sufficient for this to fall within the scope of parental responsibility. However, as noted in Part 1, this concept includes a range of factors which would need to be considered when deciding whether the decision can be made by the adolescent's parents.

In relation to the type of intervention, the MHA Code 2015 refers to decisions that are 'beyond the kind of decisions that parents routinely make in relation to the medical care of their child', advising that 'clear reasons as to why it is acceptable to rely on parental

¹⁷² *Trust A v X* (n 2) paras 57 – 61.

¹⁷³ *Trust A v X* (n 2) [57] Reference is made to 'the zone of parental control' and the 'zone of parental responsibility', presumably the latter is an amalgamation of the former and the MHA Code 2015's revised term for the same issue, namely 'the scope of parental responsibility'.

¹⁷⁴ MHA Code 2008 paras 36.9 – 36.15; MHA Code 2015 paras 19.38 – 19.41.

¹⁷⁵ *Trust A v X* (n 2) [46].

consent to authorise this particular decision will be required'. When considering the 'type and invasiveness of the intervention', it states 'the more extreme the intervention, the greater the justification will be required'. However, the reasons for the intervention cannot be considered in isolation. The MHA Code 2015 notes that even where the intervention is necessary to prevent a serious deterioration of the adolescent's health this would need to be balanced against factors such as whether the adolescent is resisting and whether the proposed treatment is invasive or controversial.

Keehan J emphasised that his decision was based on the particular facts and he declined to give wider guidance on the approach to be taken by practitioners. For this reason, while in D's case the court considered that the parents could authorise significant restrictions on behalf of their son, *Trust A v X* should not be regarded as authorising similar restrictions in other cases. In cases where parental consent is being considered as a possible route for the adolescent's in-patient psychiatric care, the MHA Code 2015 will need to be considered. As noted in Chapter 1, this is statutory guidance and therefore should be followed unless there are cogent reasons for not doing so.

3.1.2 Confusion on meaning of a deprivation of liberty

That there is confusion on the meaning of a deprivation of liberty in relation to under 18s is illustrated by the Law Commission's observation that that in 'RK v BCC the Court of Appeal accepted that "detention engages the article 5 rights of the child and a parent may not lawfully detain or authorise the detention of a child"', but that this was doubted by Keehan J in *Trust A v X*,¹⁷⁶ a view that the Judge reiterated in *BCC v D*.¹⁷⁷ As highlighted by the Law Commission, this leaves the impression that Article 5 of the ECHR does not apply to adolescents in such circumstances. Furthermore, Keehan J's interpretation of the Court of Appeal's statement on parental consent and deprivation of liberty is problematic because it fails to take into account two crucial points; the first being the requirements for a deprivation of liberty to arise and the second is that there are limits to parental powers. These two points are considered below.

3.1.2.1 Requirements for a deprivation of liberty

When discussing the law relevant to deprivation of liberty, Keehan J noted that in the Court of Appeal's decision of *RK v BCC and others*, (which concerned the accommodation of a young person under section 20 of the Children Act 1989) Thorpe LJ had said that 'a parent may not lawfully detain or authorise the deprivation of liberty

¹⁷⁶ Law Com CP No. 222, 2017 (n 15) para. 15.4.

¹⁷⁷ *BCC v D* (n 12) [61].

of a child'.¹⁷⁸ Having called into question Thorpe LJ's observation that parents cannot authorise the deprivation of liberty of their child, Keehan J added that it is 'obvious that young children will be under the "complete supervision and control" of the parents and "will not be free to leave" the family home without supervision' and that this 'would certainly not amount to a deprivation of liberty'.¹⁷⁹

While at first sight this statement has the advantage of reflecting common sense – rightly questioning why such situations, which necessarily form part of everyday family life, would amount to a deprivation of liberty – it is suggested that the dismissal of Thorpe LJ's statement does not reflect the three components of a deprivation of liberty under Article 5, namely the objective element, the subjective element and State responsibility. All three must be met for Article 5 ECHR to be engaged, which would not be the case where parents are placing restrictions on their young children as part of their normal parenting responsibilities in the family home. Applying the *Cheshire West* acid test to such situations, the children concerned will be objectively deprived of their liberty, however, a deprivation of liberty will not arise if the parents are able to give valid consent to the restrictions. Moreover, Article 5 ECHR is engaged only where the State has some responsibility for the deprivation of liberty, which is not the case in normal family life.¹⁸⁰

3.1.2.2. Limits to parental powers

Although in *Trust A v X*, the court identified the subjective element (in the form of parental consent) as being central to the decision, Keehan J makes no reference to relevant ECtHR jurisprudence. As discussed in Part 2 above, the ECtHR considered three key areas in *Nielsen* when deciding whether Jon Nielsen was deprived of his liberty. The ECtHR was concerned with whether his mother was acting lawfully and in her son's best interests and the type and duration of the restrictions placed on him while he was in hospital. The ECtHR likened the restrictions placed on Jon Nielsen to those placed on a child of his age (12 years) in a general hospital, and thus might be described as 'reasonable parenting restrictions'. The court concluded in *Trust A v X* that if the restrictions had been imposed on a non-disabled boy of the same age they 'would undoubtedly be considered an inappropriate exercise of parental responsibility and

¹⁷⁸ *RK v BCC and others* [2011] EWCA Civ 1305.

¹⁷⁹ *Trust A v X* (n 2) [30].

¹⁸⁰ Keehan J suggests that the Thorpe LJ's statement is inconsistent with comments made by Lord Neuberger [72] and Lord Kerr [79] in *Cheshire West* (n 14). However, it is suggested that Lord Neuberger's comments were directed to the lack of State involvement and Lord Kerr's comments were part of his arguments as to why it is necessary to use a comparator of a child or the same age when considering whether the objective element of a deprivation of liberty is met; see [77]–[79].

would probably amount to ill treatment'.¹⁸¹ While it may not be possible to formulate a precise definition of 'reasonable parenting restrictions' given that much will depend on the particular facts, it is suggested that the court's description of D's care regime, together with the length of time that D was hospitalised, show that the range and intensity of restrictions placed on D far exceeded the actions that parents undertake as part of the care and upbringing of their children.

In relation to the views of the adolescent, although in *Nielsen* the ECtHR paid little attention to his views, it did make reference to them. For the reasons highlighted in Part 2 above, it is argued that these would carry far greater weight today in determining whether a deprivation of liberty has arisen, notwithstanding the parent's consent. By analogy with the guardianship cases, it is suggested that where the adolescent is aware that he is being confined and objects to this, parental consent would not be sufficient and the confinement amounts to a deprivation of liberty.

3.2 Treating under 16s differently from 16 and 17s: inconsistencies

In *BCC v D* the court held that parents cannot consent 'to the confinement of a child who has attained the age of 16 because this falls outside the zone or scope of parental responsibility'.¹⁸² Questions about the reasons for making the distinction between adolescents aged under 16s and those aged 16 and 17, followed by concerns about the inconsistencies arising from this approach, are outlined below.

3.2.1 Reason for distinguishing between the two age groups

The basis for the court holding that parental consent cannot be relied upon to authorise the confinement of an adolescent aged 16 or 17 is that Parliament has distinguished between 16 and 17 year olds and those under 16. That there are areas on which Parliament has made such a distinction is noted in Chapter 1 and relevant provisions are discussed in Chapters 2 and 3. However, whether the consequence of such legislation is that parents no longer have a role in decision-making is questionable. For example, the inclusion of 16 and 17 year olds in the MCA 2005 (of which Keehan J was 'particularly persuaded by'¹⁸³ as a reason for making the distinction) was not envisaged as removing the power of parents to make decisions for their child of this age. As noted in Chapter 3, 16 and 17 years olds cannot make advance refusals of treatment or appoint a Lasting Power of Attorney because the Law Commission considered that these would be

¹⁸¹ *Trust A v X* (n 2) [57].

¹⁸² *BCC v D* (n 12) [142].

¹⁸³ *BCC v D* (n 12) [104].

inconsistent with the powers of the courts and parents.¹⁸⁴ The MCA Code of Practice states that '[u]nder common law, a person with parental responsibility for a young person is generally able to consent to the young person receiving care or medical treatment where they lack capacity under section 2(1) of the Act'.¹⁸⁵ It would seem that rather than to acknowledge their greater autonomy, the Law Commission's reason for recommending the inclusion of young people in the proposed reforms was more to do with closing a potential gap in protection, given that not all 16 and 17 year olds would be covered by the statutory protections under the Children Act 1989.¹⁸⁶

3.2.2 *Inconsistencies created by distinguishing between the two age groups*

Having found that Parliament has accorded a special status to 16 and 17 year olds, the court in *BCC v D* proceeded to highlight three important points in relation to this age group, as well as explaining why the state was responsible for D's confinement. Each of these are outlined below.

First, the court stating that 16 and 17 year olds 'are entitled to the full protection of their Article 5(1) rights irrespective of their capacity to consent to their treatment or their living arrangements'.¹⁸⁷ It is not clear why this point would not also apply to under 16s.

Secondly, in relation to substituted consent; the court held that parents cannot consent to the adolescent's confinement 'which absent a valid consent would be in breach of Art 5(1)',¹⁸⁸ even if that young person is 'incapacitous'.¹⁸⁹ Notwithstanding the discussion above in which it is suggested that the ECtHR does allow substituted consent, albeit in very limited circumstances, if there is no basis on which parents can give substituted consent in relation to their child aged 16 or 17, it is not clear why this is permitted for those aged under 16.

Thirdly, in relation to disability discrimination; the court was of the view that relying on parental consent because the adolescent 'by reason of his disabilities he cannot consent'

¹⁸⁴ Law Commission *Mental Incapacity* (Law Com No 231, 1995) paras 2.52 and 7.20

¹⁸⁵ Department for Constitutional Affairs, *Mental Capacity Act 2005 Code of Practice* (TSO, 2007 (MCA Code) 12.16

¹⁸⁶ For example, care orders cannot be made in relation to 17 year olds (or 16 year olds who are married). The Law Commission Consultation paper No. 128 para 3.5 noted that leaving the protections to the Children Act 1989 'would leave an undesirable one (or two if married) year gap during which public intervention to protect an incapacitated minor would only be available under the surviving inherent jurisdiction'.

¹⁸⁷ *BCC v D* (n 12) [115].

¹⁸⁸ *BCC v D* (n 12) [122] see also [115].

¹⁸⁹ *BCC v D* (n 12) [115].

would amount to disability discrimination.¹⁹⁰ Keehan J noted that in *Cheshire West* Lady Hale ‘emphasised that all people, including those with disabilities are entitled to the protection of the Convention and in particular to that afforded by Article 5’.¹⁹¹ In this regard, the court in *BCC v D* considered that ‘precisely because of his disabilities and vulnerability’ it was ‘vital that D is accorded the same status as a 16 year old without an disabilities and to afford him the full protection of Article 5’.¹⁹² Keehan J’s considered that his approach in *Trust A v X* could be distinguished because ‘D’s disabilities were an important, indeed, an essential, factor in determining what was a proper exercise of parental responsibility by these parents for this child’.¹⁹³ However, it is difficult to see how the essence of the issue is different. When considering ‘the exercise of parental responsibility’ in *Trust A v X* the court took into account D’s autism and his other diagnosed conditions’ because they were important factors ‘when considering his maturity and his ability to make decisions about his day to day life’.¹⁹⁴ Thus, in both cases the question of D’s disabilities is raised in connection with his decisional capacity and the parents’ authority to consent. Article 7 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) provides that States should take action to ensure that children with disabilities are able to enjoy their human rights ‘on an equal basis with other children’.

Accordingly, it is not clear why the court’s reasons for concluding that parents cannot consent to the objective element of a deprivation on behalf of their 16 and 17 year old child do not also apply to adolescents aged under 16.

Another area in which the approach taken in the two cases are very different is that of state responsibility for the confinement. In *BCC v D* the court was of the view that the state was involved both because the local authority was responsible for arranging D’s placement and in any event ‘the state has a positive obligation under Article 5(1) to protect him’.¹⁹⁵ In addition as noted in Part 2, ECtHR jurisprudence has established that the State will be involved if it implements the decisions of private individuals.¹⁹⁶ It has also commented on a number occasions that the actions of health professionals in State run hospitals will engage State responsibility.¹⁹⁷ For these reasons, the court’s view in

¹⁹⁰ *BCC v D* (n 12) [124].

¹⁹¹ *BCC v D* (n 12) [124], referring to *Cheshire West* (n 14) [46].

¹⁹² *BCC v D* (n 12) [124].

¹⁹³ *BCC v D* (n 12) [125] (emphasis in the original).

¹⁹⁴ *Trust A v X* (n 2) [55].

¹⁹⁵ *BCC v D* (n 12) [132] and [135].

¹⁹⁶ *Shtukaturov* (n 74) para 27.

¹⁹⁷ *Glass v the United Kingdom* (n 129) para 71; *MS v Croatia* No 2 (n 75) para 99 and *P and S v Poland* (App 57375/08) 30 October 2012 [2013] 1 FCR 476 para 129.

Trust A v X, that there was no reasons why the state should interfere with decisions made by the parents about their son's care and living arrangements given that the parents were following medical advice and taking action that was in their son's best interests is at odds with ECtHR jurisprudence.¹⁹⁸

CONCLUSION

This chapter has considered the two concepts of the scope of parental responsibility and deprivation of liberty and their relevance to the legal framework for adolescent psychiatric care. They are important because they are key factors in determining whether an adolescent who lacks decisional capacity can be admitted informally, or whether formal admission under the MHA 1983 is required. The following points focus on the two areas of inquiry, namely the potential areas of confusion in this area of law and their human rights implications.

(1) Potential areas of Confusion

- (a) *Scope of parental responsibility*: concerns have been raised about this concept in that it is considered to be unclear and poorly understood. This is illustrated by the decision in *Trust A v X* which did not consider the guidance in either the MHA Code 2008 or the MHA Code 2015, even though both provide detailed guidance on the scope of parental responsibility. The guidance sets out a range of factors that need to be considered before deciding on whether parental consent can be relied upon to authorise an adolescent's admission to hospital and treatment therein.
- (b) The question of deprivation of liberty and how it links to the scope of parental responsibility is only just beginning to be considered by the courts. This chapter has identified the importance of considering when a deprivation of liberty arises for the purpose of Article 5 of the ECHR (objective element plus subjective element, together with the state responsibility for the deprivation of liberty). It has highlighted that there are limits to the type of restrictions that parents can consent to on behalf of their child which is relevant to whether the subjective element is met.

¹⁹⁸ *Trust A v X* (n 2) [59] – [61].

(c) Following the decisions in *Trust A v X* and *BBC v D* there is a clear distinction in how the law operates as between adolescents aged under 16s and those aged 16 and 17. For under 16s, parents can consent to restrictions that would otherwise constitute a deprivation of liberty, whereas for 16 and 17 year olds they cannot. The basis for making this distinction was questioned, given that while Parliament has in some areas made specific provision for 16 and 17 year olds, this does not necessarily correlate with the diminution of parental decision-making powers. Moreover, the reasons given by the court for not relying on parental consent in relation to 16 and 17 year olds, would seem to be equally applicable to those aged under 16.

(2) Human rights implications

BCC v D makes clear that in relation to 16 and 17 year olds who lack the mental capacity to decide about their admission, if the objective element is met, a deprivation of liberty will arise. This is because parental consent cannot be relied upon, which means that the subjective element (lack of consent) is also met. In contrast, for adolescents aged under 16, *Trust A v X*, suggests that parents can authorise their child's placement in hospital even if extensive and prolonged restrictions are imposed on that adolescent, irrespective of that adolescent's wishes and without the safeguards available to those who are detained under the MHA 1983.

Hence, the observation in the introduction to this chapter that this is the most worrying aspect of the legal framework for adolescent psychiatric care.

CHAPTER 7: CONCLUSION: MOVING MOUNTAINS IN SPOONFULS¹

INTRODUCTION

The observation made in the Richardson report in 1999 that the area of law relating to the treatment for mental disorder of under 18s is in need of clarification, and that ‘the multiplicity of legal provision creates a climate of uncertainty’, is the prime motivator for this thesis. Its aim is threefold: to clarify how the law operates, establish where the areas of uncertainty and concern lie, and propose how these might be addressed. It has sought to do so by analysis in the legal framework for adolescent psychiatric care through a ‘human rights lens’.

This chapter reviews the findings of the analysis undertaken in the preceding chapters and makes recommendations to address concerns that have been identified. It is divided into five parts. Part 1 revisits how the legal framework for adolescent psychiatric care operates, to identify key points relevant to how the appropriate legal route for an adolescent’s admission to hospital and treatment for mental disorder is determined. Part 2 highlights the key areas of uncertainty and concern. Part 3 considers the main human rights implications. Part 4 summarises the overall conclusions. Part 5 sets out recommendations covering three broad areas: enhancing best practice, research and legal reform.

PART 1: THE LEGAL FRAMEWORK FOR ADOLESCENT PSYCHIATRIC CARE

The issues considered in the previous chapters are as follows:

Chapter 1: an overview of the legal framework.

Chapter 2: the legal basis on which adolescents can consent to their admission to hospital and treatment for mental disorder.

¹ J Le Carré, *The Honourable Schoolboy* (Hodder & Soughton 1977): ‘...there were still mountains to be moved in spoonfuls’.

Chapter 3: the legal tests for decisional capacity that are relevant to adolescents, namely the concept of *Gillick* competence and criteria for assessing whether an individual lacks capacity under the Mental Capacity Act (MCA) 2005.

Chapter 4: the powers of the High Court to override adolescents' refusal of life-saving treatment.

Chapter 5: the powers under the Mental Health Act (MHA) 1983 in relation to the detention and compulsory treatment of adolescents.

Chapter 6: the role of parental consent in relation to adolescents who lack decisional capacity, focusing on the relationship between the scope of parental responsibility and deprivation of liberty.

The key points raised in the above analysis that are core to understanding the legal framework for adolescent psychiatric care are set out below.

1.1 Consent to Psychiatric Care

There is a significant difference between adults and adolescent in relation to the basis on which they can consent (and refuse) admission to hospital and treatment for mental disorder. It is also necessary to distinguish between adolescents aged under 16 and those aged 16 and 17 given that the law treats these two age groups differently. A complicating factor in relation to 16 and 17 year olds is that in some areas the law regards them as adults, but they are also subject to laws, such as the Children Act (CA) 1983 (which defines a child as an under 18 year old²) that treat them as children. Accordingly, the situation for adults is noted first, followed by adolescents under 16 ('children') and then 16 and 17 year olds ('young people').

Adults

The starting point in law for adults is that they have both the legal capacity and mental capacity to make their own health care decisions.³ Their legal capacity is lost if they lose the mental capacity to make such decisions, the test now applied being that set out under sections 2 and 3 of the Mental Capacity (MCA) Act 2005. It is for those who consider

² Children Act (CA) 1989 s 105.

³ *Re T* (adult refusal of treatment) [1993] Fam 95, [1992] 4 All ER 649; Mental Capacity Act (MCA) 2005 s1(2).

the adult to lack the (mental) capacity to make the decision in question to establish this on a balance of probabilities.⁴

Children

The situation of adolescents aged under 16 is as follows.

- i) Children do not have the legal capacity to make health care decisions but if they demonstrate their ability to do so, they will be regarded as being '*Gillick* competent', thereby gaining the legal capacity to consent to the proposed intervention.
- ii) The burden of proof is reversed: those wishing to rely on a child's consent to provide legal authority for the proposed hospital admission or treatment, will have to establish that the child has the requisite intelligence and understanding to be considered '*Gillick* competent'. For adults, it is the mental *incapacity* that has to be established.

As discussed below, there are circumstances in which the decision of a child can be overridden even if the child has decisional capacity.

Young people

The situation of adolescents aged 16 and 17 differs from children because in some cases legislation provides that they can make specified decisions, thus conferring legal capacity to the young person in relation to those decisions. In relation to adolescent psychiatric care, the relevant statutory provisions are as follows:

- i) Sections 131(3) and (4) of the MHA 1983: young people who have capacity, determined in accordance with the MCA 2005, can make their own decisions about their admission to hospital. Consequently, their consent, or refusal, cannot be overridden by their parents (albeit if the criteria are met, they could be detained under the MHA 1983).

⁴ MCA 2005 s2(4).

- ii) Section 8 of the Family Law Reform Act (FLRA) 1969: young people can consent to their own medical treatment. As noted below, the courts have held that this does not give them the right to refuse medical treatment.

1.2 Pivotal Role of Decisional Capacity

Much depends on the assessment of the adolescents' decisional capacity when deciding on what basis an adolescent can be admitted to hospital and treated for mental disorder. This is because although the law permits the non-consensual psychiatric care of adolescents, regardless of their decisional capacity, determining the adolescent's decisional capacity is an essential first step in identifying whether that adolescent can be admitted to hospital and treated for mental disorder informally, or whether detention under the MHA 1983 should be considered.

The legal test for assessing adolescents' ability to decide about their psychiatric care depends upon their age. Whereas like adults, the decisional capacity of adolescents aged 16 and 17 is assessed in accordance with the MCA 2005 and the detailed guidance set out in the MCA 2005's Code of Practice, for children under 16, the test is whether they are 'Gillick competent'. The relevance of adolescents' decisional capacity is summarised as follows:

- a) *Adolescents aged 16 or 17 who have capacity and adolescents aged under 16 who are Gillick competent:*
 - i) can consent to their admission to hospital and treatment for mental disorder;
 - ii) their parents cannot override their decision;
 - iii) but if they do not agree to the proposed admission or treatment for mental disorder, they can be detained in hospital and treated without their consent under the MHA 1983 if the criteria are met; and
 - iv) where the MHA 1983 cannot be relied upon, an application to the court will be required - the High Court can override their refusal of psychiatric care if the court deems this to be in the adolescent's best interests to do so.

- b) *Adolescents aged 16 or 17 who lack capacity under the MCA 2005:*
- i) can be admitted to hospital and treated for their mental disorder informally under the MCA 2005 if it is in their best interests, provided that such interventions do not amount to a deprivation of liberty;
 - ii) following *Birmingham City Council v D (BCC v D)*,⁵ if the restrictions placed on the adolescent meet the ‘acid’ test (the objective element of a deprivation of liberty) the adolescent cannot be admitted informally by relying on parental consent because such restrictions fall outside the scope of parental responsibility;
 - iii) however, if the criteria are met, the young person can be admitted to hospital and treated for mental disorder under the MHA 1983;
 - iv) where the MHA 1983 cannot be relied upon, an application to the court will be required. The High Court can provide the requisite authority. Furthermore, ‘the Court of Protection can make a deprivation of liberty order in respect of young people aged 16 and 17’.⁶

c) *Adolescents aged under 16 who are not ‘Gillick competent’:*

- i) can be admitted to hospital and treated for their mental disorder informally on the basis of parental consent, provided that this is within the scope of parental responsibility;
 - a. albeit the judge stressed that such cases need to be decided upon their individual circumstances, *Trust A v X (A Child) (Trust A v X)*⁷ suggests that parents of adolescents aged under 16 can authorise significant restrictions on their child if this is in their child’s best interests;
 - b. Chapter 6 sets out a contrary view, arguing that determining whether the restrictions fall within the scope of parental responsibility involves more than considering whether the parents are acting in the adolescent’s best interests;
- ii) if parental consent cannot authorise the admission to hospital or treatment for mental disorder (because it falls outside the scope of parental

⁵ [2016] EWCOP 8.

⁶ Department of Health *Mental Health Act 1983: Code of Practice* (2015) para 19.52.

⁷ *Trust A v X (A Child)* (also known as *Re D (A Child) (Deprivation of Liberty: Parental Responsibility)*) [2015] EWHC 922 (Fam), [2016] 1 FLR 142, [2016] 3 WLR 1401.

responsibility) adolescents can be detained in hospital and treated without their consent under the MHA 1983 if the criteria are met;

- iii) where the MHA 1983 cannot be relied upon, an application to the court will be required. (As noted above, the High Court can authorise adolescents' non-consensual psychiatric care.)

Thus, not only is there a clear demarcation between those adolescents who have decisional capacity and those who do not, recent case law sets out a sharp difference in approach as between adolescents lacking decisional capacity who are aged 16 and 17 and those aged under 16.

1.3 Diminished Role of Parental Consent

The circumstances in which parents are able to consent to their child's admission to hospital for psychiatric care has been an area of long-standing uncertainty. This is due to the shifting sands of the relevant case-law and legislation as reflected by the revisions made to the Code of Practice to the MHA 1983 (MHA Code) over the years.

The first edition of the MHA Code (published in 1990) advised that adolescents could not be admitted or treated against their will.⁸ Such advice was based on the House of Lords decision in *Gillick v West Norfolk and Wisbech Area Health Authority (Gillick)*⁹ and in relation to young people section 131 of the MHA 1983 (which stated that they could consent to their admission) and section 8 of the Family Law Reform Act (FLRA) 1969 (which provides that adolescents can consent to their own medical treatment).¹⁰

In contrast, following the 'treatment refusal' cases in the early 1990s¹¹ (discussed in Chapters 2 and 3), the 1993 version of the MHA Code stated that '[n]o minor of whatever age has power by refusing consent to treatment to override a consent to treatment by anyone who has parental responsibility for the minor',¹² but had not revised the advice in relation to admission.¹³ This was addressed in the MHA Code 1999 which advised that

⁸ Department of Health and Welsh Office *Mental Health Act 1983: Code of Practice* 1990, paras 29.5 – 29.7.

⁹ [1986] AC 112 [1985] 3 WLR 830.

¹⁰ MHA Code 1990 (n 8) paras 29.5 – 29.7.

¹¹ *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11, [1991] All ER 177, [1991] 3 WLR 59 CA; *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, [1992] 4 All ER 627, [1992] 3 WLR 758 CA.

¹² Department of Health and Welsh Office *Mental Health Act 1983: Code of Practice* 1993 para 30.7(d).

¹³ R Jones *Mental Health Act Manual* (4th edn Sweet & Maxwell 1994) 476 6-249 notes this omission.

where a 'Gillick competent' child refuses admission parental consent 'may be sufficient authority to enable the child to be admitted against their wishes'.¹⁴ In relation to young people, the MHA Code 1999 advised that if they are not willing to remain in hospital detention under the MHA 1983 should be considered.¹⁵

The MHA Codes of 2008 and 2015 reflect the more recent changes to law and policy. As discussed in Chapter 2, section 131 of the MHA 1983 was amended by the MHA 2007 so that it now provides that a young person's capacitous refusal of admission to hospital cannot be overridden by parental consent. Although it is good practice to consult them,¹⁶ both the 2008¹⁷ and 2015¹⁸ MHA Codes advise against relying on parental consent to override such a young person's refusal of treatment, or a *Gillick* competent child's refusal of either admission to hospital or treatment.

In addition to limiting the circumstances in which parental consent may authorise an adolescent's informal admission to hospital and treatment for mental disorder to where the adolescent lacks decisional capacity, the MHA Code states that it will be necessary to ensure that the proposed intervention is within the 'scope of parental responsibility'.¹⁹ Moreover, as noted in Chapter 6, *BCC v D*²⁰ has narrowed the scope of parental powers in relation to young people yet further in that parents may not consent to their 16 or 17 year old child in circumstances where without their consent a deprivation of liberty would arise.

1.4 The Law and Adolescents' Psychiatric Care: Key Points

The key points relevant to the law governing adolescent psychiatric care are as follows.

- a) Like adults, adolescents who do not consent to the proposed admission to hospital and treatment for mental disorder can be detained under the MHA 1983 if the criteria under that Act are met, irrespective of their decisional capacity.

- b) Adolescents' refusal of health care can be overridden by the High Court if it considers this is in the adolescent's best interests in circumstances in which it

¹⁴ Department of Health and Welsh Office *Mental Health Act 1983: Code of Practice* 1999 para 31.6.

¹⁵ MHA Code 1999 (n 14) para 31.8.

¹⁶ MHA Code 2015 (n 6) para 19.38.

¹⁷ Department of Health *Mental Health Act 1983: Code of Practice* 2008 paras 36.33 and 36.43.

¹⁸ MHA Code 2015 (n 6) para 19.39.

¹⁹ MHA Code 2015 (n 6) para 19.40.

²⁰ [2016] EWCOP 8; [2016] COPLR 198.

would not be possible in relation to adults. The protective function of the court applies to minors, irrespective of their decisional capacity so that the adolescent's wishes can be overridden if the court thinks this is necessary to protect their welfare. In contrast, an adult's capacitous wishes cannot be overridden even if this may have a detrimental, even fatal, impact on the adult's welfare, unless the MHA 1983 applies.

- c) Decisional capacity plays a pivotal role in determining the appropriate legal route for adolescent psychiatric care. Adolescents with decisional capacity cannot be admitted to hospital, or treated for mental disorder without their consent, unless formal authority for such an intervention is obtained either through the compulsory powers of the MHA 1983 or, if that Act is not applicable, by obtaining a court order. The position differs for adolescents who lack decisional capacity, in that it will only be necessary to consider the application of the MHA 1983 if their non-consensual psychiatric care cannot be authorised in accordance with the MCA 2005 or by relying on parental consent.
- d) In the light of *BCC v D*,²¹ the circumstances in which 16 and 17 year olds can be admitted to hospital and treated informally has narrowed significantly.
- e) In contrast, *Trust A v X*²² suggests that parents have extensive powers to authorise the non-consensual psychiatric care of adolescents aged under 16 who lack *Gillick* competence but provides little guidance on the limits such powers.

Accordingly, the circumstances in which parental consent can authorise the psychiatric care of adolescents aged under 16 and who lack decisional capacity is the most uncertain area in the legal framework for adolescent psychiatric care.

PART 2: AREAS OF UNCERTAINTY AND CONCERN

Part 2 reviews the main areas of uncertainty and concern in relation to the legal framework for adolescent psychiatric care. It highlights seven issues relevant to the first of the three human rights questions set out in Chapter 1, namely the basis on which non-

²¹ (n 20).

²² (n 7).

consensual adolescent psychiatric care is justified under national law ('the justification question'). The first five areas covered are: the determination of decisional capacity, the determination of best interests by the High Court, the application of the MHA 1983, deprivation of liberty and the scope of parental responsibility. The last two points consider the role of parental consent in authorising non-consensual adolescent psychiatric care, first in relation to adolescents aged 16 and 17 and secondly, in relation to under 16s.

2.1 Determining decisional capacity

There is now greater clarity on how an adolescent's decisional capacity is determined. However, the following concerns have been identified.

a) Adolescents aged 16 or 17

The test to be applied is that set out under the MCA 2005. Thus, young people in this age group will be assumed to have capacity unless it is established that they lack capacity in accordance with sections 2 and 3 of the MCA 2005. However, Chapters 1 and 3 noted that concerns have been raised about the patchy implementation of the MCA 2005 generally while in relation to 16 and 17 year olds there are indications that its application is poorly understood.

Furthermore, there is an anomaly in relation to young people. Both the MCA Code²³ and the MHA Code 2015²⁴ anticipate that in some cases a young person may not be able to make the relevant decision, but for reasons other than the diagnostic element set out in section 2 of the MCA 2005 ('because of an impairment or disturbance in the functioning of, the mind or brain'). In such cases the MCA 2005 is not applicable because the young person does not lack capacity as defined by that Act. As noted below this has implications for the role of parental consent.

b) Adolescents aged under 16:

Whereas like adults, the decisional capacity of adolescents aged 16 and 17 is assessed in accordance with the MCA 2005 and the detailed guidance set out in the MCA 2005's Code of Practice, for under 16s, it must be established that the adolescent has '*Gillick* competence'.

²³ Department of Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice 2007*, (the MCA Code), para 12.13.

²⁴ MHA Code 2015 (n 6) para 19.31.

This term is not defined either in legislation or in case law and there is little common understanding on how it should be applied. Neither the House of Lords in *Gillick*, nor the Court of Appeal in the subsequent ‘treatment refusal’ cases provided clear criteria for assessing whether an adolescent is competent to make decisions for him or herself. As a result, the courts have applied varying interpretations of what it is required for a child to be deemed *Gillick* competent.

The MHA Code 2015 includes advice on how to assess *Gillick* competence, proposing questions for practitioners to consider which are based on the criteria set out in section 3 of the MCA 2005 for assessing whether the individual is able to make the decision.²⁵ However, it is not clear to what extent such guidance is being adopted in practice. Chapter 5 noted that, despite the advice on assessing *Gillick* competence and capacity under the MCA 2005, the Care Quality Commission (CQC) has questioned whether the legal tests are properly understood and applied.²⁶

2.2. Determining the best interests of adolescents refusing psychiatric care

Although the High Court has ‘theoretically limitless’ powers²⁷ under its inherent jurisdiction in relation to minors, it must exercise such powers in the adolescent’s best interests. However, there is a lack of clarity on how the courts determine that it is in the adolescent’s best interests to override their wishes, irrespective of their decisional capacity. Chapter 2 referred to the ‘adolescent autonomy conundrum’ to describe the concern that the wishes of adolescents are by-passed when they are perceived to be in conflict with their welfare, either by finding that the adolescent lacks decisional capacity or overruling the adolescent’s wishes irrespective of the adolescent’s decisional capacity. Moreover, as noted above, the courts have yet to adopt a consistent approach to determining whether adolescents are *Gillick* competent.

2.3 The application of the Mental Health Act 1983

The MHA 1983 sets out the circumstances in which non-consensual psychiatric care is permitted on grounds of ‘mental disorder’ (a term that is defined broadly²⁸) and is underpinned by a statutory Code which provides detailed guidance on the implementation of the Act.

²⁵ MHA Code 2015 (n 6) paras 19.34 – 19.37.

²⁶ Care Quality Commission *Monitoring the Mental Health Act in 2015/16*, (CQC 2016) 50.

²⁷ *Re W (A Minor) (Medical Treatment: Court’s Jurisdiction)* [1992] Fam 64 CA, 81 (Lord Donaldson).

²⁸ Mental Health Act (MHA) 1983 s 1.

Nonetheless, the application of the MHA 1983 depends on whether the mental health professionals involved consider that it is necessary and appropriate to do so. Although there may be sound reasons for determining that the MHA 1983 is not the appropriate legal route to authorise an adolescent's non-consensual in-patient psychiatric care, the basis for reaching such a conclusion might not always be clear. For example, Chapter 5 noted that in a case in which the psychiatrist of a young woman with a history of serious self-harm 'was unable to identify a mental disorder', the Judge questioned whether the 'real problem was to do with the scarcity of CAMHS Tier 4 beds'.²⁹ Moreover, this thesis has noted observations made by commentators and the judiciary that indicate a reticence in 'sectioning' adolescents to avoid the stigma perceived to arise from being detained under the MHA 1983.

It is also noteworthy that the Department of Health's equality analysis report, published alongside the MHA Code 2015 in January of that year, raised concerns about the connection between detention and discrimination, stating that the discrimination faced by people with mental health problems 'is particularly true for patients subject to the Mental Health Act 1983'.³⁰

2.4 Deprivation of Liberty

The question of when a deprivation of liberty arises is one that continues to occupy the courts.³¹ As explored in Chapter 6 this is an area in which some confusion has arisen due to the potential role of parental consent in determining whether the restrictions placed on an adolescent amount to a deprivation of liberty.

One of the reasons why the confusion has arisen is because in cases concerning adults the question tends to arise where the adult lacks the mental capacity to agree to their placement. Consequentially, the focus has been on whether the care regime meets the 'acid test' (in European Court of Human Rights (ECtHR) terms, the 'objective element'), which *P v Cheshire West and Chester Council; P and Q v Surrey County Council (Cheshire West)*,³² held to be whether the person is 'under continuous supervision and control' and 'not free to leave. However, this is only part of the test for a deprivation of liberty. The subjective element, which revolves round the issue of consent, must also be

²⁹ *Re P (Application for Secure Accommodation Order)* [2015] EWHC 2971 (Fam) [18].

³⁰ Department of Health *Equality for all: Mental Health Act 1983: Code of Practice 2015: Equality Analysis*, (Department of Health 2015) para 3.1.

³¹ See for example, *R (Ferreira) v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31 and *Secretary of State for Justice v MM, Welsh Ministers v P* [2017] EWCA 194.

³² [2014] UKSC 19; [2014] AC 896; 2 All ER 585.

met. In relation to adults, the matter is easily resolved because, as Lady Hale pointed out in *Cheshire West*,³³ where adults lack capacity to do so, no one can consent to the objective element of a deprivation of liberty on their behalf so the subjective element, which requires a lack of consent, is met as well. However, the position for adolescents is not as straightforward.

When applied to under 18s, the question that arises is whether parents can consent to the objective element of their child's confinement; in other words, if the confinement meets the acid test, is it possible for a parent to consent to it on behalf of their child? If they can, the subjective element is not met, and there is no deprivation of liberty. If they cannot consent to it, the subjective element is met and the adolescent is deprived of his or her liberty. Thus, the crucial issue is to establish whether the restrictions imposed on the adolescent can be authorised by the adolescent's parents. Hence, the scope of parental responsibility is engaged. Understanding what this concept means and how it applies, is therefore essential to determining whether the adolescent can be admitted informally, or if detention under the MHA 1983 needs to be considered.

2.5 The Scope of Parental Responsibility

The scope of parental responsibility is the umbrella term adopted by the MHA Code 2015 when highlighting the factors to consider when determining whether parental consent is sufficient to authorise an adolescent's admission to hospital or medical treatment. As such, it has a wider application than mental health care.³⁴ Nevertheless, it has a major significance in adolescent psychiatric care given its relevance to whether a deprivation has arisen and therefore whether the adolescent can be admitted to hospital and treated for mental disorder on an informal basis, or if detention under the MHA 1983 needs to be considered. However, as noted in Chapter 6, this concept is regarded by many as being vague and unhelpful.

That the views of the adolescent are an important factor in deciding whether the decision falls within the scope of parental responsibility provides some explanation as to why it has no clearly defined boundaries. The weight given to the adolescent's views will depend on the age, the fluid concepts of 'maturity' and the 'evolving capacities of the child', as well as the risks to the welfare of the adolescent if those views are upheld. For example, it may be acceptable, for parents to consent to a course of invasive

³³ (n 32).

³⁴ As noted in Chapter 6, guidance in the Department of Health *Reference Guide to Consent for Examination of Treatment* (2nd ed DH 2009) refers to this concept (page 35, para 19).

chemotherapy on behalf of their child who has cancer and will otherwise die. However, even in such extreme cases, the wishes of the adolescent are still relevant and will carry greater weight the older and more mature the adolescent is, while the adverse effects of the treatment will also need to be weighed against the likely prognosis.³⁵

2.6 Parental Consent, Young People and the Mental Capacity Act 2005

Although the MCA 2005 applies to adolescents aged 16 or 17 where they lack capacity under this Act, this is not to the exclusion of laws that relate to under 18s, including the role of parents. Nonetheless, the circumstances in which either parental consent, or the MCA 2005 can provide sufficient authority for a young person's non-consensual care are limited for the following reasons.

2.6.1 Admission to Hospital for Psychiatric Care

Albeit subject to the outcome of the appeal of the decision in *BCC v D* (judgment from the Court of Appeal is pending), parents are not able to consent to the confinement of adolescents aged 16 and 17 where this gives rise to the 'objective element' of a deprivation of liberty. Thus, where the *Cheshire West* acid test is met, adolescents aged 16 and 17 will be considered to be deprived of their liberty. The subject element (lack of valid consent) will be met given that the adolescent is not able to consent (lacking the decisional capacity to do so) and parents cannot consent on the adolescent's behalf. In relation to adolescent psychiatric care, this is likely to mean that the adolescent will be detained under the MHA 1983.

That leaves the question of the role of parents where the confinement does not meet the acid test threshold. If the decision is considered to fall within the scope of parental responsibility there will be an overlap between the MCA 2005 and parental consent. In practice, however, if such a case arises, this is unlikely to be a problem, given that unless there are good reasons not to do so, an adolescent's, parents would need to be consulted under the MCA 2005 as part of the process for determining whether the admission and treatment is in the young person's best interests.³⁶

³⁵ See for example discussion in Harrison and others 'Bioethics for clinicians: 9. Involving children in medical decisions', *Can Med Assoc J* [1997] 157, 156. See also C Bridge 'Religious Beliefs and Teenage Refusal of Medical Treatment' (1999) 62 *MLR* 585, 593.

³⁶ MCA 2005 s4.

2.6.2 The 'overwhelmed young person'

As noted when considering decisional capacity above, it is possible that an adolescent aged 16 or 17 is unable to make the relevant decision, but does not lack capacity for the purposes of the MCA 2005.

How often a young person's inability to make a decision will fall outside the MCA 2005 is unclear. In any event, if such a situation arises it is likely that the MHA 1983 would be required to authorise the young person's psychiatric care. This is because the effect of section 131 of the MHA 1983 is that parental consent cannot be relied upon to authorise the adolescent's admission unless the young person lacks capacity as defined by the MCA 2005. In relation to medical treatment, the MHA Code 2015 advises that this might be possible, provided that the treatment does not give rise to a deprivation of liberty and it falls within the scope of parental responsibility.³⁷ However, given the current case law on when a deprivation of liberty arises and the factors to be considered when determining whether a decision falls within the scope of parental responsibility in the MHA Code 2015, (the guidance in the MHA Code 2015 highlights the importance of taking into account the age and maturity of the adolescent³⁸) cases in which parental consent can be relied upon in such circumstances are likely to be rare.

2.7 Parental Consent and adolescents lacking 'Gillick competence'

In contrast to their older siblings, provided that such decisions fall within the scope of parental responsibility, parental consent can authorise restrictions placed on adolescents aged under 16 who lack *Gillick* competence even if these meet the *Cheshire West* acid test, thereby giving rise to the objective element of a deprivation of liberty.

Although the decision in *Trust A v X* refers to the scope of parental responsibility when considering whether it was possible for parental consent to authorise the adolescent's confinement, the MHA Code's guidance on the application of this concept was not discussed. The then current MHA Code 2008 set out a range of factors to consider before relying on parental consent, including the type of interventions and the wishes of the adolescent.³⁹ Similar, albeit revised guidance is contained in the MHA Code 2015.⁴⁰ As noted in Chapter 1, the MHA Code 2015 is statutory guidance and should be followed unless there are cogent reasons for not doing so. Accordingly, in cases where the in-

³⁷ MHA Code 2015 (n 6) para 19.63.

³⁸ MHA Code 2015 (n6) para 19.41.

³⁹ MHA Code 2008 (n 17) paras 36.10 – 36.14.

⁴⁰ MHA Code 2015 (n 6) para 19.41.

patient psychiatric care of an adolescent who is not *Gillick* competent is being considered, in deciding whether such care can be authorised by parental consent practitioners will need to follow the guidance the MHA Code 2015's guidance on the scope of parental responsibility (unless subsequent case law provides otherwise).

Unless there is a difference of opinion between the parents, or there is any reason to question the validity of the parents' consent, the key issues in deciding whether parental consent can be relied upon are likely to be the nature of the intervention and the wishes of the adolescent. The MHA Code 2015 refers to matters such as 'the type and invasiveness of the proposed intervention (the more extreme the intervention, the greater the justification that will be required'⁴¹), 'the extent to which the decision accords with the wishes of the child or young person, and whether the child or young person is resisting'.⁴² Furthermore, the MHA Code 2015's guidance on deprivation of liberty refers to the role of parental control and supervision and whether the restrictions imposed accord with the degree of parenting control and supervision that would be expected for a child or young person of that age'.⁴³

For the reasons discussed in Chapter 6 and outlined above, the 'scope of parental responsibility' is more limited than *Trust A v X* suggests. Nonetheless, the question whether parental consent is sufficient authority for an adolescent's psychiatric care turns upon the interpretation of the guidance in the MHA Code 2015 on the scope of parental responsibility. Moreover, in the wake of *Trust A v X*, parental consent can authorise restrictions on adolescents aged under 16 who lack *Gillick* competence, in circumstances in which if they were 16 or older, a deprivation of liberty would arise so that informal in-patient psychiatric care would not be possible.

Thus, in the light of current case law, a key factor in determining the legal route for an adolescent in-patient psychiatric care is the adolescent's age. Adolescents aged 16 and 17 are likely to be detained under the MHA 1983, thereby engaging a raft of safeguard available to those detained under this Act, which will not apply to adolescents aged under 16 who are admitted informally on the basis of their parents' consent. This means that there is a significant gap in the protections available to adolescents aged under 16 as compared to individuals aged 16 and above.

⁴¹ MHA Code 2015 (n 6) para 19.41.

⁴² MHA Code 2015 (n 6) para 19.41.

⁴³ MHA Code 2015 (n 6) para 19.47.

PART 3: HUMAN RIGHTS IMPLICATIONS

The findings from the analysis of the legal framework for adolescent psychiatric care focusing on the second two human rights questions of the ‘human rights lens’ are set below. These consider the extent to which the legal routes for non-consensual adolescent psychiatric care take into account the wishes of the adolescent (‘the wishes versus welfare question’) and how the legal framework for adolescent psychiatric care compares with relevant human rights standards (the human rights comparison question). The importance of the views of the adolescent are considered first, followed by the ECHR and compulsory care under the MHA. The third and last area considered is the interrelationship between deprivation of liberty and the scope of parental responsibility.

3.1 The Importance of the Views of the Adolescent

There are two features of children’s rights that sets them apart from that of adults: the concept of best interests and the role of parents. Both are relevant to adolescent psychiatric care. Significantly, neither permit the wishes of the adolescent to be ignored. To the contrary, as discussed in Chapter 1, both the decision-making powers of parents and the determination of the ‘best interests of the child’ are moderated by the views of the adolescent, such views gaining greater weight with the adolescent’s increasing age and maturity. The importance of taking the wishes of the adolescent into account, notwithstanding the power to override such wishes if these are considered to run counter to the adolescent’s welfare, is evident in the legal framework for adolescent psychiatric care, as illustrated below.

First, in exercising powers under its inherent jurisdiction, the court must take the adolescent’s wishes into account when determining what is in that adolescent’s best interests.⁴⁴ Secondly, ‘so far as reasonably ascertainable’, best interests determinations under the MCA 2005 must include ‘the person’s past and present wishes and feelings’.⁴⁵ Thirdly, although there is little in the MHA 1983 in respect of taking the views of adolescents into account, the MHA Code 2015 emphasises the importance of involving individuals in their care and treatment and considering patients’ ‘views, past and present wishes and feelings (whether expressed at the time or in advance)’ under its principle of ‘Empowerment and involvement’.⁴⁶ It also states that children and young peoples’ views,

⁴⁴ *Re W (A Minor) (Medical Treatment: Court’s Jurisdiction)* [1992] Fam 64 CA, 81.

⁴⁵ MCA 2005, s4(6).

⁴⁶ MHA Code 2015 paras 1.7 and 1.8.

wishes and feelings should always be sought and taken seriously.⁴⁷ Fourthly, the MHA Code 2015's guidance on the scope of parental responsibility includes the wishes of the adolescent as a relevant factor in determining whether parental consent can authorise the adolescent's non-consensual psychiatric care.

Thus, the views of the adolescent should be a key factor in determining the legal route for adolescent psychiatric care. The views of adolescents with decisional capacity can only be overridden if the MHA 1983 is applied or a court order is obtained. Even where adolescents lack decisional capacity, their views should be considered when determining whether the MCA 2005 or parental consent can be relied upon to authorise their psychiatric care.

Although the above points emphasise the importance of doing so, the extent to which in practice adolescents' views are taken into account when determining whether to take action without their consent, is less clear. For example, Chapter 4, highlighted that while the High Court takes into account the wishes of the adolescent, it is not clear how this is balanced against welfare concerns. Chapter 5 noted that the CQC has expressed concern about the lack of recording of adolescents' decisional capacity and consent to treatment. Chapter 6, raised concerns about the lack of consideration of the adolescent's views when determining if parental consent could be relied upon to authorise restrictions placed on their child in circumstances where, without parental consent, the adolescent's confinement would be regarded as a deprivation of liberty.

In this regard, the CRC's General Comment 14 provides a potential model for best practice. As discussed in Chapter 4, General Comment 14 sets out guidance on how to implement the UNCRC's principle, articulated in Article 3(1) that in all matters affecting them 'the best interests of the child shall be a primary consideration'. It places great emphasis on the importance of the views of children and young people in determining what is in their best interests.

- a) By following General Comment 14, decisions made in relation to adolescent psychiatric care would ensure that the views of the adolescent form an integral part of its determination, giving them due weight according to their age and maturity', and that a clear explanation of the reasons for taking action that is contrary to the adolescent's wishes is given. General Comment 14 also advises

⁴⁷ MHA Code 2015 (n 6) para 19.5.

that if conflicts between 'protection' and 'empowerment' arise, the 'age and maturity should guide the balancing of the elements'.⁴⁸

- b) Although the approach outlined in General Comment 14 does not provide a definitive answer to the question raised in Chapter 4, namely whether the wishes of an adolescent who has been assessed as having the decisional capacity to refuse life-saving medical treatment can be overridden, it underscores the requirement for a clear explanation as to why the concerns about the adolescent's welfare justify overriding the adolescent's wishes.
- c) Requiring clear reasons for overriding an adolescent's refusal may go some way to addressing the 'adolescent autonomy conundrum' identified in Chapter 2 and discussed in Chapter 4. If the justification is because the adolescent lacks capacity, and it is in the adolescent's best interests to do so, the court would need to explain the basis on which it had concluded the adolescent lacked capacity and why it was in the best interests to authorise the non-consensual intervention, and how it took into account the adolescent's wishes. If the court concludes that the adolescent has decisional capacity to make the decision, the court would need to explain why it was authorising non-consensual interventions in circumstances which would not have been possible if the adolescent had been an adult. In other words, to explain why the adolescent's age justified overriding the adolescents wishes.
- d) The framework for decision-making as envisaged by General Comment 14 could be of benefit in cases where the law permits non-consensual adolescent psychiatric care, such as compulsory care under the MHA 1983 and informal admissions of under 18s who lack the decisional capacity to decide about their admission to hospital and treatment for mental disorder. In these cases, it would underpin the importance of ensuring that the wishes of the adolescent form a central part of the decision-making process, even if they are not determinative.

⁴⁸ CRC General Comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para 1) (CRC/C/GC/14). These points are discussed in Chapter 4.

3.2 The ECHR and Compulsory Care under the MHA 1983

Chapter 5 compared provisions under the MHA 1983 concerning the detention in hospital, placement and compulsory treatment of individuals (including adolescents) with the ECHR and its jurisprudence. Such analysis highlights that although the ECHR does not prohibit compulsory care and treatment (indeed Article 5 of the ECHR makes specific reference to detention on the grounds of mental disorder), the European Court of Human Rights (ECtHR) now adopts a more intense scrutiny of the use of compulsion in relation to people with 'mental disability' (mental disorders and/or mental incapacity). This gives rise to the following points in relation to the legal framework for adolescent psychiatric care:

- a) The MHA 1983's compliance with the ECHR is in doubt. While raising concerns in relation to the criteria for detention under the MHA 1983, the provisions authorising treatment without consent and placement of adolescents in adult psychiatric wards or long distances from home. Chapter 5 identified the treatment provisions as being the most problematic. It is difficult to see how the powers of the treating doctor to authorise compulsory treatment for an initial period of 3 months under section 63 without independent review is compliant with the ECHR in the light of *X v Finland*.⁴⁹
- b) Whereas the ECtHR has traditionally set a low threshold for the justification for both detention (the 'scarcely demanding'⁵⁰ *Winterwerp* criteria for Article 5(1)(e))⁵¹ and compulsory treatment (the infamous case of *Herczegfalvy v Austria*⁵² holding that compulsory treatment does not engage Article 3 if it is medically necessary, while also indicating that Article 8 is not engaged if the person lacked decisional capacity), it requires that these are shown to be necessary and proportionate.
- c) The MHA Code 2015 plays a central role in ensuring that the legal framework for psychiatric care (for individuals of all ages) is compatible with the ECHR. In particular it reflects the ECHR jurisprudence in its emphasis on the need to ensure that the compulsory powers of the MHA 1983 are applied only when

⁴⁹ (App 34806/04) 3 July 2012, ECHR 2012 (extracts) [2012] MHLR 318.

⁵⁰ B Hale 'The Human Rights Act and Mental Health Law: Has it Helped?' *Journal of Mental Health Law* 2007 11

⁵¹ *Winterwerp v the Netherlands* (1982) 4 EHRR 188.

⁵² *Herczegfalvy v. Austria* (1993) 14 EHRR 437.

necessary and as a last resort, and that the wishes of the person are taken into account in the process for determining whether such compulsory powers should be exercised. It is therefore of concern that, in relation to the implementation of the MHA 1983, the CQC has questioned whether the MHA Code is followed sufficiently in practice.

3.3 Deprivation of Liberty and the Scope of Parental Responsibility

Chapter 6 considered the development of jurisprudence, both at the ECtHR and national level concerning the circumstances in a deprivation of liberty arises and how this relates to when parental consent can authorise an adolescent's in-patient psychiatric care. It identifies the following points that are relevant to the legal framework for adolescent psychiatric care.

a) Deprivation of liberty under Article 5(1)(e) and the views of the person being confined

The ECtHR has identified the need to consider both the 'concrete situation' of the person concerned (the objective element) and whether there was any consent to that situation (the subjective element).⁵³ While the analysis indicates that, in relation to adults there may be circumstances in which the ECtHR would accept a third party's consent to the objective element of a deprivation of liberty, with the consequence that a deprivation of liberty has not arisen (the subjective element – lack of valid consent - not being met) such situations are limited. In the cases in which this approach is observed (the 'guardianship cases'), the ECtHR has focused on the perception of the person confined and where that person has indicated in any way that he or she does not wish to be so confined, the ECtHR concludes that the subjective element has been met, thereby holding a deprivation of liberty to have arisen. This accords with the emphasis the ECtHR has placed on seeking and taking into account the views of the person concerned.

b) Limits on parental consent to in-patient psychiatric care: Nielsen v Denmark (1998)⁵⁴

An analysis of the ECtHR's decision in *Nielsen* shows three points to be of key importance. First, whether the parent is acting legally and appropriately, secondly, whether the restrictions fall within 'reasonable parenting restrictions' (a term adopted by this thesis, not found in the judgment) and thirdly, the views of the adolescent. It is suggested that the views of the adolescent are likely to be given greater consideration

⁵³ *Storck v Germany* (2006) 43 EHRR 6.

⁵⁴ (1989) 11 EHRR 175.

today, given the ECtHR's endorsement of the UNCRC's Article 12 (right of the child to be heard)⁵⁵ and its approach to the guardianship cases.⁵⁶

c) *Trust A v X and the ECHR*

The decision in *Trust A v X*⁵⁷ is at odds with the above two points. Despite the ECHR jurisprudence that places significant emphasis on the views of the person confined when determining whether substituted consent can be given on the person's behalf, *Trust A v X* makes no reference to the views of the adolescent. Moreover, although *Nielsen* makes clear that there are limits to the types of restrictions that parents can place on their child, the factors identified in *Nielsen* were not referred to by the court when determining whether it was appropriate to rely on parental consent to authorise restrictions on the adolescent. This is despite the Judge's view that such restrictions 'would probably amount to ill-treatment' if applied to a non-disabled adolescent.⁵⁸

PART 4: SUMMARY

The analysis of the legal framework for adolescent psychiatric care has demonstrated the following points.

- (1) The law in this area is uncertain given its complexity and the areas of confusion in how it should operate.
- (2) An underlying cause of such uncertainty is the convergence of three 'drivers for protection', namely mental disorder, mental incapacity or minority.

The multiplicity of legislation, case law and guidance that underpins the legal framework for adolescent psychiatric care has arisen because the law permits non-consensual adolescent psychiatric care on any one of the three drivers for protection. Adolescents may be subject to non-consensual psychiatric care due to the presence of a mental disorder, the assessment of a lack of mental capacity to make decisions about psychiatric care, or simply because they are minors and until they reach the age of 18 their parents and the courts can make decisions on their behalf. As a result, there is a range of potential legal routes for adolescents' psychiatric care.

⁵⁵ *M & M v Croatia* (App 10161/13) 3 September 2015, ECHR 2015 (extracts) [2016] 2 FLR 18.

⁵⁶ As discussed in Chapter 6.

⁵⁷ (n 7).

⁵⁸ *Trust A v X* (n 7) [57]

Recent developments in law and policy relating to adolescent psychiatric care have helped to clarify how this legal framework should operate. Mapping the legal routes demonstrates that there is little overlap between them given that the basis on which they permit psychiatric interventions differ. Nevertheless, uncertainties remain.

- (3) A significant cause of the uncertainties in this area of law operates is the lack of clarity on the meaning and application of concepts that are crucial to determining the appropriate legal route for an adolescent's psychiatric care.

There is a lack of clarity on how the courts determine that it is in the adolescent's best interests to override their wishes, irrespective of their decisional capacity. In relation to when, and whether, the MHA 1983 should be applied to adolescents in need of psychiatric care, this thesis has noted the on-going concerns about the perceived stigma arising from being 'sectioned' on grounds of a mental disorder. Moreover, it has highlighted areas in which this Act's compatibility with the ECHR is questionable.

Despite its flaws, the MHA 1983, provides a statutory framework for non-consensual intervention with a range of safeguards for those who are subject to it, while the MHA Code provides detailed guidance on its implementation. However, the MHA Act 1983 should be used as a last resort.⁵⁹ It is therefore of particular concern that there is a lack of clarity on the meaning and application of three concepts that are essential to determining whether an adolescent's in-patient care can be authorised on an informal basis, or if detention under the MHA 1983 is required.

The first of these concepts, 'decisional capacity' embraces the legal tests of *Gillick* competence (for adolescents aged under 16) and the test for mental (in)capacity under the MCA 2005 (for 16 and 17 year olds). This thesis has noted that in practice there continue to be problems with the application of both these tests. The second two concepts that have given rise to uncertainty on this area of law are 'the scope of parental responsibility' and 'deprivation of liberty'. Although the MHA Code 2015's guidance on 'the scope of parental responsibility' and 'deprivation of liberty' emphasises the limits of parental decision-making powers and the importance of

⁵⁹ MHA Code 2015 (n 6) para 1.2.

taking the views of the adolescent into account,⁶⁰ thus far, such guidance has not been considered by the courts.

Based on the court's interpretation in *Trust A v X*,⁶¹ of the scope of parental responsibility and how it relates to deprivation of liberty, parental consent can authorise the confinement of adolescents aged under 16 in hospital in circumstances where significant and prolonged restrictions are placed on them. This means that safeguards, such as an Independent Mental Health Advocate and the right to a periodic review by the Mental Health Tribunal (with a right to legal representation) is not available to these adolescents. This raises significant concerns about the lack of safeguards for adolescents aged under 16 who lack *Gillick* competence and are receiving in-patient psychiatric care informally on the basis of parental consent.

Steps therefore need to be taken to address the areas of uncertainty. Crucially, legal reform is needed to bridge the current gap in the protection afforded to adolescents who are admitted to hospital for psychiatric care on the basis of parental consent.

PART 5: ADDRESSING THE CLIMATE OF UNCERTAINTY: RECOMMENDATIONS

Final comments and recommendations on action to initiate and guide reform in this area are set out below.

5.1 Enhancing best practice: further guidance and training

This thesis has identified considerable confusion around the concepts of decisional capacity, deprivation of liberty and the scope of parental responsibility. This suggests that further guidance and training on these areas, together with advice on how to help and encourage adolescents to participate in the decision-making process is needed.

In addition, consideration needs to be given as to why there is so much uncertainty about concepts that are central to the legal framework for adolescent psychiatric care. Hopefully, as the matters come before the courts, case-law will provide greater guidance.⁶² Nonetheless, however clear the law, it will not be reflected in practice unless

⁶⁰ MHA Code 2015 (n 6) paras 19.40 – 19.48.

⁶¹ *Trust A v X* (n 7).

⁶² As noted above, the Court of Appeal's decision in *BCC v D* is pending.

it is effectively disseminated to those professionals expected to implement it. Initiatives such as training, provision of policy guidance and information that is accessible to non-lawyers are required to enhance good practice. In this regard, it is of concern that the CQC in its latest report on monitoring the MHA 1983 found that staff on 'less than half the wards' had received training on the changes to the MHA Code 2015.⁶³ Furthermore, the CQC has also highlighted the need for training of CAMHS staff on the MCA 2005, the MHA 1983 and *Gillick* competence, reporting that staff were 'unsure of the changes that were made and did not understand their roles in relation to the Acts'.⁶⁴

Accordingly, with a view to raising awareness of the issues and ascertaining practitioners' views on the key areas of concern, the following recommendations are made:

- a) *Survey of practitioners*: seek the views of those working in CAMHS, children's services and those involved in mental health assessments (AMHPs and section 12 approved doctors) on training needs and areas in which further guidance is required. Such information can be used to inform the development of training materials and guidance on a range of topics. Given the concerns identified above, areas in which practitioners may find helpful are likely to include:
 - i) the 'scope of parental responsibility';
 - ii) undertaking mental capacity assessments and assessments of adolescents' *Gillick* competence;
 - iii) key points to consider when determining whether an adolescent can be admitted to hospital informally (such as the role of parental consent and the circumstances in which a deprivation of liberty may arise).

- b) Develop guidance based on the General Comment 14 of the UN Committee of the Rights of Child (CRC) on the best interests of the child for use by the courts, policy makers and practitioners when working with children. The Supreme Court describes General Comment 14 as 'authoritative guidance'⁶⁵ on how to comply with the UNCRC's principle of the best interests of the child (considered to be

⁶³ CQC 2016 (n 22) 14.

⁶⁴ Care Quality Commission, *Review of children and young people's mental health services, Phase One supporting documentation: Inspection report analysis*, October 2017, 28.

⁶⁵ *R(SG) v Secretary of State for Work and Pensions* [2015] UKSC 16; 1 WLR 1449, (2015)18 CCLR 215 [215].

incorporated into national law, *inter alia* section 11 of the CA 1989⁶⁶), while the MHA Code 2015 states that the best interests of the child 'must always be a significant consideration'.⁶⁷

- c) In the light of the results of the survey, develop further guidance and provide training. Such guidance and training should incorporate the guidance in the MHA Code 2015, given its central importance to the legal framework for adolescent psychiatric care.

5.2 Further research

The focus of this thesis has been to identify the basis on which the law permits the admission to hospital and treatment of adolescents in need of psychiatric care so as to clarify how the law operates and pinpoint where confusion and uncertainty arise. While it has highlighted areas in which national law conflicts with human rights standards it has not considered the wide range of issues affecting adolescents who are receiving in-patient psychiatric care. Furthermore, it has analysed the legal and policy framework rather than seeking the views of practitioners (such as lawyers and mental health professionals) or adolescents and their families. Thus, further research is required. It is recommended that the following three areas are prioritised.

a) *Understanding the current situation*

As the CQC notes in its report, *Review of children and young people's mental health services, Phase 1 Report*, the 'lack of accurate and comprehensive data undermines attempts to provide care that meets the mental health needs of children and young people'.⁶⁸ As highlighted in Chapter 1, there is very little research on how the legal framework for adolescent psychiatric care operates in practice. In this regard, although the CQC monitors the use of the MHA 1983 and inspects CAMHS in-patient services, Chapter 5 noted that information that would assist in understanding how the law is implemented in practice is not collected in a comprehensive or consistent way.

Accordingly, research in this area should include:

⁶⁶ *Matheison v Secretary of State for Work and Pensions* [2015] UKSC 47, [2015] 1 WLR 3250 [39].

⁶⁷ MHA Code 2015 (n 6) para 19.5.

⁶⁸ Care Quality Commission *Review of children and young people's mental health services, Phase One Report*, October 2017, 21.

- i. Seeking the views of adolescents (and those of their families) who are, or have been receiving in-patient psychiatric services, whether as informal patients or detained under the MHA 1983. Based on their experiences, to consider how the law is operating in practice and identify areas in which improvement is required.
- ii. Addressing the data shortage by gathering information on matters including:
 - how many under 18s are detained under the MHA 1983, their length of stay and how many applied to (and how many had their cases heard by) a Mental Health Tribunal and with what result;
 - the legal basis on which adolescents are admitted to psychiatric units and treated for mental disorder as informal patients;
 - how many under 18s are placed on adult psychiatric wards, their age, how long the placement lasted, the reason for their admission, where they were discharged to (a CAMHS ward, home, or elsewhere);
 - how many under 18s are placed out of area, their age, how long the placement lasted, the reasons for their placement out of area, where they were discharged to (a CAMHS ward, home, or elsewhere).
- iii. The information noted in (ii) above should be collected and published on a regular basis, at least annually. Given its monitoring and inspection role, the CQC may be ideally suited to undertake this work and to include such systemic adolescent-focused data collection in its MHA 1983 monitoring reports and/or reports that summarise the findings of its inspection of CAMHS services.⁶⁹
- iv. Ascertaining what safeguards are in place for adolescents requiring in-patient care, over and above those available to patients detained under the MHA 1983 to ascertain, for example, how local authorities meet their responsibilities in relation to looked after children⁷⁰ and what action they take when hospitals, as required by the CA 1989, inform them that an adolescent has been accommodated for more than 3 months.⁷¹

⁶⁹ It should be noted that the Children's Commissioner for England plans to undertake work in this area; see Children's Commissioner *Briefing: Children's Mental Healthcare in England*, October 2017, Annex 2.

⁷⁰ MHA 1983 s116 and the MHA Code 2015 (n 6) paras 19.121 – 19.126.

⁷¹ CA 1988 ss 85 and 86.

b) A human rights evaluation of adolescent psychiatric care

This thesis has analysed the criteria for detention in hospital and treatment for mental disorder under the MHA 1983. However, it has highlighted concerns that extend beyond this remit, including the lack of community based services for under 18s and the lack of safeguards for adolescents who are admitted informally, in particular those who are placed long distances away from home. Given their significant human rights implications, such research should be undertaken to consider the extent to which these areas of concern conflict with the ECHR, the UNCRC and the UNCRPD and other relevant human rights standards.

c) Discrimination and the MHA 1983

Given the concerns about the stigma and discrimination arising from detention under the MHA 1983, ascertain areas in which this might arise, for example education and employment, and the extent to which this is addressed in national law, such as the Equality Act 2010, with a view to providing a fact sheet for practitioners, adolescents and their families.

5.3 Legal reform

Recommendations for legislative reform fall within the two following broad areas.

a) Comprehensive review of relevant law and policy

In its recent report, *Mental Capacity and Deprivation of Liberty*, the Law Commission recommended that 'the government should consider reviewing mental capacity relating to all children, with a view to statutory codification'.⁷²

While such recognition of the need for reform in relation to under 18s is welcome, to avoid adding another layer of legislation to this area of law, which may well exacerbate the current confusion,⁷³ it is suggested that a more comprehensive approach is required. Consideration of capacity issues relevant to adolescents would need to encompass legal

⁷² Law Commission *Mental Capacity and Deprivation of Liberty Law* (Law Com No 372, 2017) Recommendation 6.

⁷³ J Fortin *Children's Rights and the Developing Law* (3rd edn Cambridge University Press 2009) at 172 suggests that the 'extreme complexity' has been caused by legislation being 'grafted on to the common law...with little concern for clarity or coherence'.

capacity as well as the legal tests for decisional capacity (mental capacity and *Gillick* competence). In addition, given the gaps in mental health services for adolescents noted in Chapter 5, a comprehensive review of the range of laws that apply to the provision of services to under 18s is needed. This is to identify whether such laws help or hinder adolescents' access to care and support, including CAMHS, support from children's services and services to assist adolescents' transition into adulthood.

b) *Addressing specific areas of concern*

Legislation is needed to address the human rights concerns in relation to compulsory treatment under the MHA 1983 and address the gap in safeguards for adolescents admitted to in-patient psychiatric care on an informal basis. It is therefore recommended:

- i) The provisions for compulsory treatment under Part IV of the MHA 1983 must be amended, given their incompatibility with the ECHR (such reforms will be relevant to individuals of all ages). Additional areas requiring consideration are the provisions regarding the identification of the nearest relative (potential anomalies were noted in Chapter 5) and the need for regulation of out of area placements.⁷⁴
- ii) Introduce safeguards for adolescents admitted to in-patient care informally. A starting point for consideration is the safeguards proposed in the Mental Health Bill of 2004, which included a care plan (approved by an independent medical expert) to be reviewed every three months, representation by a nominated person and the right to go to the tribunal to resolve disputes.⁷⁵ However, a significant difference from the Bill (which concerned under 16s who objected to the proposed treatment⁷⁶) is that such safeguards would apply to all adolescents under 18 who are receiving in-patient care, whether on the basis of their consent, parental consent or under the MCA 2005. The inclusion of adolescents who have been assessed as being able and willing to consent to their in-patient psychiatric care is suggested given the concerns about the lack of clarity as to how the legal tests for assessing adolescents' decisional capacity

⁷⁴ On 4th October the government announced a review of the MHA 1983. See Department of Health *Policy Paper – Terms of Reference An Independent Review of the Mental Health Act 1983* < www.gov.uk/government/publications/mental-health-act-independent-review/terms-of-reference-independent-review-of-the-mental-health-act-1983> accessed October 2017.

⁷⁵ As summarised by the Joint Committee on the Draft Mental Health Bill *Draft Mental Health Bill* (2004-5, HL Paper 79-1, HC 95-1) para 209. These were proposed for under 16s who 'refuses treatment, but whose parents consent'. However, this Bill and these proposals were abandoned, with the MHA 1983 subsequently being amended by the Mental Health Act 2007.

⁷⁶ Draft Mental Health Bill, Department of Health Cm 6305-1, clause 207(6).

should be applied. Such safeguards would accord with Article 25 of the UNCRC which requires a periodic review of under 18s' placement for care, protection or treatment.

FINAL COMMENTS

The issues raised throughout this thesis reflect dilemmas and debates that have engaged scholars from a range of disciplines for many years, including children's rights advocates, medical ethicists, legal academics and philosophers, as well as the judiciary. By analysing the legal framework for adolescent care through a human rights lens this thesis has sought to provide additional insights on where the problems lie and why they have arisen. The imperative for undertaking this task is the impact of these problems on the mental health care of under 18s. It is speculative to suggest the extent to which the confusion and lack of clarity identified in this thesis undermine the level and quality of the care and support received by adolescents experiencing acute mental distress. However, at the very least, it cannot help. Achieving greater clarity in the operation of the law will not alleviate the distress and anxiety arising from an adolescent's mental ill-health, but it would at least avoid exacerbating an already fraught situation. While this thesis has proposed a number of steps that can be taken to address the problems it has identified, it is likely to require a range of initiatives – this mountain may need to be moved, if not in spoonfuls, by means of various measures, that together provide coherent and comprehensive reform.

Nevertheless, a step that requires no legislative reform and little extra resources is to place adolescents at the centre of the decision-making process - in other words, ensuring that decisions about adolescents start by ascertaining their wishes and requiring that any action taken without an adolescent's consent is a justified response to concerns about that adolescent's welfare. This cannot resolve all the problems identified in this thesis, but it might provide the catalyst for cutting through the climate of uncertainty that has pervaded this area of law for far too long.

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