Using the Measure for Measure – How the Mental Health (Wales) Measure 2010 and the NHS Redress (Wales) Measure 2008 Can Improve the Rights of the Mentally Ill.

Alun Huw Thomas

Submitted to Swansea University in fulfilment of the requirements for the Degree of Doctor of Philosophy.

Swansea University

2025

Abstract

This thesis explores the development of Welsh mental health law, focussing on how the rights of people with serious mental illness may be protected by creating an automatic financial redress mechanism to address service failure. The Mental Health Act 1983 legislates for the detention of patients, the provision of safeguards for those detained, and the authority for ongoing restriction of liberty; it does not set standards for the quality or responsiveness of service delivery. The Mental Health Act 1983 will be reviewed during this new Labour administration in Westminster; however, recent tragedies appear to be driving a fear culture in lawmakers.

This thesis examines the development of mental health legislation in the UK and its impact on the individual, from the Lunacy and Vagrancy Acts of the nineteenth and early twentieth century, through the consequences of war and trauma, to the current day. The validity of such legislation is considered with regard to the United Nations Convention for the Rights of Persons with Disabilities which opposes detention for a disability.

Welsh law and policy offer potential divergence from UK mental health legislation by focussing on early intervention, co-production, and citizenship. Devolution of powers provided opportunities for the development of Welsh mental health law, and while the Mental Health Act 1983 remains extant, Welsh law offers alternative routes for further development of a rights-based approach to mental health care. In this thesis, the divergence of Welsh and UK Governmental approaches is examined to identify potential routes for the development of Welsh mental health law which may provide reciprocity by creating financial penalties for failure to provide assessment within a reasonable timescale. While the financial redress can only compensate, the existence of such redress could shift the focus from compulsion to early intervention, fostering a more compassionate mental health system in Wales.

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed ...  **..... (candidate)**

Date .....28 September 2025.....

STATEMENTS

This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used, the extent and nature of the correction is clearly marked in a footnote(s).

Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

The University's ethical procedures have been followed and, where appropriate, ethical approval has been granted.

I give consent (a) for the thesis, if accepted for a research degree, to be made available for electronic sharing and for inter-library loan (subject to the law of copyright) and

(b) for the title and summary to be made available to outside organisations.

Signed .....  **..... (candidate)**

Date .....28 September 2025.....

Contents

Acknowledgments

There are very many people who have helped me through the creation of this thesis, and I would like to recognise them and thank them for all their support. Firstly, to my supervisory team at the Hillary Rodham Clinton School of Law at Swansea University. Initially, this was provided by Professors Jane Williams and Simon Hoffman, but for the last few years, I have been most grateful to have received both academic and personal support and encouragement from Professor Caroline Jones. I am very thankful for all the guidance, advice, and common-sense Caroline has provided during some incredibly challenging times.

This study has also benefited from the introductions to, and the time provided to me by, both the late Professor Michael Sullivan, and Professor Rick Lines at Swansea, who were kind enough to share their thoughts on Wales as a legislative environment. My engagement in studies at the Hillary Rodham Clinton School of Law at Swansea University enabled me to hear speakers such as Professor Martha Fineman, and HHJ MacDonald KC, and this offered me opportunities to reflect and refocus some of my studies.

I must also thank the Trustees of Adferiad, and those of Hafal, for their financial support in funding my studies. I am privileged to work for an organisation which has such a strong belief in the education and development of its staff. My colleagues too deserve thanks for supporting me in completing this study over a period which has included a global pandemic, and significant organisational mergers. Deepest thanks too for all those clients and carers of Hafal / Adferiad who shared with me their

personal experiences and helped provide me with the energy to take up this challenge to seek to improve the lives of those most affected.

Finally, thanks to my wife Emily, my daughter Annabel, and my family and friends, who have all provided support, encouragement, and opportunities to unwind, whilst making allowances for family events to fit in around my study schedule.

Definitions and Abbreviations

Adferiad / Hafal	**Adferiad is a charity created by the merger of CAIS, Hafal, and WCADA in 2021.**
AM	**Assembly Member of the Welsh Assembly, now known as Members of the Senedd, MS**
BMA	**British Medical Association**
CJD	**Creutzfeldt-Jakob disease**
CMHT	**Community Mental Health Team**
CTO	**Care and Treatment Order under the Mental Health Act 1983**
CTP	**Care and Treatment Plan under the Mental Health (Wales) Measure 2010**
DHSS	**Department of Health and Social Security**
DSPD	**Dangerous Severe Personality Disorder**
ECHR	**Council of Europe, Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (ETS No. 005), Entry in force 03/09/1953 European Convention on Human Rights, as amended**
ECT	**Electro-convulsive therapy**
ECtHR	**European Court of Human Rights**
EMDR	**Eye Movement Desensitisation and Reprocessing**
EU	**European Union**
GMC	**General Medical Council**
GoWA 2006	**Government of Wales Act 2006**
GP	**General Practitioner**
HIRU	**Health Informatics Research Unit at Swansea University**
HRA 1998	**Human Rights 1998**
IMHA	**Independent Mental Health Advocate**

LA	**Local Authority – Unitary Authorities / County Councils in Wales**
LCO	**Legislative Competence Order**
LHB / UHB	**Local Health Board / University Health Board. Responsible bodies for planning and delivering NHS services for a specific area in Wales**
MCA 2005	**Mental Capacity Act 2005**
MHA 1983	**Mental Health Act 1983**
MH(W)M 2010	**Mental Health (Wales) Measure 2010**
MP	**Member of Parliament**
MR	**Master of the Rolls**
MS	**Member of the Senedd**
NHS	**National Health Service**
NICE	**National Institute for Clinical Excellence / National Institute for Health and Care Excellence**
RCN	**Royal College of Nursing**
RCPsych	**Royal College of Psychiatrists**
Senedd	**Welsh Parliament**
UDHR	**United Nations General Assembly, Universal Declaration of Human Rights (adopted 10 December 1948) 217 A(III) (UNGA)**
UK	**United Kingdom**
UN	**United Nations**
UNCRPD / CRPD	**United Nations General Assembly, Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3**
WHO	**World Health Organisation**

Introduction

> Medical and mental hospitals are legally authorized to do different things. The medical patient is treated, from the legal point of view, as a person in a democratic society. He must contract for the care he wishes to receive, and the physician must obtain his "informed consent" for hospitalization and treatment (Hirsch, 1961). The mental hospital patient, in contrast, is treated not as a person, but as the occupant of a status. He is deprived of the right to contract, and the physician is given wide powers of control over hospitalizing and treating him. While the verbal similarities between medical and mental patients are many, the legal and social similarities between them are few.[1]

So noted Thomas Szasz, the prominent and outspoken psychiatrist who, whilst recognising the value of informal treatment and psychotherapy for people with "problems in living",[2] was profoundly opposed to the use of compulsion due to the impact on human freedom.[3] While Szasz wrote this in 1963, it is significant that new detention figures in England increased from 49,551 in 2017/18 to 53,337 in 2021/22.[4] This uplift occurred despite Article 14 of the United Nations Convention on the Rights of Persons with Disabilities (hereafter the UNCRPD), dealing specifically with detention on the basis of disability, being ratified by the UK in 2009.[5]

While not all mental health patients are detained, the very ability of the State, through the NHS, to deprive individuals of their liberty due to their disability, contrasts vastly

---

[1] Thomas Szasz, *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices* (MacMillan Co 1963) 88.

[2] Arthur R Williams, Arthur L Caplan, Thomas Szasz: Rebel with a Questionable Cause (2012) The Lancet Vol 380 Issue 9851, 1378.

[3] Tony B Benning, No Such Thing as Mental Illness? Critical Reflections on the Major Ideas and Legacy of Thomas Szasz BJPsych Bulletin (2016) Dec; 40(6):292*;* Benedict Carey, Dr Thomas Szasz, Psychiatrist Who Led Movement Against His Field Dies at 92 *New York Times* (New York, 11 September 2012) <www.nytimes.com/2012/09/12/health/dr-thomas-szasz-psychiatrist-who-led-movement-against-his-field-dies-at-92.html> accessed 21 January 2024*;* Anthony Stadlen, Thomas Szasz Obituary *The Guardian* (Manchester 4 October 2012) <www.theguardian.com/society/2012/oct/04/thomas-szasz> accessed 21 January 2024.

[4] NHS Digital (2024), *Mental Health Act Statistics, Annual Figures* <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures> accessed 21 January 2024.

[5] United Nations Treaty Collection, *Status of Treaties: Chapter IV Human Rights* <https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&clang=_en> accessed 21 January 2024.

with the experience of citizens seeking help with other health conditions. There is no requirement for an individual detained under the Mental Health Act 1983 (hereafter MHA 1983) to have committed an offence, nor to have caused harm to any other person, nor failed to follow a lawful instruction from an authorised person. Neither is there a requirement for a judicial process to be followed before determining that a detention need take place.[6] This is in contrast to other health legislation such as s.45G of the Public Health (Control of Disease) Act 1984, where any such need to detain an individual who poses a risk to others due to infection, can only happen under an order of a magistrate. As will be explored further in Chapters Three, Four, and Five, there are also greater nuances as to the nature of that detention; the treatment or non-treatment of an individual; and the impact of capacity and consent, which varies between the physical health and mental health legislation.

This focus of this thesis has evolved over many years, morphing from an original concept of the development of a rights-based approach for individuals seeking first time help with their mental health, into a more pragmatic stalking horse for the introduction of reciprocity in Welsh mental health law. Through my work with mental health campaigning organisations, I have been closely engaged in both Westminster Government and Welsh Government consultations on a number of health and social care policy and legislative developments. These include the draft Mental Health Bill 2002, the Mental Health Act 2007, and the Mental Health (Wales) Measure 2010. In discussions with a wide range of stakeholders during this work, the theme of

[6] It should be noted that s 135 of the Mental Health Act 1983 requires a constable to have a warrant from a justice of the peace to allow them to enter a specified premises and thereafter remove a person if appropriate to a place of safety.

reciprocity, deemed an entitlement by Genevra Richardson,[7] was of key importance. For Richardson and the Expert Committee on the Review of the Mental Health Act 1983, this was about imposing a 'duty on health and social care authorities to provide an appropriate standard of treatment and care'[8] in relation to detained patients. For me, and my organisation, Hafal (now known as Adferiad), this posed the question, why should this duty arise only at/after the point of detention? Why not have a duty to provide appropriate treatment and care to prevent the need for compulsion in the first place, if this were possible? While not all patients may seek help or be willing to accept help at an early enough stage in their illness, surely if a patient asks for treatment, it would seem particularly troubling to wait until they needed to be detained to provide them with that treatment?

The inherent discrimination apparent here between the powers under the Public Health (Control of Disease) Act 1984 for physical health and the MHA 1983 for mental health should be an anathema to all of us. The NHS has the power and resources to provide a service for people who may be at risk of detention which helps them avoid detention, but it fails to provide any meaningful guarantee of treatment times or accessibility in such matters. Indeed, it appear to be a the very one-sided way that the NHS operates in the application of these powers in mental health services. I would suggest that it is only with greater public awareness of mental health issues that this longstanding discrimination between physical and mental health as highlighted in Chapter Six may come under closer scrutiny. In this thesis, I will consider how this discrimination impacts on the rights of individuals, how it leads to an anti-therapeutic relationship,

[7] Department of Health, 'Report of the Expert Committee Review of the Mental Health Act 1983' (1999).
[8] ibid 27 para 3.2.

and how, in particular in a Welsh context, there may be opportunities for change. In Chapters Two, Seven and Eight I consider how devolution in Wales has hinted at the Social Contract, and why citizenship and rights may be viewed in a more reciprocal way. I refer throughout the thesis to the desire, from a predominantly Labour administration in the Senedd, to recognise Wales as a society of citizens, with an entitlement to and expectation of universal services.[9] Such universalism may result in reduced choice,[10] and for me, this suggests an opportunity to consider rights to a standard of services, with accompanying redress should the standard not be met, as a prelude to a Welsh reciprocity approach. The Westminster Government, by retaining powers in relation to the Mental Health Act 1983 whilst placing duties on the Welsh Ministers under the NHS (Wales) Act 2006, remind us that Wales is somewhat constrained in completely moving towards a more rights-based approach. However, I hope to show that through Welsh legislation and regulation, there are potential green shoots of rights-based citizenship that can be achieved.

Thesis Aims and Research Question

The primary aim of this thesis is to explore the feasibility of the introduction of reciprocity in Welsh mental health law. While the power held by the State to detain an individual for a health condition is generally very limited, mental health law is predominantly focussed upon detention and compulsory treatment without consent.[11]

[9] Mark Drakeford, 'Social Justice in a Devolved Wales' (2007) The Journal of Poverty and Social Justice Vol 15 no 2 171, 173.
[10] Rhodri Morgan, 'Clear Red Water' (Speech to the National Centre for Public Policy, Swansea University, 11 December 2002) <https://sochealth.co.uk/the-socialist-health-association/sha-country-and-branch-organisation/sha-wales/clear-red-water/> accessed 13 July 2024.
[11] Howard Ryland, Sarah Bunn, 'Reforming the Mental Health Act – Approaches to Improve Patient Choice' POSTnote 695 UK Parliament 11 May 2023, 2 <https://researchbriefings.files.parliament.uk/documents/POST-PN-0695/POST-PN-0695.pdf> accessed 3 November 2024.

Most of us will never experience detention but we have all seen and experienced significant restrictions on movement, personal liberty, and 'life' during the global Coronavirus (COVID-19) pandemic, under the Coronavirus Regulations (see further Chapter Seven).[12] Currently, there is no right to receive *specific* treatment from the NHS in the United Kingdom,[13] although in *Burke*[14] the European Court of Human Rights (ECtHR) found that artificial nutrition and hydration should not be ceased against the wishes of a competent patient. The ECtHR also found in *Winterwerp*[15] that Article 5 (1)(e) of the European Convention on Human Rights[16] (ECHR) does not provide for a right to appropriate treatment even where detained. In the Mental Health Act 1983, s.117 does set a duty on local authorities and the NHS to provide aftercare for those who have been detained for treatment (not for assessment), but again this is focussed on the purpose rather than the nature of the treatment.[17] Conversely, the State, under the Mental Health Act 1983 (hereafter MHA 1983) has the power to *impose specific* treatment on mentally ill individuals even where they have capacity. This is an imbalance, which in itself is sufficient to raise concerns.[18]

[12] Coronavirus Act 2020; The Health Protection (Coronavirus) Regulations 2020, SI 2020 No 129.
[13] Mental Capacity Act (2005) Code of Practice s 9.5; *R v Cambridge Health Authority ex p B* [1995] 2 All ER 129.
[14] *Burke v The United Kingdom* ECHR No. 19807/06 11 July 2006, The Court held that, "It would quite clearly be murder, it said, to withdraw life-prolonging ANH from a patient who, competent, desired the treatment to continue." Such treatment arguably is not a specific treatment but one of basic medicine, and this case did not argue for the right for such treatment to commence, only that Burke's concerns were that once he lost capacity, such treatment could be stopped against prior wishes.
[15] *Winterwerp v The Netherlands* (1979) 2 EHRR 387 para 51.
[16] Council of Europe, Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (ETS No. 005) Entry in force 03/09/1953.
[17] Mental Health Act 1983 s 117(6) 'In this section, "after-care services", in relation to a person, means services which have both of the following purposes—
(a) meeting a need arising from or related to the person's mental disorder; and
(b) reducing the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder)'.
[18] Mental Health Act 1983 Part IV.

But, consider the following situation: an individual may ask for treatment, and the State fails to deliver it. The individual's condition deteriorates to the point where the State determines they need to be detained to receive the very treatment they first requested. The State, through its failure to intervene in a timely fashion, could be said to have contributed to the exacerbation of the individual's health condition (or deterioration of the individual's health), and the impact this has on the individual's rights. It then rather perversely exacerbates the situation by impinging on the liberty of that individual to give them the very treatment they earlier sought but now under compulsion. This abhorrent outcome could, in many instances be avoided, and so it is vitally important therefore that the power imbalance in these cases be addressed as a matter of urgency. Why should a duty to provide a timely assessment and /or an appropriate standard of treatment and care[19] in respect of mental health patients only arise at, or after, the point of detention?

This thesis seeks to examine whether the development of a right to treatment within a reasonable but defined timescale, *before detention,* is feasible using Welsh law.[20] To establish a special case in relation to mental illness, it is vital to understand the way in which mental health legislation affects the rights of an individual. For this examination, the impingement upon a person's rights is considered with a focus on liberty and freedom as two separate concepts: one to relate to physical liberty, the other in respect of autonomy and freedom to exercise rights. In order to understand how this impacts on patients I will examine the development of mental health legislation from

[19] Mental Health Act 1983 ss 2-3.

[20] As will be seen in Chapter Six, this approach has been modified, as during this study I have come to realise that this would be too great a leap in one step. Chapter Six sets out the challenges for an individual seeking intervention from mental health services where she is a new referral: this is expanded and considered further in that chapter to explain why I believe there is a different approach which offers an initial step towards Welsh reciprocity.

the mid-18th Century up to the current day, including the role of Welsh law, and policy, and reflecting a little on Welsh law from the 10th Century. This allows an exploration of the potential for the development of rights-based legislation or regulation for reciprocity in Wales which seeks to provide for a right to assessment and / or treatment before compulsion so as to avoid such compulsion.

Thesis Structure: Chapter Outlines:

In this thesis, a key theme will be the impact detention under the MHA 1983 has on an individual's liberty and positive human rights. In Chapter One, the concept of liberty is examined in relation to understanding what is meant by liberty and freedom, why is it important, and how liberty is and has been protected in law. This discussion includes an introduction to the United Nations Convention on the Rights of People with Disabilities (UNCRPD),[21] which the UK ratified in 2009. In this chapter I also explore the impact of detention on human rights, both negative and positive to demonstrate how this also affects the individual's ability to have and maintain a private and family life.

Chapter One considers how these words Freedom and Liberty are currently used and sets a definition and differentiation of these concepts for this thesis. Additionally, this chapter starts our journey to understanding why devolution in Wales offers a unique opportunity to develop a mechanism to perhaps change the way that the NHS in Wales understands and implements a least restrictive approach in mental health services. In this chapter, I consider Freedoms 'to' and Freedoms 'from' in relation to the European

[21]United Nations Treaty Collection (n5).

Convention in Human Rights (ECHR),[22] and how the difference in this concept is reflected in our relationship with our State. The role of the Welsh Government, and the political will of a predominantly Labour administration in developing a citizenship and universalist approach to public services, is also considered in the upholding of rights. This Chapter also provides our first engagement with the United Nations Declaration of Human Rights (UNDHR),[23] and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD),[24] before considering some of the protections in the UK. The concept of a social contract, and the work of Berlin,[25] Rousseau,[26] and Rawls,[27] are an initial examination of what we as citizens may consider fair or oppressive in State rules. Chapter One examines the mental health context of the societal rules and introduces the basic components detention under the MHA 1983 before considering briefly the nature of autonomy ahead of a fuller review in Chapter Two.

In Chapter Two, I examine what humans need to be able to exercise their fundamental freedoms, and ask why capacity, consent, and self-determination are all impacted by mental health law. Autonomy is explored from a philosophical basis, a practical one in relation to health and health services, and finally in how capacity and power imbalance influences decision-making. Decision-making, even when Liberty is restricted, is considered as a challenge posed by detention under the MHA 1983, along with the role of the courts in establishing what decisions can be taken under the MHA

[22] Council of Europe (n16).
[23] United Nations General Assembly, Universal Declaration of Human Rights (adopted 10 December 1948) 217 A(III) (UNGA).
[24] United Nations General Assembly, Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3.
[25] Isaiah Berlin, Two Concepts of Liberty in *Four Essays on Liberty* (1969 Oxford; Oxford University Press).
[26] Jean-Jacques Rousseau, *The Social Contract* (1968, St Ives, Clays Ltd.).
[27] John Rawls, *Theory of Justice* (1999 Oxford, OUP).

1983 and those that cannot.[28] Free will is a key consideration in the discussion in Chapter Two, as while the philosophical arguments for autonomy make interesting study and debate, the practical implications for patients are both more mundane, but also more fundamental. The impact of detention upon the ability even to choose when and what to eat, to develop relationships, and to achieve potential, are all areas under consideration, along with a discussion of why these are so important to the human condition. Much of this chapter builds on my learning for a Masters in the Ethics of Social Welfare completed in 2007, where my dissertation was focussed on whether short term paternalism could be justified in promoting longer term autonomy.[29] My findings there were that even when such a paternalistic approach is based on beneficence, it can damage the longer term ability of an individual to choose to make decisions as they may be used to others doing so on their behalf. This ultimately risks restricting any ability to be autonomous. This chapter also considers the differentiation between the right to make bad decisions, and how doctors determine when such decisions, however capacitous the patient, are ones that they may override.[30]

This is not an issue for the patient alone; social work practitioners seeking to promote the independence of their clients are often stymied by the legislation, and their practice can work against client liberty.[31] The MHA 1983 provides for compulsory second opinions to be sought for treatment where the patient has capacity, if they are seeking irreversible treatment,[32] or where consent has been refused but such treatment is

[28] *Re. C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819.
[29] Alun H Thomas, 'Promoting Long Term Autonomy through Recovery – Is Short-Term Paternalism Justified If It Promotes an Increase in Autonomy in the Longer Term?' (2007) Dissertation submitted to Keele University.
[30] Mental Health Act 1983 Part IV.
[31] John Williams, 'Social Work, Liberty and Law' (2004) British Journal of Social Work (2004) 34 37, 50.
[32] Mental Health Act 1983 s 57.

considered necessary.[33] Such decisions are a key part of the role of psychiatrists, and the work of Beauchamp and Childress[34] in identifying the key components which underpin professional codes of conduct are also considered here. Chapter Two concludes by briefly touching on the 'least restrictive approach' required of mental health services in Wales,[35] and reflects on how partial autonomy must be maintained even while under compulsion.

The development of law relating to mental health, detention and restrictions is examined in Chapter Three, and I consider capacity and/or intent as an issue in criminal law. This chapter reflects on laws starting from 1744 but with a nod to the laws of the Welsh King Hywel Dda from the 10th Century. For a study considering the opportunity for Wales to develop a more compassionate approach to the law affecting the mentally ill, the approach of King Hywel Dda some 1,500 years ago offers a sensible and pragmatic entry point. As will be discussed, although the language reflected the approach and culture of the time, the recognition of mental disorder and the ability to form a *mens rea,* seems many centuries ahead of more recent developments. This chapter focuses on the law's protective approach in respect of family assets and how the development of mental health law tended to be linked to ensuring financial stability for families where the individual was seen to be unable to manage such resources. It goes on to consider the development of the insanity defence (for criminal proceedings), the potential restriction of movement, and how public order was managed before mental health services were established. I highlight the pejorative and stigmatising legislative language of the time, before exploring how the

[33] ibid s 58.
[34] Tom L Beauchamp, James F Childress, *Principles of Biomedical Ethics* (2001, 5th edition, Oxford: Oxford University Press) 5-12.
[35] Welsh Assembly Government, Mental Health Act 1983 Code of Practice for Wales (2008) para 1.8.

Victorian era started providing some of the structure and protections we see in some of the more modern legislation from the Mental Treatment Act 1930 onwards.

A number of thoughtful and humane consultations and reviews were undertaken from Victorian times onwards in relation to the inappropriate use of commitment to asylums, leading to legislation to codify many of the protections set out in common law. These are discussed in detail in Chapters Three, Four, and Five. It is however significant that the impact of World War I hastened the development of legislation as a consequence of stigma and the need for a more compassionate approach for those who served. The Mental Treatment Act 1930 and the reconstruction of the UK post-World War II, with the development of the Welfare State takes us up to Chapter Four.

Chapter Four takes up the discussion from the introduction of the NHS in 1948, the recognition of human rights post-World War II, and the desire to develop, 'a new world imbued with liberal values and anchored in effective international institutions'.[36] The creation of the World Health Organisation,[37] and the European Convention on Human Rights,[38] provide an opportunity for an initial analysis of how human rights are impacted by mental health related detention. This is explored in detail with a journey through the development of mental health legislation in the UK post-1948, where the State became responsible for a much broader range of health services. The Welsh journey towards devolution is discussed, including the historical beginnings of the

[36] Andrew Rawnsley, 'Brave new world: the search for peace after the second world war' *The Guardian* Sun 1 Sep 2019.
[37] United Nations International Health Conference, Constitution of the World Health Organization, (adopted 22 July 1946, entered into force 7 April 1948) Wld Hlth Org 2 100.
[38] Council of Europe (n16).

NHS in Wales offering much in considering a Welsh approach based upon a social contract.

The development of the NHS along with the consequences of war, both individual and globally through the creation of the United Nations,[39] provides a logical step forward into how rights have started to be of greater relevance in the development of mental health legislation. In Chapter Four, the impact of the sociological, economic, and health focus of post-war governments is examined, recognising both the positive changes based upon our journey towards greater recognition of rights, but also the knee-jerk reactions to high profile tragedies, for example the cases involving Christopher Clunis and Jonathan Zito,[40] and Ben Silcox.[41] We see too the initial development of campaigns for better treatment for people with serious mental illness and the transition from lunacy legislation to mental health legislation. The development of the Mental Health Act 1983 is explored with reference to a more rights focussed and least restrictive approach. This chapter also considers the impact of a wide range of health and social care legislation before concluding at the end of the millennium.

Chapter Five starts in the year 2000 where Welsh devolution was in its infancy with the launch of the National Assembly for Wales some seven months before the new millennium.[42] In considering the role of the Welsh Government in the development

[39] Charter of the United Nations (adopted 26 June 1945, entry into force 24 October 1945) 1 UNTS XVI (UN Charter).
[40] Jeremy W Coid, 'The Christopher Clunis enquiry' (1994) Psychiatric Bulletin (1994) 18 449.
[41] Douglas Bennett, '"No Lion can him Fright"' (1995) Psychiatric Bulletin (1995) 19 565.
[42] Senedd Cymru, 'History of Devolution' (7 October 2020) <https://senedd.wales/how-we-work/history-of-devolution/> accessed 11 August 2024.

of mental health law, Chapter Five also examines how Welsh policy diverges from that in England, despite the MHA 1983 being an England and Wales law. The development and maintenance of a separate and different Code of Practice[43] offered me the first insight into how Wales might offer a chance for people to receive a more humane approach, and I was heavily involved in the 2016 review of that 2008 Welsh Code. Chapter Five also discusses the language used in relation to 'should' and 'must', and the implications of such wording, and offers the initial suggestions as to how human rights may be protected through the stroke of a pen. An exposition of the political differences between Cardiff and Westminster Governments, despite both at one point being run by the same political party, also adds grist to the mill for a Welsh paradigm. The first Welsh mental health law since Hywel Dda, the Mental Health (Wales) Measure 2010 (hereafter MH(W)M 2010), followed shortly after the 2008 Code of Practice for Wales to the Mental Health Act 1983. How this was developed, the key principles, and the potential for its use in improving the rights of the mentally ill in Wales, is explored briefly before Chapter Six takes us to a reflection on how it may feel being subject to the MHA 1983.

In setting out some of the challenges faced by people in such circumstances I have devised a reflective scenario using a number of experiences shared with me over the last twenty years working in the serious mental illness field for Chapter Six. Imagine that you are having disordered thoughts but are aware enough of these that you know you need to seek help. You have had this experience before and know that early intervention can keep you in work so that you may support your family, can keep you well so that you and your loved ones are able to live your usual lives, and help you

[43] Welsh Assembly Government (n35).

regroup and move from the dark place you are in. You approach the NHS for help: there is currently a right to ask for a more expedited review of your circumstances but no overt set timescale. You really need an assessment of your needs and likely a course of medication and/or counselling but cannot access this until you have been assessed. Your condition continues to progress, and you have not yet been assessed. You are unable to work, and your family life is suffering both financially and emotionally. You become so distressed when you are out with family that you end up being detained by the police under s.136 of the MHA 1983,[44] transported to a place of safety, and ultimately detained for up to 28 days under s.2 of the MHA 1983[45] for assessment. You are now in a mental hospital, removed from your family, with the detention permanently on your medical records and thus reportable to insurance companies, and you have lost your liberty. For what? To receive the very assessment you asked for but which the NHS had failed to provide until it detained you because your mental health had deteriorated.

This is not a fantasy situation, but a reflection of the experiences of people who reached crisis point before receiving support despite previously seeking help and is included at Chapter Six. This reflection is intended to provide a focus on the reason for this research and to provide the reader with an understanding of the situation that individuals may face in accessing mental health services. While it is unlikely that a clear right to access support of a particular nature, and within a guaranteed timescale, could be introduced in Wales for mental health patients, it is important to understand why this is different from other health needs.

[44] Mental Health Act 1983 s 136.
[45] ibid s 2.

Chapter Seven considers that need in terms of a Welsh solution seeking justice and fairness. I explore parity of esteem between mental and physical health, and examine the role of the UNCRPD,[46] and the Human Rights Act 1998 in UK mental health law. The development of mental health law in Scotland is contrasted with that in Wales, before I undertake an in-depth analysis of Parts Two and Three of the MH(W)M 2010 and consider how they may be applied so as to enhance rights. Our experiences during COVID-19 are examined, particularly in relation to how criminal and public health law and mental health law differ, using examples of those who denied the existence of the virus and committed offences. Chapter Seven sets out the key components of a rights-based approach to mental health service provision in Wales. It builds upon existing legislation, offering a perspective on whether a citizen could, and if so should, go to law to support their rights, and suggests a phased development of the MH(W)M 2010.

Chapter Eight considers how devolution may offer an opportunity for Welsh mental health policy, practice, and indeed legislation, to become more humane, person centred, and compassionate by the adoption of a human rights approach. What Wales has done so far in mental health legislation has had an impact in the development of the draft Mental Health Bill 2022[47] and the very recent Mental Health Bill 2024.[48] This offers hope that Wales can be seen as a test bed for such innovations,[49] and how it can influence the development of policy, practice and legislation at Westminster.

[46] United Nations General Assembly (n24).
[47] Department of Health and Social Care, Draft Mental Health Bill (2022), CP 699 s 18 Care and Treatment Plans.
[48] Mental Health HL Bill (2024) 47 (59/1).
[49] Morgan (n10), "Indeed, that sense of Welsh communities as a test-bed for larger scale experimentation is paralleled in the way in which devolution itself has provided a 'living laboratory', in which different approaches to common problems can be worked out and applied".

During my studies, there was both a review of the MHA 1983, headed up by Professor Sir Simon Wessley,[50] and the proposal for a new Welsh mental health law by James Evans MS.[51] It was in the consideration of how much of the legislative work of the Senedd could and perhaps should have been developed through regulation, as pointed out by Clements,[52] that led me to consider a rework of the existing MH(W)M 2010. There already exist a number of duties, though without sufficient teeth in my opinion in this Measure, and this thesis seeks to find a mechanism to both give real effect to the intention behind the Measure, and redress for failure to deliver.

As someone personally involved in the journey from idea to legislation in 2010, I explain the initial discussions, through the experience of giving evidence to the Senedd and Parliamentary Committees, and in the campaigning and media work which led to this Welsh law. The recurring theme of reciprocity is arguably paramount in any mental health legislation, policy, or practice, and I believe this offers a way for the State to provide restitution for the impingement on human rights. The overwhelming need for mental health services that are responsive, compassionate, safe, effective, and least restrictive, is so that we may ensure the health, safety, and wellbeing of all, while also ensuring the rights of all are respected and upheld**.**

[50] Department of Health and Social Care, Modernising the Mental Health Act: Final Report of the Independent Review of the Mental Health Act 1983 (2018) <https://assets.publishing.service.gov.uk/media/5c6596a7ed915d045f37798c/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf> accessed 28 January 2024.
[51] Senedd Commission, 'Development of the Mental Health Standards of Care (Wales) Bill' (2023) <https://senedd.wales/senedd-business/legislation/proposed-member-bills/development-of-the-mental-health-standards-of-care-wales-bill/> accessed 28 January 2024.
[52] Luke Clements, 'The Social Services & Well-being (Wales) Act 2014: An overview' (2022) Rhydian Briefing by Luke Clements 1 <www.lukeclements.co.uk/wp-content/uploads/2022/02/Wales-SS-Well-being-Act-34-2022.pdf> accessed 22 January 2023.

While I have concerns about how mental health detention is applied in respect of our law being aligned with the UNCRPD, I am not opposed to the use of detention where it is demonstrably in the best interests of the patient. My concerns are in relation to how the determination to detain is made, how it impacts the patient's social and familial relationships, and how detention has a greater focus on harm prevention rather than guaranteeing the necessary treatment. I raise the dichotomy of powers for detention for wider public health and safety for physical illnesses restricted to quarantine, whereas those for mental health allow us to forcibly treat even where an individual has capacity.

What Needs to be Done?

In Chapter Nine, I set out the argument that Wales can lead on a human rights based mental health system, by setting absolute duties on services to act within a set timescale for those patients already known to services and who seek reassessment. The set timescale can be based on the maximum current timescale with the intention on reducing that timescale year on year so that services are given an opportunity to adjust. Where failure to meet these timescales means that an individual is detained for the purpose of receiving a mental health assessment, I suggest an approach which reflects our current legal redress for unlawful detention and aligning it with the NHS Redress (Wales) Measure 2008. This is the first step towards demonstrating that reciprocity may be developed through existing legislation, be targeted and achievable, and offer the potential for system change to prevent detention, to maximise quality of life, and to level up the relationship between patient and State. I referred to this approach earlier as a 'stalking horse', and in the conclusion to this thesis I explain why I believe this may the case, and how this offers the potential for further research and development.

As a Registered Nurse and having worked in a service user led mental health organisation for over twenty years, observing multiple NHS reorganisations, I have little confidence that guidance changes practice without clear consequences for poor practice. I do believe therefore that legislation is key to changing practice, and as much as we may hear that a carrot is preferable to a stick, sometimes a stick is the catalyst for change. Our current system penalises patients rather than service providers for failure to respond appropriately, and the unnecessary loss of an individual's Liberty does not generally result in any sanction for the service provider. The next chapter explains why Liberty is a fundamental Right, and the reasons for us to protect physical liberty, choice, and hope.

Chapter One - Explaining Liberty

Introduction

> All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.[53]

This thesis is predominantly focussed on the interference on the rights of the individual by the State under health-related legislation. As such the starting point must be an examination of Liberty and fundamental freedoms. The words Freedom and Liberty[54] are often conflated,[55] and this chapter will explore these concepts before setting a syntax position for this thesis as to where Liberty and Freedom will be used to identify a particular right, or interference with that right. A key part of this examination will be the exploration of the positive and negative ways that Liberty may be recognised: for example, being *at Liberty* to act as positive, and *Liberty from* persecution being negative. As noted in the Introduction Chapter, the most basic impact on an individual subject to detention under the Mental Health Act 1983 (hereafter MHA 1983) is the loss of physical liberty or free movement. It is therefore necessary for the purposes of this thesis to explore and clarify whether Liberty and Freedom are synonymous, or whether the words may be similar in everyday use but actually have significant applications which differ from each other in the meaning and understanding in this specific context.

---

[53] United Nations General Assembly, Universal Declaration of Human Rights (adopted 10 December 1948) 217 A(III) (UNGA) Article 1.

[54] As Liberty and Freedom are being referred to as a concept rather than simply the words, I have used capitalisation to mark the difference.

[55] Eugene F Miller, *Hayek's The Constitution of Liberty, An Account of Its Argument* (IEA 2010 London) 29-30; Hannah Pitkin, Are Freedom and Liberty Twins? (1988) Political Theory Vol 16 No 4 November 1988 523.

This chapter will also explain why the Right to Liberty, the most recognisable right engaged by mental health detention, perhaps most evident through the impingement on freedom of movement, is of such significance for this thesis and will set out some of the legal protections in England and Wales in respect of detention of citizens. In examining the impact of detention this chapter will also consider what it means to an individual subject to the MHA 1983 in terms of the ability of that individual to exercise their other rights and freedoms.

Language and Etymology

As noted by Pitkin[56] and Cassin,[57] of all the European languages it is only the English speaker who can choose between the words Liberty and Freedom. Both authors note that German offers *Freiheit,* and French *Liberté.* Welsh, a Celtic language, also has one word, *Rhyddid,* which translates as freedom, liberty, flexibility, and interestingly, autonomy,[58] a subject that will be discussed in more detail in Chapter Two. Pitkin explores the meaning of the words Freedom and Liberty from a linguistic and philosophical perspective and identifies Freedom as relating to unimpeded motion with a particular reference to slavery;[59] an interesting reflection when considering the restriction on movement identified in the Introduction Chapter as a basic impact of detention under the Mental Health Act 1983.

[56] Hannah Pitkin, Are Freedom and Liberty Twins? (1988) Political Theory Vol. 16 No. 4 November 1988, 523.
[57] *Dictionary of Untranslatables: A Philosophical Lexicon* (2014 Princeton University Press) 252.
[58] University of Wales Trinity Saint David, *'Geiriadur* search term "freedom*"'* (2019) <http://geiriadur.uwtsd.ac.uk/index.php?page=ateb&uni=y&prefLang=&term=rhyddid&direction=we&whichpart=exact&type=noun> accessed 23 July 2019.
[59] Pitkin (n56) 536.

The word Liberty is predicated on the Roman goddess Libertas who was the personification of liberty and personal freedom.[60] In Roman society, Libertas related to protection against the abuse of power – a negative right rather than a positive one.[61] The most significant modern personification of Liberty is that of the Statue of Liberty in New York,[62] though commentary on the plaque on the pedestal of the statue refers to the Greek goddess Eleutheria.[63] Eleutheria, while representing the fundamental notion of Liberty,[64] is said to refer more to the idea of freedom within a people, or an ethnic group – belonging to one's people[65]- rather than the concept of undetermined choice and self-determination.[66] This may also be viewed as freedom within a set of societal rules, not consisting of unrestrained will, but more of acting within a moral framework where choices are limited. This meaning has some resonance with the work of Rousseau who argues that as a member of a society that sets the rules, obedience to those rules is freedom.[67] Rawls too suggests that where there is an expectation to comply with such societal rules, in a moral society it is unlikely that any such rules would be so oppressive otherwise they would not have been agreed in the first place.[68] This position will be considered later in this chapter under the heading 'Mental Health Context'. Though this does not always provide absolute clarity, understanding the foundation for the concepts and use of the words Liberty and Freedom is important when we consider how the words are used in everyday language, and in commentary

[60] *Encyclopaedia Britannica*, (2008) <www.britannica.com/topic/Libertas-Roman-religion> accessed 24 July 2019.
[61] Pitkin, (n56) 354.
[62] UNESCO, 'Statue of Liberty' <https://whc.unesco.org/en/list/307> accessed 3 November 2024, criterion (vi),'She endures as a highly potent symbol – inspiring contemplation, debate, and protest – of ideals such as liberty, peace, human rights, abolition of slavery, democracy, and opportunity.'
[63] *Encyclopaedia Britannica* (n60).
[64] *Dictionary of Untranslatables* (n57) 250.
[65] ibid 251.
[66] ibid 252.
[67] Rousseau (n26) 65.
[68] Rawls (n27) 311-312.

on Rights and the law. This next section explores how they are used in both positive and negative ways, and where they are reflective of Rights and duties.

Contemporary Use of Liberty and Freedom

Berlin noted that Freedom as a term is 'so porous that there is little interpretation that it seems able to resist'.[69] He went on[70] to define Negative Freedom as that where there is protection from coercion and impingement on Liberty by the State or societal rules, and Positive Freedom as the ability to self-determine. He refers to Liberty and Freedom as interchangeable words, and argues that Negative Liberty is Freedom *from* interferences while Positive Liberty is more about self-mastery or personal autonomy.[71] Berlin went on to highlight that Positive Liberty may be used to justify oppression as others redefine what freedom means, while Negative Liberty provides for a minimum area of personal freedom to live a meaningful life.[72] Liberty appears then to be a broad concept and encompasses both freedom from oppression and 'human liberty' which Mill defines as: 'The only freedom which deserves the name, is that of pursuing our own good in our own way so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it'.[73] Mill was also a proponent of the Greatest Happiness Principle,[74] arguing that every individual has the right to have their happiness regarded as anyone else and they:

> [H]ave a right to equality of treatment, except when some social expediency requires the reverse. And hence, all social inequalities which have ceased to be

[69] Berlin (n25) 121.
[70] ibid 124-124.
[71] ibid 121-127.
[72] ibid 122-129.
[73] John Stuart Mill, On Liberty in *On Liberty and Other Essays* (1998 Oxford; Oxford University Press) 16-17.
[74] John Stuart Mill, Utilitarianism in *On Liberty and Other Essays* (1998 Oxford; Oxford University Press) 197-200.

> considered expedient, assume the character not of simple inexpediency, but of injustice…[75]

Such social inequalities and their relevance in freedom *from* and freedom *to* will be discussed further below as part of the understanding of the mental health context.

In defining Freedom, Mill identifies three components of Human Liberty.[76] First, a Liberty of conscience, thoughts, feelings, opinions, and sentiment.[77] This forms the basis for Freedom of opinion, expression and the ability to share those opinions. Secondly, he argues for the ability to 'frame the plan of our life to suit our character',[78] but in full understanding of the consequences (a theme which will be developed further in Chapter Two); and thirdly, a Freedom to unite for any purpose that does not cause harm to others.[79] Without respect for these Liberties, Mill argues, the society is not free; he states that: 'the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self protection.'[80] This may perhaps be argued as justifying the formation of societal rules on behaviours which impact on others, indeed, the development of law which offer protection for all.

For example, statutes such as the Offences Against the Person Act 1861, or the Sexual Offences Act 2003 (which is introduced as 'An Act to make new provision about sexual offences, their prevention and the protection of children from harm from other sexual acts, and for connected purposes') aim to provide societal protection through

[75] ibid 200.
[76] Mill (n73) 16-17.
[77] ibid 17.
[78] ibid.
[79] ibid.
[80] ibid 14.

their rules. As noted earlier, Rawls[81] and Rousseau,[82] argue that such rules, made by consensus, would not have an oppressive impact on Freedom. The law also offers support to Mill's justification for 'self protection',[83] with s.76 of the Criminal Justice and Immigration Act 2008 setting out the parameters for self-defence in law so as to provide protection while allowing reasonable force. Mill appears to suggest with the explanation of the Greatest Happiness Principle that, as a libertarian, he accepts the need for social rules, but that such rules only relate to actions which harm others. From a consequentialist perspective, as a concept this is difficult to argue with; self-defence being legally permissible[84] subject to such actions being proportionate and using reasonable force[85] to a threat. This is however more difficult to relate to situations where such rules permit detention on the basis that an individual has the *potential* to harm another even if there is no actual threat. It then poses further challenges when such detention is for the purpose of preventing harm to an individual by another individual who has capacity but is deemed to have a mental illness. This will be explored in further detail in Chapters Three, Four, and Five.

As expressed by Martin Luther King Junior,

> 'Injustice anywhere is a threat to justice everywhere… Whatever affects one directly, affects all indirectly… We know through painful experience that freedom is never voluntarily given by the oppressor; it must be demanded by the oppressed.'[86]

[81] Rawls (n27) 311-312.
[82] Rousseau (n26) 65.
[83] Mill (n73) 14.
[84] Criminal Law Act 1967 s 3.
[85] *R v Martin* [2001] All ER (D) 435 (Oct).
[86] Dr Martin Luther King Jr, 'Letter from a Birmingham Jail' 16 April 1963 African Studies Center – University of Pennsylvania <www.africa.upenn.edu/Articles_Gen/Letter_Birmingham.html> accessed 4 November 2024.

Berlin notes that it does not follow that freedom in itself is justice, equality, happiness, or morality, as Liberty to the detriment of others is unjust and immoral.[87] It is though fundamental for the human condition that we are free from oppression, and the ECHR sets out a number of areas in a person's life where the State should refrain from behaviours which impact on the Liberty of a citizen. For example, Article 5 provides for the Right to liberty and security; Article 6 provides for the Right to a fair trial to protect Liberty, and Article 2 for the Right to life (without which there is no chance of exercising Liberty). The ECHR was incorporated into UK law through the Human Rights Act 1998 (hereafter HRA 1998) which was enacted in 2000.[88] These Rights are fundamental to the relationship between a citizen[89] and the political/social State in which people live. In many places in the world such rights are not in place and detention without trial, the death penalty, and summary 'justice' are a part of daily life,[90] but as stated by Berlin, 'Liberty is not the goal of men'.[91]

Negative Liberty may be considered as Freedom *from,* a protective system aimed at ensuring the power of the State is utilised for the benefit of the citizens. Freedom from oppression may also be considered as a society where an individual is free from arbitrary detention, punishment, cruel and inhuman treatments. There are however the duties on the State that flow from the positive Rights and Fundamental Freedoms.

---

[87] Berlin (n25) 124.

[88] Equality and Human Rights Commission, 'The Human Rights Act' <www.equalityhumanrights.com/human-rights/human-rights-act#:~:text=The%20Human%20Rights%20Act%201998,the%20UK%20in%20October%202000> accessed 4 November 2024.

[89] 'Citizens' is a concept that will be discussed further in this chapter but also in Chapter Nine which considers the Welsh paradigm.

[90] Amnesty International, *The State of the World's Human Rights* (2018) <www.amnesty.org/download/Documents/POL10670020 18ENGLISH.PDF> accessed 28 July 2019.

[91] Berlin (n25) 124.

While all of the Articles in section I of the ECHR protect against State interference, we can see some distinction in the how an individual may exercise these Rights. In short of the eleven substantive Articles, five are primarily negative rights (Articles 3, 4, 9, 10, and 11). These are where the State must not interfere with the citizen through torture, by imposing slavery, coercing, censoring, or banning peaceful assembly. There is however a duty on the State to prevent others interfering with these Rights so they are not only negative, there is a positive component to these Rights too. The other six Articles (2, 5, 6, 7, 8, and 12) while appearing primarily positive rights to life, liberty, a fair trial, against punishment without law, to respect for a private and family life, and a right to marry, also require State action to protect them. So, while these may be considered primarily positive, there is a duty on the State to interfere to protect these Rights.

Two of the primarily positive Rights, Article 8, the Right to a private and family life and Article 12, the Right to marry, are protections, or Freedoms *from* interference, and place a duty on the State to provide protective measures. However, the exercise of these Rights may be beyond the individual. In exercising these Rights, the individual relies upon others choosing to take up those Rights with them. The Right to a private and family life is an important positive freedom where the individual has the Freedom *to* choose to have a family life; but there is no responsibility on the State to *provide* that family life. These Article 8 and 12 Rights are not therefore a set of duties on a State where a citizen may require performance, but more a protection of the Right *should an individual be in a position to take advantage of the opportunity,* against

interference or restriction[92] from a malevolent State. These can be contrasted with the primarily negative Article 9 Right to Freedom of thought, conscience and religion which can be expressed individually without reliance upon others. Freedoms *to* offer a somewhat different approach, where they encompass Freedoms *from* (oppression for example), but Freedom *to* relates to choices about how a person wishes to live their life and to exercise their Rights.

The Citizen in Wales – a philosophical divergence from Westminster and a focus on undefined rights

As noted above, Freedom *from* is a protective system for citizens of a State, rather than one where it creates an entitlement for a service or product or any other means to an end. This section reflects on the approach taken by successive Welsh Governments in seeking a social contract with the citizens of Wales to see what this means in relation to Freedoms *to* and/or Freedoms *from*. The Labour party as Government in Wales has led a particular focus on the citizen and engagement with citizens,[93] and this is significant when we consider the social contract approach to Rights.

In Wales, policy and law-making on health and social care are largely devolved, which has enabled the Welsh Government to take a different approach from that of the UK

[92] *B and L v The United Kingdom* 36536/02 Judgment 13 September 2005. This case relates to the marriage between two divorced individuals where B was the father of L's first husband. The Marriage Act 1949 prevented a marriage between B and L unless B's first wife and his son (L's first husband) had died. The European Court of Human Rights found that this violated Article 12 of the Convention.

[93] Senedd Wales, 'Citizen Engagement'<https://senedd.wales/visit/across-wales/citizen-engagement-1/> accessed 4 November 2024; Senedd Wales, 'Citizens' Assembly' <https://senedd.wales/how-we-work/devolution-20/citizens-assembly/> accessed 4 November 2024; Welsh Government, 'Citizen Voice Body for Health and Social Care' <www.gov.wales/citizen-voice-body-health-and-social-care> accessed 4 November 2024; NHS Wales, 'Putting the Citizen First' <https://nwssp.nhs.wales/a-wp/governance-e-manual/putting-the-citizen-first/> accessed 4 November 2024.

Government and has allowed Wales-specific legislation to emerge. Even when the Labour Party formed administrations in both London and Cardiff, a political space emerged between Wales and England, exemplified in the then First Minister of Wales' so called 'clear red water' speech at Swansea University in 2002:[94]

> The actions of the Welsh Assembly Government clearly owe more to the traditions of Titmus, Tawney, Beveridge and Bevan than those of Hayek and Friedman. The creation of a new set of citizenship rights has been a key theme in the first four years of the Assembly – and a set of rights, which are, as far as possible: free at the point of use; universal; and unconditional.[95]

In explaining the importance of new citizen rights under the Welsh Government such as free bus travel and free school milk for the youngest children, Rhodri Morgan[96] spoke of the universalist reforms of the Labour Government of 1945-1951. These provided free education for all, a National Health Service, and universal benefits such as family allowances in contrast to the approach taken by the Thatcher administrations where the Welfare State became a safety net for those who, "demonstrate the failure to be able to help themselves". He argues that such an approach is central to the improvement of the services for the most-needy as "services reserved for the poor very quickly become poor services" and that a set of rights: i) free at the point of use, ii) universal, and iii) unconditional, was intrinsic to Assembly policy in the first four years. Morgan[97] refers to these as "(T)he creation of a new set of citizenship rights" but does not explain who the citizen is nor what (if any) positive rights have been identified further than free access to galleries and museums. There is a strong focus on the duty of the citizen to ensure social cohesion along with a responsibility to see

---

[94] John Osmond, 'Making the 'red water' really clear' Institute for Welsh Affairs (2010) <www.clickonwales.org/2010/07/making-the-%E2%80%98red-water%E2%80%99-really-clear/> accessed 21 June 2015.
[95] Morgan (n10).
[96] ibid.
[97] ibid.

themselves as part of the whole Welsh society rather than acting as an individual consumer seeking services for oneself. These are strong socialist aims, and it is an admirable ambition to ensure that we do not reduce the support the State offers to those who are unable to help themselves to a 'poor house' type approach. Unfortunately, as would be expected from a speech rather than a policy statement, there is significant rhetoric and limited detail on how the new Welsh citizen has gained additional Rights in return for these community duties.

Mark Drakeford (latterly First Minister of Wales), while a policy advisor, wrote extensively about social justice in Wales. He detailed eight key social justice core principles including what he refers to as *progressive universalism,*[98] supporting the approach of Rhodri Morgan, and arguing for universal services plus additional investment in those areas most disadvantaged – "universal services with a progressive twist".[99] This citizenship approach has been taken further in the work of the Bevan Commission in the development of the *Prudent Healthcare* approach. This approach relies upon the concept of co-production where:

> Co-production refers to a way of working whereby decision makers and citizens, or service providers and users, work together to create and deliver services. This includes consideration of broader social, economic and cultural issues to avoid unnecessary medical and therapeutic interventions to resolve health care needs.[100]

What devolution has provided for, has been the delivery of the NHS in Wales through a universalist approach, based upon improving services for all, remaining free at the point of delivery, and through a prudent healthcare model. It is however, as a

[98] Drakeford (n9) 173.
[99] ibid 174.
[100] Bevan Commission, A Prudent Approach to Health: Prudent Healthcare Principles (2015) 6 <www.bevancommission.org/sitesplus/documents/1101/Final%20Prudent%20Health%20Principles.pdf> accessed 1 November 2015.

Universalist model, one which does not promote choice in who provides services,[101] and thus, little or no option between good or bad providers. It is an approach which suggests that State provision ensures equality,[102] but services across Wales are inconsistent and the postcode lottery remains.[103] This approach suggests that however well-intentioned a Universalist system may be, there is little Freedom to choose for a citizen in the micro, with only the macro governmental elections offering Freedom to choose. But does this approach offer any enhancement in the Freedom *from*?

The very fact that a citizen is detained under the MHA 1983 means there is an obvious engagement with their 'negative' Rights which may particularly include Articles 3, 5, 6, and thus 14.[104] The consequence of detention means that they cannot engage in society which means that the ability to exercise choices in relation to their Article 8, 9, 10, 11 and 12 Rights is affected. This is particularly galling where they have been detained to receive treatment they may have previously requested to receive as an informal (non-detained) patient, but the failure of the health system has led to their detention to receive that very treatment. There is of course also an impact on their Article 9 Rights in that they may receive treatment that alters their way of thinking

[101] David Matthews, 'The Battle for the National Health Service: England, Wales, and the Socialist Vision' *Monthly Review,* (2017) Mar 01 2017 <https://monthlyreview.org/2017/03/01/the-battle-for-the-national-health-service/> accessed 10 November 2024.
[102] ibid.
[103] Audit Wales, 'Postcode lottery for new 'front door' to adult social services' (2019) <www.audit.wales/news/postcode-lottery-new-front-door-adult-social-care-services> accessed 10 November 2024; Jennifer R Roberts and others, '"It's a Postcode Lottery"; How do People Affected in Wales Experience Their Diagnosis and Post-Diagnostic Support, and How May These Be Improved?' (2024) Int J Environ Res Public Health 2024 21(6) 709, 1.
[104] Article 3, Victoria Macdonald, "'It's like torture' – Patient with autism fears for his safety in mental health units" *Channel 4 News* 8 Nov 2023 <www.channel4.com/news/its-like-torture-patient-with-autism-fears-for-his-safety-in-mental-health-units> accessed 4 November 2024; Article 5 is the very nature of the detention; Article 6, the right to a Mental Health Tribunal is after the point of detention not before; Gov.uk, 'Apply to the Mental Health Tribunal' <www.gov.uk/mental-health-tribunal> accessed 13 June 2022. Article 14, the rate of detention for black people under the MHA 1983 is 3.5 times higher than for white people; Gov.UK, 'Detentions under the Mental Health Act' 16 August 2024 year to March 2023 <www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest/#main-facts-and-figures> accessed 4 November 2024.

against their capacitant wishes, either through forcible medication or ECT.[105] A Universalist approach can only improve these Freedoms *from* if there are consequences when the State fails in its part of the social contract, but where the State is the only provider, there is little competition to drive improvement. As will be seen in later Chapters (see especially Chapter Seven, Eight, and Nine), this thesis seeks to suggest a mechanism to support the impact on the Freedom *from* Rights of the seriously mentally ill.

The Exercise of Freedoms *to*

For this section, it is useful to consider how an individual may wish to exercise their choices under their Freedom *to,* or positive Rights. Even if an individual may not wish to exercise a Right while detained, this does not justify impingement of that Right. Berlin sought to differentiate between the ability to exercise a Freedom *to* from a personal inability, rather than inability due to coercion by the State:

> If I say that I am unable to jump more than ten feet in the air, or cannot read because I am blind, or cannot understand the darker pages of Hegel, it would be eccentric to say that I am to that degree enslaved or coerced. Coercion implies the deliberate interference of other human beings within the area in which I could otherwise act. Mere incapacity to attain a goal is not lack of political freedom. This is brought out by the use of such modern expressions as `economic freedom' and its counterpart, `economic slavery'. It is argued, very plausibly, that if a man is too poor to afford something on which there is no legal ban--a loaf of bread, a journey round the world, recourse to the law courts--he is as little free to have it as he would be if it were forbidden him by law.[106]

Berlin wrote this over fifty years ago, and indeed many years before the United Nations Convention on the Rights of People with Disabilities was ratified.[107] It is interesting to reflect that the positive duties on the State to ensure that the rights of

[105] Such an individual who receives compulsory medication which affects thought processes has had their thoughts, and beliefs altered by the medication.
[106] Berlin (n25) 121.
[107] United Nations General Assembly (n24).

people with disabilities are not restricted due to their disabilities, conflicts with the first hypothesis that being blind is not enslavement. Unless positive action is taken to reduce the impact of that disability then the individual will be unlikely to be able to be able to assert their Rights, and as such the State is failing to ensure there is no impingement on these Rights.

It is also worth reflecting that poverty can lead to significant injustice thus entrenching that poverty[108] which is exacerbated by the cuts to legal aid in the UK:

> The best protection against injustice is good legal advice and, for those who cannot pay, that means good legal advice funded by legal aid. Exclusion from legal aid is exclusion from justice. We cannot return to the situation encapsulated in the wellworn quotation of US Judge Sturgess, 'Justice is open to everyone in the same way as the Ritz Hotel'[109]

Unfortunately, there is little national legislation in place to give effect to the UNCRPD in England and Wales. While the Equality Act 2010 seeks to protect from discrimination in relation to consumer and employment law among other areas, it remains woeful on providing positive rights for the standards of health and rehabilitation set out in Articles 25 and 26.[110]

A fundamental issue for this thesis is the delay in receiving treatment at the time it is requested, which then may lead to detention to receive that very same treatment. This flies in the face to Article 25 (b) of the UNCRPD:

> Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as

[108] Kate Donald, 'The Vicious Circle of Poverty and Injustice' (2013) Open Democracy <www.opendemocracy.net/en/shine-a-light/vicious-circle-of-poverty-and-injustice/> accessed 25 August 2019.
[109] Anne Singh, Frances Webber, 'Excluding Migrants from Justice: The Legal Aid Cuts' (2010) IRR Briefing Paper No. 7 Institute of Race Relations 6 <www.bl.uk/britishlibrary/~/media/bl/global/social-welfare/pdfs/non-secure/e/x/c/excluding-migrants-from-justice-the-legal-aid-cuts.pdf> accessed 28 July 2019.
[110] Appendix I.

appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons.

Chapters Four and Five will explore the duty (if any) on the UK Government and/or the Welsh Government to give effect to these Articles in relation to both the current review of the MHA 1983, Welsh mental health policy, legislation and policy, and existing case law on the duty to provide health services and ration expenditure including *Child B*.[111]

The Legal Context of Liberty and Freedom

The United Nations Universal Declaration of Human Rights[112] sets out four fundamental freedoms: Freedom *of* speech and belief, and Freedom *from* fear and want (emphasis added). Here again, there are positive and negative Rights forming, in that the oppressive 'fear and want' require protection, but it suggests that the ability to have a 'voice and a belief' should be promoted. This is also of particular interest when considered alongside the current political challenges relating to the European Union where Freedom of Movement of citizens of EU nations is considered the *cornerstone* of Union membership.[113] As noted earlier, the most obvious manifestation of detention under the MHA 1983 is the impact on the right of the individual to physical freedom, and consequently this impacts on freedom of movement.

Such matters were historically integral in the development of mental health legislation in the UK. Eccles[114] notes that the Vagrancy Act 1744 applied specific clauses only to those who, 'by lunacy or otherwise, are furiously mad or so disordered in their senses

[111] *R v Cambridge Health Authority ex p B* [1995] 2 All ER 129.
[112] United Nations General Assembly (n23) 71.
[113] European Parliament, 'Factsheet: Free Movement of Persons' (2019) <www.europarl.europa.eu/factsheets/en/sheet/147/free-movement-of-persons> accessed 28 July 2019.
[114] Audrey Eccles, ''Furiously Mad': Vagrancy Law and a Sub-Group of the Disorderly Poor' (2013) Rural History (2013) 24 1 25, 26.

that they may be *dangerous to be permitted to go abroad*'[115] (emphasis added). Fennell[116] and Eccles[117] also reference this as the first occasion where there was a requirement (under s.20 of the Vagrancy Act 1744) that two Justices of the Peace were required to agree to such detention. This is a point that will be explored further in Chapter Five in relation to current legislation, as following changes introduced in the Mental Treatment Act 1930, the requirement for judicial oversight to certify detention was removed.[118] Fennell also observed that this was the first express statutory power in contrast to the common law powers to 'detain and restrain' to prevent a breach of public order.[119] Eccles[120] suggests that legislation may have been introduced partly due to increasing mobility of the population and concerns that the common law did not provide a means of prosecution for even capital offences committed by 'lunatics' and 'idiots'.[121] This was a situation resolved by the introduction of the Criminal Lunatics Act 1800 which addressed the case of James Hadfield who was initially acquitted of treason, despite having shot at King George III, on the grounds that he was insane.[122]

In considering the development of the law to prevent the individual from arbitrary detention it is worth considering the historical need for such protections. In Common

[115] Philip Fennell, Mental Disorder in Gostin L, and others (ed), *Principles of Mental Health Law and Policy* (OUP 2010) 6.
[116] ibid.
[117] ibid.
[118] Claire Hilton, '90 years ago: the Mental Treatment Act 1930 by Dr Claire Hilton' (2020) Royal College of Psychiatrists 9 September 2020 <www.rcpsych.ac.uk/news-and-features/blogs/detail/history-archives-and-library-blog/2020/09/09/90-years-ago-the-mental-treatment-act-1930-by-dr-claire-hilton> accessed 23 November 2024.
[119] Fennell (n115) 6.
[120] Eccles (n114) 26-27.
[121] This was the language of the time and thus included in parenthesis.
[122] Richard Moran, 'The Modern Foundation for the Insanity Defence: The Cases of James Hadfield (1800) and Daniel McNaughtan (1843)' (1985) The Annals of the American Academy of Political and Social Science Vol 477 The Insanity Defense (Jan. 1985) 31, 32.

Law there has long been a protection for the right of the individual not to be detained without just cause by State agents.[123] This protection, both historical and in place today, relies upon the tort of trespass to the person in the form of false imprisonment,[124] which is actionable both by the individual themselves in the County Court and by the Crown under Criminal Law. Proof that imprisonment occurred is sufficient to give rise to the action with the onus then on the defendant to prove the imprisonment was justified.[125]

While the modern role of the Monarch is more in way of a Ceremonial Head of State this was not always the case, and it was often the result of actions or abuse of power by Monarchs such as King John[126] that led to the development of charters and statutes which are the foundation of the right to liberty in England and Wales. While Royal Prerogative and Royal Assent to statute remain in place these are in effect bound by constitutional convention and the power of the Monarch to impact the liberty of the individual is negligible. Unlike jurisdictions where a written constitution, and subsequent amendments to such a constitution, provide a route map of the development of the law,[127] the development of the law in England and Wales has taken many centuries to emerge. The following review of legislation and case law is in chronological order.

[123] British Library, 'Habeus Corpus Act (1679)' <www.bl.uk/learning/timeline/item104236.html> accessed 25 August 2019.
[124] *Halsbury's Laws of England* (5th edn 2010) 97 para 542 Lexis Library 3 August 2014.
[125] ibid.
[126] Lord Irving, 'The spirit of Magna Carta continues to resonate in modern law' (2003) LQR 229.
[127] This is the case in Germany: Basic Law for the Federal Republic of Germany in the revised version published in the Federal Law Gazette Part III, classification number 100-1, as last amended by the Act of 19 December 2022 (Federal Law Gazette I 2478).

In 1100, Henry I swore his Coronation oath promising to 'observe justice and equity',[128] and this 'Charter of Liberties' is what Lord Irving cites may be considered as a precursor to the Magna Carta.[129] The Magna Carta 1215 limited powers of the monarch thereby giving rights to the individual. Of interest here is chapter 29 which states:

> No freeman shall be taken or imprisoned, or be disseised of his freehold, or liberties, or free customs, or be outlawed, or exiled, or any other wise destroyed, nor will we not pass upon him, nor (condemn him, deal with him) but by lawful judgment of his peers, or by the law of the land. We will sell to no man, we will not deny or defer to any man either justice or right.

It should be noted that this applied to 'freemen' and was not therefore a universal statement of protection of liberty, but it did offer protection to landowners and noblemen who were previously subject to the whim of successive Monarchs.

The Monarch still retained a great deal of power through the Royal Prerogative and while the rights embedded in Magna Carta referred to judgment against the 'law of the land', the Monarch could take it upon himself to create new law and indeed make such law retrospective thereby creating an uncertainty that acts committed while legal one day might be made illegal in the future. This was addressed in part by the Case of Proclamations[130] where it was held:

> [A] thing which is punishable by the law, by fine, and imprisonment, if the King prohibit it by his proclamation, before that he will punish it, and so warn his subjects of the peril of it, there if he permit it after, this as a circumstance aggravates the offence; but he by proclamation cannot make a thing unlawful, which was permitted by the law before: and this was well proved by the ancient and continual forms of indictments.

And further:

---

[128] Irving (n126).
[129] William Stubbs, *The Constitutional History of England--in its Origin and Development*, *Vol I* (4th edn 1883) 328-330 cited by Lord Irving.
[130] *Case of Proclamations* [1610] EWHC KB J22.

> Also it was resolved, that the King hath no prerogative, but that which the law of the land allows him.

Unfortunately, this did not stop the Monarch creating new laws within his powers which could impinge on Liberty as can be seen below.

The redress that Magna Carta provided for deprivation of liberty took the form of a writ of habeas corpus. This, rather than being a writ to ensure the right of an individual to a trial, was an order to physically bring before the court a defendant so that his case might be answered in his presence. This did in fact ensure that the defendant was present when cases were heard.[131] Habeas corpus writs were used for centuries in this way, but in 1627 in what is known as *Darnel's Case*[132] the court held that the five knights, who were detained by order of the King for the non-payment of a new monarch enforced loan, were rightly subject to the detention as ordered by King Charles I, as the Crown retained the power to order such detention within the Royal Prerogative. This led to a significant period of political debate and the development of the Petition of Right in 1628[133] which stated that the 'King's Subjects should not be taxed but by Consent in Parliament'. The ongoing debate ultimately led to the Habeas Corpus Acts of 1640 and 1679, which gave teeth to the principle and led to the embedding of the writ in the protection of liberty.

---

[131] David Blundell, 'Habeas Corpus', Westlaw Insight para 4 <http://login.westlaw.co.uk/maf/wluk/app/document?&srguid=i0ad69f8e000001479c1a66e4282a8da6&docguid=IC2A83CE0206811E39061D5F52664A015&hitguid=IC2A83CE0206811E39061D5F52664A015&rank=1&spos=1&epos=1&td=6&crumb-action=append&context=58&resolvein=true> accessed 29 June 2014.

[132] (1627) 3 State Tr 1.

[133] ibid paras 6-10.

A reported case[134] *Somerset v. Stewart*[135] is of particular interest when we consider the abolition of slavery. Somerset was a slave brought to England from Virginia who refused to remain in servitude and when Stewart attempted to return him to Virginia a writ of habeas corpus was served to bring the matter before the English courts who held that slavery could not be tolerated (as set out in the Magna Carta) and freed Somerset. However, it should be noted that the United Kingdom was one of the major slave trade nations at the time.[136] This came some 35 years before the Slave Trade Act[137] which led to multiple statutes prohibiting the trade of slaves in any British territory and hence the prohibition of slavery itself. This case was supported by Granville Sharp who one year later became an inaugural committee member of the Committee for Abolition of Slavery.[138]

Despite the experiences of King Charles I in challenging the British Parliament which led to the development of the Habeas Corpus Acts, the Monarchy continued to exceed its powers leading to the Glorious Revolution of 1688[139] against King James II. This led to the Bill of Rights 1688 which in effect restated much of the substance of the Magna Carta. However, with limited statutory protections, the common law system led to many cases which have defined liberty and false imprisonment[140] being brought on the basis of trespass to the person.

---

[134] ibid para 13.
[135] (1772) 12 GEO 3 KB.
[136] International Slavery Museum, 'European Traders' <www.liverpoolmuseums.org.uk/ism/slavery/europe/index.aspx> accessed 3 August 2014.
[137] Slave Trade Act 1807.
[138] British Library, Minutes of Committee for Abolition of Slavery (1776) <www.bl.uk/onlinegallery/takingliberties/staritems/66minutesofcommitteeabolition.html> accessed 3 August 2014.
[139] Daniel Greenburg, 'Bill of Rights 1688' *Westlaw Insight* (2014); Bill of Rights 1688.
[140] *Bird v Jones* (1845) 7 QB 742; *Herd v Weardale Steel Coal and Coke Co Ltd* [1915] AC 67; *Meering v Grahame-White Aviation Company Ltd* [1918-19] All ER Rep Ext 1490; *Sayers v Harlow Urban District Council* [1958] 2 All ER 342.

The principles set out in Magna Carta and the Bill of Rights require that detention be within the law, and this is where some of the challenges to liberty are more apparent. Parliament has passed a number of laws which restrict personal liberty including those permitting internment during conflict,[141] mental health legislation,[142] and anti-terror legislation.[143] Internment was used between the World Wars, during World War 2, and in Northern Ireland during the conflicts. As noted by Lowe,[144] as well as being: 'an extreme measure taken by a government', internment is:

> a process where persons are imprisoned on the authority of a senior politician and without due process or judicial trial proceedings solely on the grounds that they are perceived as a threat to the State, is both politically and legally a sensitive subject.'

Internment, particularly in relation to citizens of the State which applies it, can appear to be a slippery slope to censorship, restriction of political opposition, and the imposition of a Police State. Habeas Corpus has been used to challenge the Government's use of internment. In Ireland in 1923,[145] internment was found to be illegal as the internees were citizens of another State, and in 1940[146] in the case of Oswald Moseley internment was found to be legal due to the threats posed. More recently internment has been challenged under the ECHR[147] and the Human Rights Act 1998[148] which will be discussed later in this chapter.

The United Kingdom ratified the ECHR in 1951 which sets out under Article 5:

Right to liberty and security

---

[141] Aliens Restriction Act 1914.
[142] Mental Health Act 1983.
[143] Terrorism Act 2000.
[144] David Lowe, 'Internment' (2014) <https://researchonline.ljmu.ac.uk/id/eprint/498/3/Internment.pdf> accessed 12 October 2024.
[145] *Secretary of State for Home Affairs v O'Brien* [1923] 2 KB 361.
[146] *The King v. Secretary of State for Home Affairs, Ex parte Lees* [1941] 1 KB 72.
[147] *The Republic of Ireland v The United Kingdom* (1979-80) 2 EHRR 25.
[148] *Serdar Mohammed v Ministry of Defence* [2015] EWCA Civ 843.

1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

(a) the lawful detention of a person after conviction by a competent court;
(b) the lawful arrest or detention of a person for noncompliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;
(c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;
(d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority; the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;
(e) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.

2. Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.

3. Everyone arrested or detained in accordance with the provisions of paragraph 1 (c) of this Article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear for trial.

4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

5. Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation

The United Kingdom did not permit individual petition to the European Court of Human Rights in Strasbourg until 1966[149] which meant there was no opportunity to challenge outside the British Courts until after 1966. The nature of treaties such as the ECHR allow for exclusions for nations in times of national exigencies, and it was this

[149] BBC, 'Human Rights: The European Convention' (2000) <http://news.bbc.co.uk/1/hi/uk/948143.stm> accessed 3 August 2014.

that was the key issue in the challenge made by Ireland against the United Kingdom over internment as noted earlier.

Within the ECHR[150] it is recognised that so long as any measures taken are consistent with international obligations, a State may derogate from the ECHR at a time of war or other public emergency which threatens 'the life of the nation.'[151] This was the defence successfully used in the ECtHR by the UK,[152] though further challenges were made in respect of the lack of judicial oversight of the process which led to the UK issuing a notice of derogation to permit this approach.[153] The lack of judicial oversight is a theme which will be seen in later challenges to United Kingdom management of detention without charge, and will form part of the argument for determination of loss relating to unnecessary detention under the MHA 1983 in Chapters Five and Seven.

Mental Health Context

As noted earlier in the discussion on Liberty as Freedom within societal rules as postulated by Rousseau and Rawls, the legitimisation of such an approach relies upon the belief that a moral society would not impose oppressive rules on itself. We have seen the development of Charters that flow from the UDHR[154] such as the International Covenant on Economic, Social and Cultural Rights 1966,[155] and the UN Convention

[150] ECHR Art 15.
[151] Lowe (n144) para 5; ECHR Article 15 Derogation in time of emergency.
[152] *The Republic of Ireland v The United Kingdom* (1979-80) 2 EHRR 25.
[153] Ben Fitzpatrick, Clive Walker, 'Holding Centres in Northern Ireland, the Independent Commissioner and the Rights of Detainees' (1999) European Human Rights Law Review para 28.
[154] Claude Welch, 'Universal Declaration of Human Rights: Why does it matter?' (2015) <www.buffalo.edu/ubnow/stories/2015/12/qa_welch_udhr.html> accessed 26 August 2019.
[155] United Nations International Covenant on Economic, Social and Cultural Rights 1966, adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966. Entry into force 3 January 1976, in accordance with Article 27.

on the Rights of the Child 1989,[156] along with national legislation such as the HRA 1998 aimed at protecting those vulnerable individuals in society. It is of course arguable that if society was moral and non-oppressive, then such Charters and Conventions would be unnecessary, but until that utopian society is in place we must recognise that obedience to even societal rules can and often does lead to oppression. As will be seen in Chapters Four, Five, and Seven, the involvement of patients in the development of mental health law is particularly challenging. The nature and operation of parliamentary committees, the complexity of legislation, and the political drivers of public safety are often significant obstacles for people struggling with serious mental illness. This then means that we have to rely upon the morality of the rest of the State who are able to engage and contribute, to understand the oppression mental health legislation may bring.

The legislative framework in which mental health services and detention under the MHA 1983 operates will be discussed in more detail in Chapters Four and Five, but for contextual understanding, a brief explanation of the framework that regulates detention for health grounds will be provided here. In England and Wales, mental illness is the only condition where an individual with capacity may be treated against their will.[157] For individuals who lack capacity, the Mental Capacity Act 2005 (hereafter MCA 2005) s.4 provides safeguards for *best interest* decisions. Where necessary the Court of Protection or the High Court will intervene and make a *best interest* decision where medical staff and the family either disagree or indeed where

[156] United Nations General Assembly, Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3.
[157] NHS, 'Do I have the right to refuse treatment?' (2017) <www.nhs.uk/common-health-questions/nhs-services-and-treatments/do-i-have-the-right-to-refuse-treatment/> accessed 25 August 2019; GMC, 'Legal Annex' <www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life/legal-annex> accessed 25 August 2019.

they agree but wish to have the Court provide judgment in order for a particular treatment to be undertaken[158] or indeed withdrawn.[159] The MCA 2005 will also be discussed in Chapter Four in the context of prima facie detention for individuals who lacked capacity to object to their conditions of residency in care.[160] It is worth noting here too that the MCA 2005 has resulted in greater scrutiny of those situations where *de facto* interference with Liberty takes place in care provision. The *Bournewood*[161]judgment related to an individual in a psychiatric hospital and led to amendments of the MCA 2005 by the Mental Health Act 2007,[162] and the introduction of Deprivation of Liberty Safeguards, (soon to be replaced by the Liberty Protection Safeguards).[163]

It is worth noting here that in the Supreme Court's *Cheshire West*[164] ruling, the Right to Liberty was defined by Lady Hale as:

> Those rights include the right to physical liberty, which is guaranteed by article 5 of the European Convention. This is not a right to do or to go where one pleases. It is a more focussed right, not to be deprived of that physical liberty. But, as it seems to me, what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities. If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage.[165]

---

[158] John Paris, AC Elias-Jones, '"Do we murder Mary to save Jodie?" An ethical analysis of the separation of the Manchester conjoined twins' (2001) Postgraduate Medical Journal 2001;77:593.
[159] *Airedale National Health Service Trust v Bland* [1993] AC 789.
[160] *R (L) v Bournewood Community and Mental Health NHS Trust* [1998] UKHL 24.
[161] ibid.
[162] Mental Health Act 2007 Part 2 Chapter 2 s 50.
[163] Gwent Safeguarding, 'The Liberty Protection Safeguards (LPS) explained <www.gwentsafeguarding.org.uk/en/safeguarding-adults/deprivation-of-liberty-safeguards/the-liberty-protection-safeguards-explained> accessed 10 November 2024.
[164] *P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents)* [2014] UKSC 19.
[165] ibid para 46.

Whilst Lady Hale notes the challenges in determining a standard test for Deprivation of Liberty,[166] this case did provide the 'acid test' for Deprivation of Liberty, 'whether they were under the complete control and supervision of the staff and not free to leave'.[167] This suggests that the key point to consider in the use of the word Liberty is that of physical Liberty. Whilst I recognise and appreciate the view of Pound that there is more to Liberty,[168] for the purposes of this thesis, I will take Liberty as the antonym of detention.

For those individuals with capacity who may pose a danger to society through infection or disease, the State has the power to detain and hold an individual (subject to a Magistrate's order[169]) to cleanse them of infestation (against their wishes if ordered by a Magistrate[170]), but not to medically or pharmaceutically treat them against their wishes.[171] Compare this then with the MHA 1983 where an individual may be deemed to have capacity, but that capacity can be subsequently overridden by medical professionals should they deem that the individual has a:

> [M]ental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
>
> (b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.[172]

---

[166] ibid para 48.
[167] Lady Brenda Hale, 'Psychiatry and the law: An enduring interest for Lord Rodger' The Lord Rodger Memorial Lecture 2014 <www.supremecourt.uk/docs/speech-141031.pdf> accessed 10 November 2024 24.
[168] Williams refers to Pound as considering liberty as those '*fundamental reasonable expectations involved in civilised society* and a freedom from *arbitrary and unreasonable* exercise of the power and authority of those who are designated or chosen in a politically organized society to adjust relationships and order conduct…' Roscoe Pound, *The Development of Constitutional Guarantees of Liberty,* (1957) New Haven and London Yale University Press) cited in John Williams, 'Social Work, Liberty and Law' (2004) British Journal of Social Work (2004) 34 37, 38.
[169] Public Health (Control of Disease) Act 1984 s 45.
[170] Public Health Act 1936 s85(2).
[171] Stephen Monaghan, *The State of Communicable Disease Law* (2002 The Nuffield Trust, London) 24-25.
[172] s 2 Mental Health Act 1983 as amended.

In these cases, the individual in question can be detained without judicial oversight prior to detention.[173] Detention under s.2 MHA 1983 can last for 28 days while detention under s.3 lasts in the first instance for up to six months before renewing on an annual basis. Where an individual held under ss.2-3 seeks judicial oversight, then a Tribunal must be convened within seven days.[174] This may be postponed and, in some cases, s.17 of the Rules[175] means that documents may be withheld from the patient if they are deemed to have potential to cause the patient harm.

Section 2 of the MHA 1983 refers to medical treatment (see below for some examples of medical treatment) and Section 3 requires that this medical treatment must be appropriate and available. Therefore, unlike the Public Health (Control of Disease) Act 1984 where a capacitant individual can withhold consent to treatment - and should there be a need to clean the individual then a court order is required[176] - the MHA 1983 permits a range of treatments without consent.[177] Psychosurgery is not permitted to be forcibly administered to a capacitant patient against their will,[178] while other treatments such as electroconvulsive therapy require a range of safeguards before administration to capacitant patients. There are however a range of pharmacological treatments that doctors may administer without judicial oversight prior to their administration which often have the effect of making patients more compliant and cooperative with clinical staff.[179] The MHA 1983 defines those treatments that may be

[173] Details of Tribunal protections post-detention will be discussed in detail in Chapters Four and Six.
[174] The Mental Health Review Tribunal for Wales Rules 2008 s 24.
[175] ibid.
[176] Public Health (Control of Disease) Act 1984 s 45G.
[177] Mental Health Act Part IV s 56(3).
[178] ibid s 57.
[179] Antipsychotic medication may be administered which by its very actions affects thought processes and behaviours.

administered without further oversight as any deemed appropriate which have not been excluded under ss.57, 58, or 58A[180] which provides a broad range of options.[181]

In considering the use of the words Liberty and Freedom, Pitkin offers a useful opinion which builds upon some of the earlier discussion on the views of Mill and Berlin. Freedom is more of a state of being, an holistic view[182] of the individual and their personal beliefs, thoughts and desires. She argues that Liberty is more formal, rational and limited, and is often defined by the lack of constraint. This sits well with Article 5 Rights to liberty and security as defined by the HRA 1988 (most relevant clauses for the purposes of this chapter only – emphasis added):

> Everyone has the right to liberty and security of person. *No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:*
>
> (a)the lawful detention of a person after conviction by a competent court;
>
> (b)the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;
>
> (c)the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;
>
> *(e)the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;*

[180] Mental Health Act 1983 s 63.
[181] The treatability of a mental health condition and the definition of 'appropriate' treatment under the Mental Health Act 1983 will be explored in further detail in Chapters Four and Five, ahead of Chapter Six where a critique of the current legislation and a discussion on how it unreasonably impacts on an individual's rights will form the key argument for why a Welsh paradigm is needed to safeguard rights and improve patient outcomes.
[182] Pitkin (n56) 542-3.

Conclusion

As we have seen in this chapter, the law has seen Liberty predominantly as relating to the physical status of an individual, and the protections against interference with that Liberty. It is more recent human rights focussed developments that talk of Freedom and the separation of Freedom *from*, and Freedom *to* in relation to prevention of harms, or abilities to choose. The discussion of Latin, Greek, Anglo Saxon or Celtic roots for the syntax applied provides historical perspectives on how and why the words may have been used. For the purposes of this thesis, it is important to note that it is intended that the thesis should develop a cogent argument which may be developed further to offer challenge to existing legal frameworks. The deprivation of physical freedom / freedom of movement caused by the loss of liberty due to detention under the MHA 1983 becomes one of a social inequality as identified by Mill.[183] Mill notes that those who exercise power are not always those who might be subject to that power, and power is granted with the will of most, not of all, thus permitting potential oppression.[184]

Positive freedoms, or the *Freedom to*, are those where citizens are not simply able to express a view without interference from the State but where the State protects and supports their right to behave in such a manner. As the purpose of this thesis is to identify how the Right to liberty and security may be used to protect and promote the Rights of the mentally ill, it seems that Liberty does not have the same characteristics as Freedom; as to me, Liberty is a freedom *from* oppression, coercion, detention and

[183] Mill (n73) 8.
[184] ibid.

restriction, whereas Freedom is the promoted ability of the individual *to* self-determine the matters which make life human.

On that basis this thesis will refer to Freedom in the context of an individual being able to make choices and steer their own life, whilst Liberty will be used to discuss coercion, detention and restriction under the Mental Health Act 1983. The ability to make choices may be simply referred to as autonomy,[185] but as we will see in Chapter Two, there is significantly more to be considered in understanding autonomy, and the importance of respecting autonomy. Chapter Two both seeks to understand whether autonomy is possible in mental health services, and to examine the impact of the inability to act on Freedoms *to* as a consequence of loss of Liberty. In developing this, it is necessary to demonstrate the unintended consequence of detention, in that Freedoms *to* are restricted in a way that is not comparable with other health conditions. Chapter Two will develop the argument that the impingement upon the Freedoms *to* may provide areas of challenge on a duty of care basis which offer potential for action for redress. This will be considered particularly where the impingement is not the least restrictive option nor absolutely necessary.

[185] Collins English Dictionary, 'Autonomy, (HarperCollins) <www.collinsdictionary.com/dictionary/english/autonomy> accessed 4 November 2024.

Chapter Two – Autonomy in mental health services: moral nirvana or the opportunity to choose between permitted options?

Introduction

> The concept of autonomy has assumed increasing importance in contemporary moral and political philosophy.[186]

Autonomy is generally identified as the ability to self-govern, as derived from the original Greek where it was applied to the autonomy of a city State; but more recently it has been applied to individuals.[187] We now, particularly in a health or social care context, see autonomy, or being autonomous, as part of a set of complex legal definitions regarding an individual who is able to make decisions about treatment option, including the ability to refuse treatment.[188] These decisions are however often only possible within a pre-determined clinical decision framework, as cost, availability of care services, or indeed NICE guidelines may stipulate what choices may be offered.[189] There is considerable philosophical argument about the nature of autonomy,[190] whether decisions are deemed autonomous,[191] how our choices impact on others,[192] how the views of and relationships with others informs our ability to be

---

[186] Gerald Dworkin, *The Theory and Practice of Autonomy*, (1997, Cambridge; Cambridge University Press) 1.
[187] ibid 108.
[188] Reidar Pedersen, Bjørn Hofmann, Margarete Mangset, 'Patient autonomy and informed consent in clinical work' (2007) Nor Lægeforen, 127 1644, 1645, translation from <https://tidsskriftet.no/2007/06/oversiktsartikkel/pasientautonomi-og-informert-samtykke-i-klinisk-arbeid> accessed 2 January 2020; V Mallardi, 'The origin of informed consent', (2005), Acta Otorhinolaryngol Ital 2005 Oct;25(5):312 translation from <www.ncbi.nlm.nih.gov/pubmed/16602332> accessed 2 January 2020.
[189] Stijntje Dijk, Pat Lok, 'NICE rejects cannabidiol for two types of treatment resistant epilepsy in children' (2019) BMJ 2019;366.
[190] Jack Crittenden, 'The Social Nature of Autonomy' (1993) The Review of Politics Vol 55 No 1 35; Charles S Carver, Michael F Scheier, 'Autonomy and Self-Regulation' (2000) Psychological Inquiry Vol 11 No 4 284; Gerald Dworkin, 'Autonomy and Behavior Control' (1976) The Hastings Center Report Vol 6 No 1 23; Jean Keller, 'Relationality, and Feminist Ethics' (1997) Hypatia Vol 12 No 2, 152.
[191] Robert S Taylor, 'Kantian Personal Autonomy' (2005) Political Theory Vol 33 No 5 602; John Coggon, José Miola, 'Autonomy, Liberty, and Medical Decision-Making' (2011) Cambridge Law Journal 70(3) November 2011 523.
[192] Daniel Callaghan, 'Principlism and communitarianism' (2003) J Med Ethics;29:287.

autonomous,[193] or even how our choices are limited by our dependency on others.[194] This chapter will set out the position on autonomy for this thesis. In doing so it will consider how such choices and decisions are made, and how they are viewed by the individual and others. It will explore whether any choices are *free* choices; or, if there are significant influences in play, does this mean that any 'choice' is Hobson's Choice – a matter of take it or leave it,[195] and thus not an autonomous choice.

As articulated in Chapter One, this thesis will refer to Freedoms as those abilities to make choices and to steer one's own life; Freedom *to* make choices and Freedom *from* impingement on those choices. Liberty relates to the absence of restrictions on movement and in the context of autonomous decisions may best be expressed as the ability to exercise those choices.[196] Autonomy is the key theme in this chapter, but it is not accepted at this point that it exists or could exist. Although the pure philosophical definitions of autonomy are not likely to provide a great deal of clarity for the argument around free choice for this thesis, it is important that we consider what is understood about autonomy from a moral position. This will include personal autonomy,[197] Kantian autonomy,[198] autonomous decisions within a social contract,[199] and whether in fact autonomy is desirable or indeed possible within our current socio-

[193] Jonathan Herring, 'Relational autonomy and family law' in *Rights, Gender and Family Law* ed Julie Wallbank, Shazia Choudhry, Jonathan Herring, (2010 Routledge-Cavendish); Roy Gilbar, 'Family Involvement, Independence, and Patient Autonomy in Practice' (2011) Medical Law Review 19 Spring 2011 192.
[194] Martha A Fineman, *The Autonomy Myth: Lies We Tell Ourselves about Dependency and Self-Sufficiency* (2004 New Press, New York) xii-xiv.
[195] Joseph Raz, *The Morality of Freedom* (1998 Oxford University Press) 154-157.
[196] Coggon (n191) 530.
[197] Richard H Fallon, 'Two Senses of Autonomy' (1994) Stanford Law Review Vol 46 No 4 875-878; Begüm Bulak, Alain Zysset, ''Personal Autonomy' and 'Democratic Society' at the European Court of Human Rights: Friends or Foes?' (2013) UCL Journal of Law and Jurisprudence Vol 2 230, 231.
[198] Taylor (n191) 602-628.
[199] Rousseau (n26) 65.

political construct.[200] In examining autonomy from a moral/philosophical perspective it is intended that this chapter identifies the *fons et origo* of the importance of Liberty and Freedoms relied upon for the arguments in the previous chapter. While this will provide a working definition of autonomy for the discussion to follow, it is not intended that this chapter provides a definition of autonomy for use other than in this context and indeed, defining autonomy in the context of bioethics, medicine, social and health care has been the subject of many papers and ongoing debate.[201]

A question will be posed as to whether individuals in our society are autonomous, if they have free will, or merely a belief they do based on the definition developed which is intended to explain the concepts in a way that most people would understand. This will be applied to the question of whether such autonomy or free choice can actually be achieved by people with a serious mental illness: either when well, where they have an understanding the legislative and health and social care context they will fall under if they become unwell, or indeed when they may be deemed as capacitant but detained under the Mental Health Act 1983 (MHA 1983).

Autonomy and Free Will

> A person's will is free only if he is free to have the will he wants.[202]

[200] Sarah Conly, *Against Autonomy* (2013 Cambridge University Press).
[201] Raanan Gillon, 'Autonomy and the principle of respect for autonomy' (1985) BMJ Vol 290 1806-1808; Jan Keenan, 'A concept analysis of autonomy' (1999) Journal of Advanced Nursing 29 (3) 556-562; Wim J M Dekkers, 'Autonomy and dependence: Chronic physical illness and decision-making capacity' (2001) Medicine, Health Care and Philosophy 4: 185: Raanan Gillon, 'Ethics needs principles—four can encompass the rest—and respect for autonomy should be "first among equals"' (2003) J Med Ethics 2003; 29:307; Mary Twomey, 'Why Worry about Autonomy?' (2015) Ethics and Social Welfare Vol 9 No 3 255.
[202] Harry G Frankfurt, 'Freedom of the Will and the Concept of a Person' (1971) Journal of Philosophy Jan 1971 Vol 68 No 1 5.18.

When examining what autonomy and free will means, there are many examples of circular definitions and statements such as the one above. Coggon notes that in English law there is, 'not…one generally accepted definition of the concept or limits of its [autonomy] validity',[203] and thus we need to adopt one that is defensible for the purposes of this thesis. In this section, consideration will first be given to examining the Principalist perspective of autonomy – one focussed on the individual and how decisions impact on oneself. I will then consider how a Communitarian philosophy which, 'assumes that human beings are social animals, not under any circumstances isolated individuals, and whose lives are lived out within deeply penetrating social, political, and cultural institutions and practices'[204] views autonomy.

Dworkin[205] explains that autonomy is a notion, not obviously definable, but is characterised by the ability and capacity to make critical decisions on our desires, and our desire to achieve our desires in order to morally identify and take responsibility for oneself. Conloy[206] identifies autonomy as, 'something of a portmanteau word, including many distinct concepts', and this chapter is seeking to identify a workable definition; understandable by those who may feel disempowered and isolated in mental health services. Darwall[207] suggests that there are four ways of distinguishing autonomy:

> *Personal autonomy.* The agent's determining his own conduct by his own most highly cherished values.
>
> *Moral autonomy.* The agent's choosing in accord with his own moral convictions or principles.

[203] John Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) Healthcare Analysis 15: 235, 236.
[204] Daniel Callaghan, 'Principlism and communitarianism' (2003) J Med Ethics;29:287, 288.
[205] Dworkin (n86) 3-20.
[206] Conloy (n200) 16.
[207] Stephen Darwall, 'Value of Autonomy' (2006) Ethics 116 263, 264-5.

> *Rational autonomy.* The agent's acting on the basis of what he believes to be the weightiest reasons.
>
> *Agential autonomy.* The agent's behaviour being a genuine action and so attributable to him as an agent.

For the purposes of this discussion, it is proposed that agential autonomy will be considered in a relational context as defined by Bagnoli:[208]

> On this view, autonomy is a capacity of individual rational minds that is exercised and developed in social contexts, through social relations that promote and protect mutual respect and recognition. Our autonomy constitutively implicates the recognition of others. In claiming authorship on one's self, one represents oneself as a member of an ideal community of agents having equal standing.

The philosophical basis for autonomy is supported by both a deontological approach recognising the work of Kant, and the utilitarian views of Mill and Bentham, but for very contrasting reasons.

> Those interested in (Kantian) autonomy are concerned with the essence of a decision and how it is reached. Those interested in (Millian) liberty are concerned that a decision is made by the person whose right it is to make it, be that an individual on her own behalf or a third party deciding for her, rather (directly) than the rationality underpinning it.[209]

Kant emphasises autonomy when he considers morality.[210] Whilst we are considering Kantian autonomy, it is worth noting that learned proponents of Kantian theory believe that the modern conception of autonomy is not well linked to morality.[211] Kant argues that autonomy only exists for rational beings where they make moral decisions, based on rules which one sets for oneself and which are not influenced by outside

---

[208] Carla Bagnoli, 'Practical necessity and agential autonomy. A Kantian response to Williams' objection of misrepresentation relational account of agential autonomy' (2009) Northwestern Ethics Conference 31 March 2009 13 <www.philosophy.northwestern.edu/community/nustep/09/papers/Bagnoli.pdf> accessed 29 February 2019.

[209] John Coggon, José Miola, 'Autonomy, Liberty, and Medical Decision-Making' (2011) Cambridge Law Journal 70(3) November 2011 523, 526.

[210] Ignaas Devisch, 'Oughtonomy in healthcare. A Deconstructive Reading of Kantian Autonomy' (2010) Med Health Care and Philosophy; 13(4):303, 307.

[211] Onora O'Neill, 'The Inaugural Address: Autonomy: The Emperor's New Clothes' (2003) Proceedings of the Aristotelian Society Supplementary Volumes Vol 77 (2003) 1.

forces, individual wishes or desires.[212] Such autonomy in decision making is not simply the ability to make one's own decisions.[213] Autonomous decisions are those made by rational beings and are not based on what an individual desires as a consequence of that decision, but more fundamentally that the decision is morally the correct one.

Velleman[214] notes that Kant differentiates rules and duties set and imposed by society, State, or religion, from those which are truly moral duties and which form part of Kant's Universal Laws. The correct moral decision is one based on rules or laws that one makes for oneself, but they are universal in that the same decision would be made in the same situation regardless of who is involved.[215] Thus it might be argued that it is impossible for individuals to be totally autonomous if autonomy is about free will and choice as there are always competing pressures and political wills. This view of compliance with a set of rules one sets for oneself will also be considered in a discussion of the views of Rousseau and Rawls further in this chapter. Kant states the 'autonomy or sovereignty of the will to lead fairly directly to the sovereign status of

[212] Matti Häyry, 'Prescribing cannabis: freedom, autonomy, and values' (2004) Journal of Medical Ethics; 30; 333, 334.
[213] "Do not choose otherwise than so that the maxims of one's choice are at the same time comprehended with it in the same volition as universal law" (Groundwork, 4:440). Or again: "Act in accordance with maxims that can at the same time have themselves as universal laws of nature for their object" (Groundwork, 4:437).cited in Allen W Wood, The Supreme Principle of Morality in *The Cambridge Companion to Kant and Modern Philosophy,* A.W, ed. Paul Guyer (2006 Cambridge University Press Online version (2007) 355; Matti Häyry, 'Prescribing cannabis: freedom, autonomy, and values' (2004), Journal of Medical Ethics; 30; 333, 334; Andrews Reath, Autonomy, Ethical, in *The Shorter Routledge Encyclopedia of Philosophy* ed Edward Craig (2005 Routledge) 75-76.
[214] J David Velleman, A Brief Introduction to Kantian Ethics in *Self to Self* (2006 Cambridge University Press New York) 17-20.
[215] Harry J Gensler, 'A Kantian Argument against Abortion' (1985) Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition Vol 48 No 1 57, 63.

individual agents as ends in themselves – a status describable as their *moral autonomy*'.[216]

From a utilitarian perspective, autonomy is intrinsic to the individual making the best of their being, as it is a reflection of that individual's wishes and desires. Any individual who does not have their own desires and wishes was said by Mill to have as little character as a steam engine.[217] It is the almost circular argument of the utilitarian that the ability to make such choices without interference or impingement means that an individual cannot be free without autonomy, but that freedom itself means that one has autonomy. O'Neill suggests that Mill's view of autonomy appears to be based upon the belief that each person is the best judge of his or her own happiness, and that the very pursuit of autonomy is itself a major source of happiness.[218] This might reasonably be considered as *personal autonomy*. Mill argues that the moral aspect in decision making relates to the case in hand rather than an instinctive belief as to right and wrong,[219] and that, 'the foundation of morals, Utility, or the Greatest Happiness Principle, holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness'.[220]

[216] Oliver Sensen ed, *Kant on Moral Autonomy* (2012 Cambridge University Press online edn 2013) 51 (emphasis added): J David Velleman, A Brief Introduction to Kantian Ethics in *Self to Self* (2006 Cambridge University Press New York) 42-43. Velleman supports this point in noting that the moral individual rather than the decision is 'the end'.
[217] Mill (n73) 67.
[218] Onora O'Neill, 'Paternalism and Partial Autonomy' (1984) Journal of Medical Ethics; London Vol 10 Iss 4 (Dec 1984): 173.
[219] Mill (n74) 132.
[220] ibid 136. Mill here defines happiness as intended pleasure and absence of pain and unhappiness the reverse. He goes on to explore this in more detail in the essay expanding on the types of pleasure, including music, emotions and other sensual experiences and the moral good in seeking such pleasure.

The Greatest Happiness Principle was developed into a more collective concept by Bentham as he considered that with such a simple concept, the good of the few or the individual may come at a cost to the good of the many or of the society.[221] This perhaps is an indication of a direction of travel for autonomy from a *personal autonomy* approach to one more of a *rational autonomy,* in that the happiness of many may result in unhappiness of some but as Bentham stated, 'it is the greatest happiness of the greatest number that is the measure of right and wrong'.[222] In understanding both *personal* and *moral autonomy,* we must recognise that for decisions to be autonomous the individual has to be both rational and reflective.[223]

In discussing *rational autonomy* care should be taken not to confuse the use of the word rational to align this concept of autonomy with *Kantian autonomy.* Kantian autonomy is predicated on the individual being of rational mind, and both Kantian and Millian autonomy rely upon both the ability to and practice of reflecting upon actions. *Rational autonomy* is a different concept and relates to the use of reflection on our desires in defining our autonomous choices.[224] Frankfurt differentiates between man and other animals in the hypothecation that 'no animal other than man, however, appears to have the capacity for reflective self-evaluation that is manifested in the formation of second-order desires'.[225] These second level desires are those which a person is able to make only if they have rational capacities and that they are capable of becoming critically aware of their own will and of forming volitions of the second

[221] James H Burns, 'Happiness and Utility: Jeremy Bentham's Equation' 2005 Utilitas 17(1): 46, 50-51.
[222] ibid 46.
[223] Marilyn Friedman, 'Autonomy and Male Dominance' (2004) Soundings: An Interdisciplinary Journal Vol 87 No 1/2 (Spring/Summer 2004) 175, 180.
[224] Frankfurt (n202) 6.
[225] ibid 7.

order.[226] This does not however suggest that such second order desires are necessarily moral and indeed Frankfurt notes that such desires may be 'capricious', and that, 'there is no essential restriction on the kind of basis, if any, upon which they are formed'.[227]

This approach, unless read in conjunction with Bentham's view on the Greatest Happiness Principle, appears to be heavily founded on a libertine philosophy rather than a moral one and this contradicts many of the principles that underpin *personal autonomy* and *moral autonomy.* If we are to consider *rational autonomy* here it must be on the basis of the second level desires being underpinned by a Greatest Happiness Principle and thus more of a *relational rational autonomy.* O'Neil offers a useful explanation of how she differentiates between autonomous choices and 'mere' choices in that autonomous choices follow from and reflect a greater degree of self-knowledge, or of self-control, or of capacities to review, revise and endorse other desires.[228] This offers a useful route map for understanding what would make a second level desire an autonomous matter rather than simply a compounding of a first level desire.

An example of a first level desire might be to quench a thirst. The second level desire might be in the decision making behind how that is done, how it might impact on others, what the consequences might be. If, for example an individual is driving a car with two passengers, and there was an hour before they might be able to stop for refreshments. A first level desire might be that the driver is thirsty. There is one bottle of water in the car. The second level desire, if we consider the Greatest Happiness

[226] ibid 11-12.
[227] ibid 13 footnote.
[228] Onora O'Neill, *Autonomy and Trust in Bioethics* (2002 Cambridge University Press) 50.

Principle, would be that the driver would consider whether the passengers were thirsty too, and that there was only one bottle of water. The autonomous action might then be to share rather than drink the whole bottle, so that the happiness of the three is generally increased (or the unhappiness diminished), rather than the happiness of one increased and the unhappiness of two increased.

This consideration of others, and the positive influence of others, has come more into focus in recent times[229] with the recognition that autonomy is impacted by class, wealth, gender, the ability to influence, and the social relationships one holds dear.[230] In developing the understanding of autonomy for this thesis and considering that it relates to individuals who may well be more reflective of the groups above, a *relational autonomy* concept is becoming more appealing. This does however need exploration as to how and if this can provide a more relevant understanding of how an impacted individual may have free will or achieve the benefits of feeling autonomous. An exploration of autonomy in a social contract with societal rules will provide an opportunity to develop these ideas further.

Societal Rules and 'Free Choice'

As noted earlier when attempting to define autonomy it is clear that there is significant debate relating to the role of societal rules and norms, how these are shared, and

[229] Friedman (n223) 180; Martha A Fineman, 'The Significance of Understanding Vulnerability: Ensuring Individual and Collective Well-Being' (2023) Int J Smiot Law (2023) 36:1371, 1380: Roy Gilbar, 'Family Involvement, Independence, and Patient Autonomy in Practice' (2011) Medical Law Review 19 Spring 2011 192; John Coggon, José Miola, 'Autonomy, Liberty, and Medical Decision-Making' (2011) Cambridge Law Journal 70(3) November 2011.523, 540.

[230] Martha A Fineman, 'Vulnerability and Social Justice' (2019) 53 Val U L Rev 341, 355; Joanna R Peppin, 'Beliefs About Money in Families: Balancing Unity, Autonomy, and Gender Equality' (2019) Journal of Marriage and Family 81 (April 2019): 361, 362-365.

reinforced.[231] The ability to make decisions within a set of societal rules may constitute autonomy as identified for health care consent, but are such decisions truly without influence? We have expectations placed on us by a number of agents including those beliefs we hold, the hopes and wishes of family and care givers, and the broader societal and cultural norms. Perhaps this offers some insight into the understanding of autonomy within a societal context, where an individual may never be able to express totally free will except in their own thoughts, and autonomy may be limited to second level desires where the ability to determine first level desires is limited by cultural, political or legal boundaries? Even where the individual may believe themselves to be free in their own thoughts, how we process those thoughts is likely to reflect the social construct in which we have lived.

Autonomous action, understood literally, is self-legislated action. It is the action of agents who can understand and choose what they do. When cognitive or volitional capacities, or both, are lacking or impaired, autonomous action is reduced or impossible.[232] The forthcoming Chapters, Three, Four, and Five consider the impact of detention upon an individual's ability to enjoy their human rights, and the dichotomy of a legislative system which allows for forced treatment even when an individual has capacity. In the UK, if it is established that an individual lacks capacity, we take a best interests approach,[233] and such matters are scrutinised both for how the determination of capacity was reached, and the least restrictive impact on their rights.

[231] Gerben A van Kleef, Michele J Gelfand, Jolanda Jetten, 'The dynamic nature of social norms: New perspectives on norm development, impact, violation, and enforcement' (2019) Journal of Experimental Social Psychology Vol 84 September 2019; Matt J Rossano, 'The Essential Role of Ritual in the Transmission and Reinforcement of Social Norms' (2012) Psychological Bulletin 2012 Vol 138 No 3 529.
[232] O'Neill (n218) 173.
[233] Mental Capacity Act 2005 s 1(5).

As will be seen in Chapters Five and Eight, the impact of a best interests approach when compared to a paternalistic[234] approach, as set out in the MHA 1983, on an individual's rights is stark. An individual detained under a law intended to allow actions against the free will of that person is a very clear case of State paternalism,[235] and this may not in fact be a "best interests" type decision. If we consider a situation where a patient with a known mental illness refuses to take their medication, if they are considered to pose a risk to their own health and safety, they may be detained[236] for assessment or treatment. This potential harm could be due, for example, to them taking an overdose of over-the-counter medication and doing themselves physical harms. If, however we have a person with a known alcohol addiction, who continues to use alcohol despite it causing clear harms, both physically and mentally, no detention is likely as we have deemed it not to justify detention in itself.[237] So, while we are recognising that alcohol dependence is a mental disorder, we see that the decision to continue drinking, despite it being obviously unwise, is seen as one of personal choice, and not to be subject to State paternalism.

If State paternalism is intended to ensure people are protected from harm, why is there such a difference in approach? It appears to me that the harm to self is of fairly minor consideration, but the fear of harm to others is the main driver of such legislation. In Chapters Three, Four, and Five there is commentary on the development of mental health legislation, the reasons for way this has developed, and the impact it has on

[234]Stanford Encyclopedia of Philosophy 'Paternalism' (2020) <https://plato.stanford.edu/entries/paternalism/> accessed 25 May 2025.
[235] ibid.
[236] Mental Health Act 1983 ss 2-3.
[237] Mental Health Act 2007 s 3.

individuals. For this chapter onwards however, the focus is on the impact State-imposed detention has on autonomy, and is this complete, or partial?

State Paternalism and Free Choice

During the period of study for this thesis, we have experienced a global pandemic where many restrictions have been imposed on movement, private and family life, and indeed requirements to demonstrate vaccination status.[238] Such lockdowns and restrictions were unprecedented and resulted in public demonstrations and civil disobedience,[239] despite there being 16,546 excess deaths in England and Wales in January 2021 alone.[240] Much of the anger shown in respect of the lockdowns was intensified by the perception that MPs and advisors set the rules but did not follow them.[241] In the UK we have policing by consent, and a key component of this is:

> To recognise always that to secure and maintain the respect and approval of the public means also the securing of the willing co-operation of the public in the task of securing observance of laws.[242]

So, despite Rousseau's notion that obedience to rules set in a society where the individual is a part of that society may be considered freedom,[243] this may not survive where lawmakers ignore the rules. A more detailed discussion in Chapters Four, Five,

---

[238] Institute for Government, 'Timeline of UK government coronavirus lockdowns and restrictions' (2022) <www.instituteforgovernment.org.uk/sites/default/files/2022-12/timeline-coronavirus-lockdown-december-2021.pdf> accessed 25 May 2024.

[239] BBC, 'Covid: Arrests during anti-lockdown protests in London' (2021) 20 March 2021 <www.bbc.co.uk/news/uk-56469687> accessed 25 May 2025; Mattha Busby, and others, 'Dozens of arrests as thousands march in London against Covid lockdown' (2021) *The Guardian* 20 March 2021.

[240] Office of National Statistics, 'Excess deaths in England and Wales: March 2020 to June 2022' (2022) <www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/excessdeathsinenglandandwalesmarch2020tojune2022/2022-09-20> accessed 25 May 2024.

[241] Emma Haslett, 'Timeline: all the lockdown breaches by politicians and government employees so far' (2021) *New Statesman* 8th December 2021 <www.newstatesman.com/science-tech/coronavirus/2021/12/timeline-all-the-lockdown-breaches-by-politicians-and-government-employees-so-far> accessed 26 May 2024.

[242] Home Office, 'Definition of policing by consent' (2012) para 3 <www.gov.uk/government/publications/policing-by-consent/definition-of-policing-by-consent> accessed 26 May 2024.

[243] Rousseau (n26) 65. See Chapter One – Explaining Liberty for a more detailed discussion.

and Seven will consider this conflict where the UK is a signatory of the UNCRPD,[244] but yet still provides for detention on the basis of disability in the MHA 1983.

The inherent unfairness of a society where we are all expected to follow laws developed under a democratic process, but where only 67.3% of people eligible to vote, did so in 2019,[245] and many marginalised people do not vote,[246] seems obvious. People experiencing serious mental illness and who are detained under most sections of the MHA 1983 are entitled to vote,[247] and of course they may vote when they are not in hospital. Are there though sufficient individuals potentially subject to the legislation to influence any political party sufficiently to focus on their rights? This for me is the challenge with State paternalism; it supports the strong and able, and even when well intentioned, it impacts significantly on marginalised groups.

State paternalism also has some dreadful history, particularly where it has failed to act despite there being a groundswell of concern. Commercial and political interests played prominent roles in the failure to address the risk of CJD in the human population,[248] the infected blood scandal,[249] and salmonella in eggs.[250] In the first two

[244] United Nations General Assembly (n24).
[245] UK Parliament,' General Election 2019: Turnout' (2020) *Insight* published 7th January 2020, <https://commonslibrary.parliament.uk/general-election-2019-turnout/> accessed 26 May 2024.
[246] The Electoral Commission, 'Voter engagement among black and minority ethnic communities' (2002) 3.
[247] East London NHS Foundation Trust , 'Guidance Note of Voting Rights for People in Mental Health Units' (2019) <www.elft.nhs.uk/sites/default/files/2022-01/voting_rights_guidance.pdf> accessed 26 May 2024.
[248] Canadian Medical Association Journal, 'From nannyism to public disclosure: the BSE report' (2001) CMAJ 2001 Jan 23; 164(2): 165.
[249] Rebecca Thomas, Tara Cobham, 'Infected Blood Inquiry: Politicians and doctors complicit in cover-up leading to thousands of deaths' (2024) *The Independent* 21 May 2024 <www.independent.co.uk/news/health/infected-blood-inquiry-scandal-nhs-hiv-hepatitis-b2547977.html> accessed 26 May 2024.
[250] David Millward, 'Currie 'was right' on salmonella' (2001) *The Telegraph* 26 December 2001 <www.telegraph.co.uk/news/uknews/1366276/Currie-was-right-on-salmonella.html> accessed 26 May 2024.

of these cases, cover up was the approach, in the third, the health minister was vilified for the impact on the commercial interests of egg farmers, but it became clear that there was a very serious issue.[251] Sadly, the whole point of State paternalism in reducing harms, seems to be failing for people detained under the MHA 1983, as patients detained under the Act are dying at three times the rate of people held in prison.[252] Such statistics though are only a small component of the harms caused by detention and the impact on an individual's ability to make life choices, as we will discuss further.

Autonomy in Healthcare Decision Making

The concepts of decision-making capacity and competence have close ties to the concepts of (individual) autonomy and independence,[253] but it seems that already there is a conflict between the philosophical perspective of autonomy relating to moral decisions, and decisions which appear at first to have no obvious moral component. These, as can be seen from a utilitarian perspective, consider the moral component as part of the *Greatest Happiness Principle*[254] where such decisions that increase the happiness are themselves moral.

In relation to bioethics, medicine, social and health care, a useful starting definition for discussion of a patient making an autonomous decision is:

[251] ibid.
[252] Amy-Clare Martin, 'People detained under the Mental Health Act dying at three times the rate of those held in prisons' (2024) *The Independent* 23 April 2024 <www.independent.co.uk/news/uk/crime/deaths-custody-mental-health-act-report-b2532790.html> accessed 26 May 2024.
[253] Wim J M Dekkers, 'Autonomy and dependence: Chronic physical illness and decision-making capacity' (2001) Medicine, Health Care and Philosophy 4: 185.
[254] Mill (n74) 197-200.

> ...the competent patient, after receiving appropriate disclosure of the material risks of the procedure or treatment, understanding those risks, the benefits, and the alternative approaches, makes a voluntary and uncoerced informed decision to proceed.[255]

This starting point has been further clarified by the judgment in *Montgomery v Lanarkshire Health Board,*[256] where there was recognition of the ability of patients to understand and interpret information in order to make informed decisions.[257] Lady Hale also stated that:

> It is now well recognised that the interest which the law of negligence protects in a person's interest in their own physical and psychiatric integrity, an important feature of which is their autonomy, their freedom to decide what shall and shall not be done with their body…[258]

This is a helpful reminder that this is both physical and mental integrity. Medical ethicists and bioethicists have a well-established framework of moral principles in relation to what they consider *professional morality* and which inform the range of professional codes of conduct.[259]

This framework relies heavily on the four principles of: respect for autonomy, nonmaleficence, beneficence, and justice.[260] For professional bodies and those seeking to justify decisions made in the delivery of health or social care services, such an approach, where their decision making is permitted within set boundaries, provides for an interesting argument about the nature of professional autonomy. Is it in fact that professional autonomy is, when taken to the basic parameters, a pattern of compliance

---

[255] Andrew D Feld, 'Informed consent: not just for procedures anymore' (2004) The American Journal of Gastroenterology; New York Vol 99 Iss 6 (Jun 2004): 977.
[256] *Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland)* [2015] UKSC 11.
[257] ibid at 76.
[258] ibid at 108.
[259] Tom L Beauchamp, James F Childress, *Principles of Biomedical Ethics* (2001 5th edition Oxford: Oxford University Press) 5-12; Katie Page, 'The four principles: Can they be measured and do they predict ethical decision making?' (2012) BMC Medical Ethics 13:10, 1.
[260] Tom L Beauchamp, James F Childress, *Principles of Biomedical Ethics* (2001 5th edition Oxford: Oxford University Press) 5-12.
Katie Page, 'The four principles: Can they be measured and do they predict ethical decision making?' (2012) BMC Medical Ethics 13:10, 1.

with a set of professional standards? Such professional autonomy as there is, may be argued as not autonomous practice, but heteronomous practice as those rules are external to the individual in practice. This does not diminish the role or value of the professions, as it is the ability to make choices within such frameworks and dependent upon skilled assessments which then results in predictable, reliable care, but this does not necessarily mean that any particular profession can claim autonomy as integral to their practice. An example would be the doctor who wishes to use medication not licensed for that particular purpose but that in their belief would benefit the patient. Such a decision might appear to be a courageous one particularly in light of medico legal litigation. But even such a decision is governed by a set of professional guidelines,[261] and the Courts in making judgments on claims for professional negligence apply the *Bolam* test[262] to determine whether the conduct of the professional in question would be seen as proper by a responsible body of fellow professionals. Again, these are external rules and argue more for a heteronomous professional code than an autonomous one.

Is Partial Autonomy possible – what impact does detention make to the assertion of personal freedoms?

> Judges in England and Wales tell three apparently contradictory stories about the relationship between autonomy and mental capacity. Sometimes, capacity is autonomy's gatekeeper: those with capacity are autonomous, but those without capacity are not. Sometimes, capacity is necessary for autonomy but insufficient; for voluntariness, freedom from undue external influences, is also required. Finally, sometimes autonomy survives incapacity, and a person without capacity is nevertheless treated as autonomous. These three accounts coexist, so no story of evolution, in which one account comes to replace

[261] General Medical Council, 'Prescribing Unlicensed Medications' (2020) <www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices/prescribing-unlicensed-medicines> accessed 5 January 2020.
[262] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

> another, can be told. Similarly, no story of judicial factions is plausible, for judges switch account to suit the facts of a particular case.[263]

> *(A)utonomy* relates to free will, so an *"autonomous agent"* is someone with free will, and *liberty* relates to freedom to act without the interference of a third party.[264]

Coggon and Miola go on[265] to refer to a prisoner enjoying a high level of autonomy but with extremely limited liberty and this is a useful comparator with the detained mental patient. Contrast this with the legislation relating to suicide in individuals who have other disabilities such as cancer. In England and Wales, suicide has not been a criminal act since 1961,[266] though it remains a crime to assist another in taking their own life.[267] In guidance from the Crown Prosecution service it is interesting to note the public interest factors tending against prosecution. These seem to suggest that "A prosecution is less likely to be required if: the victim had reached a voluntary, clear, settled and informed decision to commit suicide".[268]

In *R (Nicklinson and anor) v MOJ,*[269] LJ Neuberger set out that, "In three subsequent decisions, the Strasbourg court has stated in clear terms that article 8.1 encompasses the right to decide how and when to die, and in particular the right to avoid a distressing and undignified end to life (provided that the decision is made freely)." This suggests that the option of taking one's own life is a human right, and *particularly* so where the

---

[263] Paul Skowron, 'The Relationship Between Autonomy and Adult Mental Capacity in the Law of England and Wales' (2018) Medical Law Review Vol 27 No 1, 32.
[264] John Coggon, José Miola, 'Autonomy, Liberty, and Medical Decision-Making' (2011) Cambridge Law Journal 70(3) November 2011, 525.
[265] ibid.
[266] Suicide Act 1961 s 1
[267] Suicide Act 1961 s 2
[268] Crown Prosecution Service, 'Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide' (October 2014) <www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide> accessed 22 January 2023.
[269] *R (on the application of Nicklinson and another) (Appellants) v Ministry of Justice (Respondent)* [2014] UKSC 38 para 29.

alternative is a distressing potential end to life. It is however particularly challenging where an individual has a serious mental illness to determine whether they are able to make, 'a voluntary, clear, settled and informed decision to commit suicide'[270] while they are suffering from that mental illness. It is though interesting to note that an individual detained under the MHA 1983 is deemed competent to cast their vote in an election,[271] and able to make decisions on their physical health,[272] but has restricted choices related to their mental health treatment. The Mental Capacity Act 2005 (MCA 2005) sets a presumption of capacity unless proven otherwise,[273] and is clear that a person is not to be considered as incapable simply because they make an unwise decision.[274] This presumption of personal agency and statutory reticence to interfere, demonstrates a far less paternalistic approach to the situation of persons with limited capacity when compared to mental health legislation.

The guiding principles of the Welsh Code of Practice to the Mental Health Act 1983[275] set out that:

> Alternatives to avoid the use of compulsory powers should be explored before making an application for admission, and the least restrictive options should be considered. This should include creative approaches to offer choice in service delivery and alternative means of providing treatment and care, subject to the need to prevent harm. This should always be balanced with ensuring patients receive treatment appropriate to their needs and which is aimed at preventing them from harming themselves or others.

[270] Crown Prosecution Service (n268).
[271] East London NHS Foundation Trust (n247).
[272] *Re. C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819. This is however only applicable where medical treatment is required to address matters which cannot be deemed to be part of the symptoms of the disorder – see John Williams, '1998 Human Rights Act: Social Work's New Benchmark' (2001) British Journal of Social Work (2001) 31 831, 836.
[273] Mental Capacity Act 2005 s 1(2).
[274] Mental Capacity Act 2005 s 1(4).
[275] Welsh Assembly Government, Mental Health Act 1983 Code of Practice for Wales (2008) para 1.8.

This least restrictive approach must also be considered in the nature of the facilities in which patients are detained,[276] and it is here, that the issues of how even partial autonomy is often denied for those detained. Meal times are set, there are limited choices of food and drink, and the food may not be of a reasonable quality, despite a multitude of initiatives to improve hospital catering.[277] My personal experience of working on a mental health ward highlighted that risk management could lead to kitchen facilities being closed except for mealtimes, and thus restrictions on drink availability. The ability to take exercise, manage financial matters online, see family when the patient wants to (if there are set visiting hours), and the opportunity to maintain educational engagement, are all impacted by detention. Choices on day-to-day matters therefore are not real choices: they are more Hobson's choice, and thus no real choice at all. The impact of detention is clearly far greater than the deprivation of liberty: the ability to choose when to eat, what to eat, what to watch on television (again often a communal situation), when to go to bed, when to wake up, are all governed by a hospital system. Relationships, the ability to engage with friends, and the opportunity to make decisions about how one lives are all affected by detention, and this, to me, does not even come close to a partial autonomic situation.

When we consider the ability to make choices in treatment, this again is a power relationship. The patient, who should be at the centre of all decision making about their care,[278] is also the individual detained by powers held by the people making

[276] ibid para 1.11
[277] Department of Health and Social Care, 'Report of the Independent Review of NHS Hospital Food' (2020) 7 <https://assets.publishing.service.gov.uk/media/5f930458d3bf7f35e85fe7ff/independent-review-of-nhs-hospital-food-report.pdf> accessed 25 May 2024.
[278] Welsh Assembly Government (n275) 1.

treatment decisions. The Independent Review of the Mental Health Act, Interim Report noted:

> It is concerning that people often do not feel safe, treated with dignity or that their human rights are respected whilst detained. The inherent power imbalance means detained patients are vulnerable to potential coercive mistreatment, abuse and deprivation of human rights, leading to physical and psychological harm.
>
> Throughout all of our engagement with service users and carers, we have been made aware of a wide variety of distressing experiences including but not limited to, experiencing or witnessing physical violence, verbal abuse and threats, bullying and harassment, sexual predation, pain-based restraint, coercive reward and punishment systems for access to open air, leave or family contact.
>
> We have been told that issues can sometimes escalate when trying to discuss or challenge diagnosis or treatment decisions. There are further issues surrounding the circumstances which medication if administered to service users.[279]

So, how much choice is there in decisions about treatment? The very nature of detention to receive treatment, because that treatment could not be provided without the detention,[280] suggests that this treatment is against the will and choice of the patient. Under the MHA 1983, even though the patient may have capacity, (not just assumed capacity under the MCA 2005[281]), this can be overridden by medical staff by seeking the agreement via a second opinion of another doctor.[282] There are of course opportunities to seek a Mental Health Act Tribunal judgement or a judicial review of such decisions, but in reality, patients are massively disadvantaged in any such actions or even in seeking assistance in considering them.

[279] Department of Health and Social Care, The Independent Review of the Mental Health Act, 'Interim Report' (2018) <https://assets.publishing.service.gov.uk/media/5ae82f6540f0b63154caac53/The_independent_Mental_Health_Act_review__interim_report_01_05_2018.pdf> accessed 25 May 2024.
[280] Mental Health Act 1983 s 3(2).
[281] Mental Capacity Act 2005 s 1.
[282] Mental Health Act 1983 Part IV.

Conclusion

Life choices and the consequences are what creates our imprint on the world and our families and relationships – restricting choices and options here impacts on the greatest happiness and thus diminishes the happiness of all. Everything possible should be done to avoid impingement on capacitous decisions, and even where capacity is diminished, choice where possible should be respected. Most people do not have autonomy, but they can make personal choices unless detained in mental health services. For my purposes in this thesis, this is the understanding I will take forward of autonomy, to include that of partial autonomy, and the restrictions placed on even this partial autonomy by mental health detention.

A new paradigm within services is needed to shift the power balance – where there are powers there must be a reciprocal right if 'autonomy' is to mean anything. Chapter Nine will set out a vision for this in Wales, but over the next three chapters we will explore the development of mental health legislation in the UK to provide further context to the need for a radical change to mental health law.

Chapter Three: Mental health legislation in England and Wales prior to the formation of the NHS.

Introduction

> The involuntary placement and involuntary treatment of mentally ill patients are central issues in mental health care. Their massive impact upon the liberty and freedom of the persons concerned have made them a topic of controversial legal and ethical debates for more than 100 years.[283]

Fennell[284] notes that there has been some form of mental health law as far back as the fifth century BC where Plato's *Laws* required a family to keep a 'mad' man at home or pay a penalty. Indeed, Wales' own King Hywel Dda (c.904-949/50 AD[285])[286] held that "an idiot" would not be required to pay 'galanas' (compensation) for a murder; though he also specified that should compensation be due to the kin of one who had been murdered, "an idiot", along with one who is ecclesiastic, leprous or dumb should not receive it either. Much of the legislation and commentary up to the twentieth century referred to people with a mental illness as 'mad', 'idiots', 'imbeciles', or 'lunatics'.[287] This observation offers some insight into the perception of those persons who were seen by societies as in need of protection or control, because they were either incapable of managing their affairs or criminal in their behaviours.[288]

This chapter explores some of the socio-political drivers for mental health legislation between 1744 and 1948. Moving from an initial focus on chancery matters and criminal justice, both prior to and throughout the nineteenth century, legislation

---

[283] Hans J Salize, Harald Dreßing, Monika Peitz, 'Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in EU-Member States' (2002) 2 <http://ec.europa.eu/health/ph_projects/2000/promotion/fp_promotion_2000_frep_08_en.pdf> accessed 13 May 2014.
[284] Fennell (n115) 4.
[285] John Cannon ed, *A Dictionary of British History*, (1st Edn 2009 OUP) Hywel.
[286] Mary Jones, The Laws of Hywel Dda Harleian MS 4353 (V) with emendations from Cleopatra A XIV (W) ca. 1285 <www.maryjones.us/ctexts/laws_hywel_dda.html> accessed 12 October 2024.
[287] Hilton (n118).
[288] Akinobu Takabayashi, 'Surviving the Lunacy Act of 1890: English Psychiatrists and Professional Development during the Early Twentieth Century' (2017) Med Hist (2017) vol 61(2) 246.

developed to order the treatment of the mentally disordered offender and related public protection issues. This period also saw the introduction of regulations and standards of care.[289] The relevant Welsh historic context is included along with an examination of some of the key points of development of statutes in England and Wales in general terms from 1744.

Sir Thomas, later Lord Bingham MR noted that in common law there had long been protection for the right of the individual not to be detained without just cause;[290] this was further protected under statute by the Habeas Corpus Act of 1679.[291] This protection, both historical and in place today, relies upon the tort of trespass to the person in the form of false imprisonment, which is actionable by the individual themselves in the County Court, and by the Crown under Criminal Law.[292] Proof that imprisonment occurred is sufficient to give rise to the action, with the onus then on the defendant to prove the imprisonment was justified.[293]

Chapter One and Two, which considered Liberty and Autonomy, have explored the effect that detention under mental health legislation brings both from the direct effect of the detention and the consequential impact on the free will of the individual. Key legislation prior to 1744 related generally to chancery matters, public order, and vagrancy, and this was not particularly focussed on the individual's needs or their Liberty or Autonomy. Law, up to that point, focussed more on how society

[289] Nurses' Registration Act 1919 9 and 10 Geo V c 94; Madhouses Act 1774; Fennell (n115) 10.
[290] *In Re. S-C* [1995] EWCA Civ 60.
[291] Habeas Corpus Act 1679 31 Cha 2 c 2.
[292] Kirsty Horsey, Erika Rackley, *Tort Law* (2019 6th Edn OUP) Ch 15 Intentional interference with the Person 410-458.
[293] *Halsbury's Laws of England* (5th edn 2010) 97 para 542 Lexis Library 3 August 2014. Tort will be addressed specifically in Chapters Six, Eight, and Nine but it is worth noting here that justification for such trespass was examined in a writ of *Habeas Corpus* in *Rex v. Turlington* 1761 97 ER 741, and continues to be challenged at the highest level, *HL v United Kingdom* ECJ 45508/99 [2004] ECHR 720.

incorporated the incarceration/financial management of the mentally ill and those with learning disabilities in control mechanisms normally applied to those who were on hard times, homeless, or criminals.[294]

The Vagrancy Act 1744[295] distinguished itself from prior legislation by taking an approach which started to clarify the determinants for powers to detain in relation to a mental illness.[296] While this chapter is not intended to provide a comprehensive review of *all* legislation and relevant case law, an identification of the relevant trends in public opinion, professional interest, and political will is essential. Such trends, which have resulted in either the development of original statutes, or amendments and updates to law governing the treatment of the mentally ill, offer much to understanding the potential of an evolution to a more rights-based approach. Therefore, this chapter will focus in the main on legislation relating to individuals with mental disorders from the Vagrancy Act 1744.[297]

The chapter will conclude at the turn of the year 1948. This is just before the formation of the NHS, and the Universal Declaration of Human Rights, and this is a key moment in the development of health and care services in England and Wales, and also the beginning of the post-war human rights focus. The impact and influence of war, from the Great War through the wars and social changes of the latter twentieth century, will be explored with this chapter in particular considering the notion of "shell shock" and psychological injury and how this changed public and political opinion of mental illness.

[294] Fennell (n115) 6, 1.07.
[295] Vagrancy Act 1744.
[296] Eccles (n114) 26*;* Fennell (n115) 6.
[297] Vagrancy Act 1744.

Historical Development of Legislation

Leading up to 1800 - Money, criminal justice, and protection from arbitrary detention

Prerogativa Regis (1322)[298] was a document which set out the use of the Royal Prerogative[299] in taking control of the lands of 'natural fools' and the associated profits of the land, but with the needs of the 'fool' being taken care of from the profit. It further set out that after the death of the 'fool', the land would pass to the rightful heirs. Fennell[300] notes that this may have been the first time learning disability and mental illness were distinguished - in that the King could take the profit from 'natural fools' (perhaps a learning disability), but for those people where they had previously 'had wit and memory' (one who was mentally ill[301]), the King had a duty to maintain the lands from within the profit for the benefit of the household. While this distinction appears somewhat primitive in the categorisation of such vulnerable people, Fennell[302] notes a similar approach is adopted much later in the Idiots Act 1886,[303] the Lunacy Act 1890,[304] and through to the separation of learning disability and other mental disorders in the MHA 1983. It is significant too that the use of Prerogativa Regis was in relation to the privileged, the wealthy, the landowners and titled people; but the overwhelming majority of 'lunatics' were none of these.[305] The development of legislation applicable to people with a mental illness up to 1800 was predominantly

---

[298] Prerogativa Regis. Of the King's Prerogative (temp incert) (1322) 1322 CHAPTER 13 15 Edw 2 cc 13 17.
[299] Andrew Roberts, 'Mental Health History Words' <http://studymore.org.uk/mhhglo.htm> accessed 7 October 2018.
[300] Fennell (n115) 5.
[301] And possibly a reference to dementia as memory loss had been noted as early as 2 AD as either a delirium or a cognitive aging process. Dementia in this context however does appear to have been seen more as an aging disease, but the reference to memory does indicate this was considered more broadly than perhaps a psychosis type departure from previous wit. IP Vatanabe, PR Manzine, MR Cominetti, 'Historic concepts of dementia and Alzheimer's disease: From ancient times to the present' (2019) *Revue Neurologique* 176 (2020) 140, 140-142.
[302] Fennell (n115) 5.
[303] Idiots Act 1886.
[304] Lunacy Act 1890.
[305] Eccles (n114) 26.

one of management of any assets and how to deal with criminal or public law matters.[306] Much of the legislation was named in such a way as now provides us with an insight into how the mentally ill were viewed. This was not simply with use of the terms 'lunatics' or 'madhouses',[307] but importantly in how the consequences of their illness often resulted in poverty, and thus classified them in society as vagrants, and as such, governed by a series of Vagrancy Acts.[308]

Eccles[309] notes that the 1714 Vagrant Act had provided for maintenance of the person from their own estate or from poor funds locally. This requirement was repeated in the 1744 Vagrancy Act, but with clarity that such clauses applied only to those who, 'by lunacy or otherwise, are furiously mad or so disordered in their senses that they may be dangerous to be permitted to go abroad'.[310] Fennell[311] and Eccles[312] also reference this as the first occasion where there was a requirement, (under s.20 of the 1744 Act), that two Justices of the Peace were required to agree to such detention. Fennell observes that this was the first express statutory power in contrast to the common law powers to 'detain and restrain' to prevent a breach of public order. Eccles[313] though suggests that legislation may have been introduced partly due to increasing mobility of the population and concerns that the common law did not provide a means of prosecution for even capital offences committed by lunatics and idiots. This latter situation was resolved by the introduction of the Criminal Lunatics Act 1800[314] which

[306] Fennell (n115) 5-6.
[307] Madhouses Act 1774.
[308] Vagrancy Act 1609; Vagrancy Act 1714; Vagrancy Act 1744.
[309] Eccles (n114) 26.
[310] Fennell (n115) 5.
[311] ibid.
[312] Eccles (n114) 26.
[313] ibid 26-27.
[314] Criminal Lunatics Act 1800.

addressed the case of James Hadfield who was initially acquitted of treason, despite having shot at King George III, on the grounds that he was insane.

Up to the eighteenth century there was scant provision for hospital care for mental illness. The Bethlehem Hospital (more widely known as Bedlam, but now the Bethlem Royal Hospital[315]) was opened in 1247[316] in London, becoming known from 1403 as a hospital for the insane;[317] but in general it was prisons or workhouses that provided 'care' for the majority.[318] There was however a growth in the development of private 'madhouses'. The use and management of these facilities will be discussed in further detail below, both in relation to regulation pre-1800, and changes post-1890 which dramatically changed the role and focus of psychiatry to be less dependent on asylum-based care.[319]

Despite the protection offered in the 1744 Vagrancy Act, detention for mental illness in private madhouses was permissible under the common law doctrine of necessity, as demonstrated in two cases[320] in the 1770s. Fennell notes that there was no statutory authority for private madhouses,[321] and as such, the courts noted that so long as the detention was justified, for example by way of preventing a breach of the peace, then no offence was committed.

---

[315] Bethlem Museum of the Mind, 'Bethlem Royal Hospital' <https://museumofthemind.org.uk/projects/european-journeys/asylums/bethlem-royal-hospital> accessed 14 October 2018.
[316] South London and Maudsley Foundation NHS Trust, 'About us' <www.slam.nhs.uk/about-us/who-we-are/art-and-history/our-history/> accessed 14 October 2018.
[317] Bethlem Royal Hospital, 'European Journeys: Asylums' <https://museumofthemind.org.uk/projects/european-journeys/asylums/bethlem-royal-hospital> accessed 14 October 2018.
[318] John R Hamilton, 'Mental Health Act 1983' (1983) British Medical Journal Vol 286 28 May 1983, 1720.
[319] Takabayashi (n288) 246-269.
[320] *Rex v. Coate (Keeper of a madhouse) 1772 Lofft 73; Brookshaw v. Hopkins (1773) Lofft 240*.
[321] Fennell (n115) 8.

The Beginnings of Regulation

The growing use of private madhouses, the increasing number of cases being identified where people were incarcerated in such facilities with little if any recourse save that of a writ of *Habeas Corpus,*[322] and the 'flourishing trade in lunacy'[323] led to the introduction of a regulatory statute: the Madhouses Act 1774 (the 1774 Act).[324] This Act appeared in part to address the dichotomy between the protections in the Vagrancy Act 1744 and the common law powers applied in private madhouses, and introduced licensing, requirements for written orders, and the institution of a Royal College of Physicians' led Lunacy Commission. This Commission had powers to remove the licences of madhouses and required that Commissioners would not have any personal interest in a madhouse.[325] As will be seen later however, the common law doctrine of necessity remained.

The 1774 Act provided both legal standing for private madhouses along with basic safeguards,[326] such as requiring lawful detention in a place which was licensed and authorised for such purposes. Fennell also notes that this established the principle in mental health law that confinement could only be justified with medical evidence of unsoundness of mind,[327] and that confinements of private patients too had to be registered and the madhouse inspected.[328] A significant point of note here too is that while the 1774 Act created a body of Commissioners to license such places, the

[322] Fennell (n115) 7-8.
[323] Clive Unsworth, 'Mental Disorder and the Tutelary Relationship: From Pre- to Post-Carceral Legal Order' (1991) Journal of Law and Society Vol 18 No 2 (Summer 1991) 254, 259.
[324] Madhouses Act 1774.
[325] Unsworth (n323) 259-60*;* Fennell (n115) 9.
[326] Fennell (n115) 9.
[327] ibid.
[328] ibid 10.

Commissioners could not order the release of any patient, and any such patient who wished to object to their detention had to do so through a writ of *Habeas Corpus*.[329]

Fennell[330] notes, however, that the Commission was ineffectual and that while the 1774 Act began the process of a Commission responsible for regulation of detention in hospital,[331] it was unsuccessful in addressing many of the existing issues, and did not impact on the influence psychiatrists still retained in the decision to detain patients. Public awareness of the wrongful detentions and the insanity of King George III[332] meant that the issue remained significant. Indeed, the "curative treatment" that it was believed King George III had received via a psychiatric behavioural regime, led to a focus on *treatment of a condition,* rather than a simple classification of behaviours as criminal.[333]

The Nineteenth Century: the development of psychiatry and the introduction of professional governance

Back to Criminal Justice

The Criminal Lunatics Act 1800 (the 1800 Act)[334] set out the power to detain individuals found not fit to plead or not guilty by reason of insanity in such cases at His Majesty's Pleasure, with the power resting with the Crown and responsible Minister.[335] This 1800 Act did not provide for maximum terms of detention. Thus, it

[329] Fennell (n115) 10.
[330] ibid 11.
[331] A mechanism continued today through the Mental Health Act Commission, and the successors Care Quality Commission in England and Health Inspectorate Wales who produce Mental Health Act Monitoring Reports.
[332] Hamilton (n318) 1720-1725.
[333] Trevor Turner, in Basant Puri, Ian Treasaden, Eds, *Psychiatry: An evidence-based text* (2009 CRC Press Boca Raton) 9.
[334] The 1800 Act was imposed retrospectively, thus providing for the detention of Hadfield noted above.
[335] Valerie Argent, 'Counter-Revolutionary Panic and the Treatment of the Insane: 1800' (1978) <http://studymore.org.uk/1800.htm> accessed 14 October 2018.

can again be argued that such legislation was not related to the care and treatment of individuals per se, but rather as a means of managing public order and public opinion as to the guilt or otherwise of individuals who committed offences while deemed legally incapable.[336]

Criminal Justice and Further Regulation of Asylums

Shortly after, in 1808,[337] the County Asylums Act legislated for local Magistrates to build local asylums;[338] most did not[339] until this became a requirement with the 1845 Lunatics Act.[340] The 1808 Act resulted from the work of Charles Watkins Williams Wynn (MP for Montgomeryshire), with the 1808 Act often referred to as Mr Wynn's Act.[341] During the early 1800s further scandals - which centred on the dire conditions within these asylums, barbaric treatments and confinements, and the deaths of hundreds of inmates - led to the appointment in 1815 of a Parliamentary Select Committee. This was followed by a further investigation in 1827, which led to the establishment of the Board of the Metropolitan Commissioners in Lunacy for London. The 1842 Lunatics Act[342] extended this geographic coverage, and the Lunatics Act 1845 (the 1845 Act) renamed it the Commissioners in Lunacy.

---

[336] This is a trend that continues into modern times, with evidence of public support for the punishment of insane lawbreakers, and belief expressed that the insanity defence procedures fail to protect the public. Valerie P Hans, 'An Analysis of Public Attitudes Toward the Insanity Defence' (1986) Criminology Volume 24 Issue 2 May 1986 393; Jennifer L Skeem, Jennifer Eno Louden, Jennee Evans, 'Venirepersons's Attitudes Toward the Insanity Defense: Developing, Refining, and validating a Scale' (2004) Law and Human Behavior Vol 28 Iss 6 Dec (2004) 623, 624; Brooke Butler, 'NGRI revisited: Venirepersons' Attitudes Towards the Insanity Defense' (2006) Journal of Applied Psychology 2006 36 8 1833, 1834.

[337] County Asylums Act 1808.

[338] National Archives, 'Mental Health' (2018) <www.nationalarchives.gov.uk/help-with-your-research/research-guides/mental-health/> accessed 7 October 2018.

[339] Fennell (n115) 10-11.

[340] Lunacy / Lunatics Act 1845 8 & 9 Vict c 100.

[341] Middle Temple Library Blog, 'Mental Health Law' (2018) <https://middletemplelibrary.wordpress.com/tag/mental-health-law/> accessed 2 August 2020; History of Parliament, 'Williams Wynn MP' <www.historyofparliamentonline.org/volume/1790-1820/member/williams-wynn-charles-watkin-1775-1850> accessed 2 August 2020.

[342] Lunatics Act 1842 5&6 Vict Ch 87.

It is worth noting here (in an effort to maintain chronology) that significant case law in the context of mental illness was developed in 1843 with the M'Naghton case.[343] Here, the defendant was acquitted on grounds of insanity of the murder of Edward Drummond. M'Naghton was suffering from a persecutory disorder and intended to kill Robert Peel, the Prime Minister. In this case the House of Lords set out what became known as the M'Naghton rules:

> In all cases of this kind the jurors ought to be told that every man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction: and that to establish a defence on the ground of insanity, it must be clearly proved that at the time of commiting [sic] the act the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or as not to know that what he was doing was wrong.[344]

As Ooseterhuis and Loughnan[345] note, these rules remain the criteria for an insanity defence not just in England and Wales but in many other jurisdictions to this day.

Care, Patient Safety, and Stigma – a first outcome focus

The 1845 Act[346] was a key point in the development of mental health legislation aimed at protecting the patient and seeking to provide positive outcomes for both society and the patient.[347] The Lunacy Commission had responsibilities over the insane, whether poor or not.[348] The Government took responsibility for their treatment at county asylums, and decisions were made where those who would appear to benefit from treatment would go to the asylum, whereas those with chronic conditions would go to the poorhouse.[349] As noted previously, from an early stage, there has been a separation

[343] *Daniel M'Naghten's Case*: UKHL 1843 J16.
[344] ibid [200].
[345] Harry Oosterhuis, Arlie Loughnan, 'Madness and crime: Historical perspectives on forensic psychiatry' (2014) International Journal of Law and Psychiatry 37 (2014) 1, 4.
[346] Lunatics Act 1845.
[347] Hamilton (n318) 1720-1725.
[348] Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England with special Emphasis on Leicestershire and Rutland* (1993) PhD Theses 285 <http://discovery.ucl.ac.uk/1317954/1/307853.pdf> accessed 14 October 2018.
[349] Hamilton (n318) 1720-1725.

in law of the treatment of people with a mental disorder into those who now may be considered to have a learning or cognitive disability, and those with a mental illness. This differentiation appears again to be a recognition of what may be a transient condition requiring treatment.

The 1845 Act,[350] in response to the concerns over wrongful detention of family members committed to asylums, required certification from two medical doctors for private patients, though pauper patients required judicial authorisation accompanying a medical certificate.[351] Fennell[352] notes the development of the law through the following forty five years, including clarification of the criteria for detention, legal challenge to detention, challenges for negligence on the behalf of the Commission, use of restraint, seclusion and chemical sedation. This also included dismembering surgical procedures particularly with female patients based on beliefs of sexual links to hysteria.[353]

It was a requirement in the 1845 Act[354] that the petitioner would need to state whether the person was suicidal or dangerous to others, a similar expression of concern to that noted above. However, following a legal challenge for wrongful imprisonment (*Nottage v. Ripley*[355]) it was determined that anyone determined to be of unsound mind could be detained.[356] A further amending Act of 1853[357] required that certification for

[350] Lunatics Act 1845.
[351] Takabayashi (n288) 249.
[352] Fennell (n115) 14-23.
[353] It should be noted that while there is righteous outrage today at the practice of female genital mutilation and a focus on this taking place in societies considered to be oppressive and misogynistic, such practices were carried out openly around 150 years ago in the UK and reported in the Times as a successful form of treatment. See Fennell (n115) 20.
[354] Lunatics Act 1845.
[355] *Nottidge v. Ripley* [1849] The Times 25-30 June 1849.
[356] Fennell (n115) 15.
[357] Lunacy Act 1853 Vict C 96.

the detention of a non-pauper patient, was completed separately by two physicians, surgeons, or apothecaries who were not in partnership and had independently examined the patient;[358] this provided significant independent decision making.[359]

Challenging detention remained an issue with the courts unlikely to grant *Habeas Corpus* or to find medics negligent for their assessment, and even if detention paperwork was incomplete, such detention was not invalid.[360] The 1853 Act offered some hope here in that it required more detailed information and as such certificates could be found to be insufficient in law. However, Fennell notes that the courts refused to accept that the common law powers of necessity were extinguished by statute.[361] The 1853 Act did however specifically provide for an offence of *ill treatment of lunatics*[362] and a potential fine of £20, an equivalent sum exceeding £2,500 today.[363]

Stebbings[364] notes that government figures produced for the Royal Commission on the Care and Control of the Feeble-Minded 1908[365] identified that 25,000 individuals were officially recognised as insane in 1845, rising to 77,000 in 1883, and almost 124,000 in 1907. Stebbings states that these increases were due to increased life expectancy and as a consequence of the industrial revolution, but recognises too that this was a period where the State became far more involved in the regulation of mental illness. As identified earlier, prior to the introduction of the County Asylums Acts and

[358] Lunacy Act 1853 ss 45-46.
[359] A principle which is followed today with the use of Approved Mental Health Practitioners and two doctors as set out in ss 2 and 11 of the Mental Health Act 1983.
[360] Fennell (n115) 16.
[361] ibid.
[362] Lunacy Act 1853 s 9.
[363] Bank of England, 'Inflation Calculator' <www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator> accessed 14 October 2018.
[364] Chantal Stebbings, 'An Effective Model of Institutional Taxation: Lunatic Asylums in Nineteenth-Century England' Journal of Legal History 2011 April; 32(1): 31, 33.
[365] ibid 33 footnote.

the Lunacy Acts, the management of the mentally ill was often a private matter, and it may be argued that the legislation brought such matters to light. While detention became more regulated, this did not mean that Liberty or Autonomy were protected any more than had been so in the past. The 1800s were a time of significant experimentation in chemicals, physical restraint, seclusion, and punishment as treatments.[366] As noted earlier in Chapters One and Two, the essence of an individual is to be able to make choices, self-determine (as far as possible), and to have freedom of thought. It would surely be assumed that an environment where a patient is subject to physical punishment for non-compliance with a treatment regime would be subject to the aforementioned Lunacy Acts as amended by the Lunatic Asylums Act 1853,[367] for ill treatment. Unfortunately, due to the reluctance of the courts to rule against medical judgements, it required the Lunacy Commission to expressly prohibit behaviours used as punishments.[368]

While there were some notable examples of Victorian charity in the provision of care facilities, concern over unlawful detention, and indeed a focus on 'cure',[369] it took until the 1890s for the focus of psychiatry to move away from the predominant use of private asylums. This was in large part due to the increased judicial oversight introduced in the Lunacy Act 1890 (the 1890 Act) which reduced private compulsions to asylums owned or run by psychiatrists, and thus reduced the 'most profitable part of the psychiatric economy'.[370] Takabayashi, while recognising that psychiatry was struggling for professional recognition partly due to the stigma of asylums for the poor and general opposition to private asylums, notes that while private admissions were

[366] Fennell (n115) 18-23.
[367] Lunacy Act 1853 s 9.
[368] Fennell (n115) 19.
[369] ibid 33; Takabayashi (n288) 249.
[370] Takabayashi (n288) 250.

unchallenged, there were increasing numbers of psychiatrists in practice.[371] Despite this, there was significant concern in the psychiatric profession as the 1890 Act led to an increase in judicial oversight and a reduction in private compulsions.[372]

The 1890 Act introduced a requirement that any detention was overseen by a judicial authority,[373] defined as a magistrate, county court judge, or justice of the peace especially appointed for the purpose.[374] There was no expectation that the patient would actually be seen by the judge, but rather that the judge would simply made an order based upon the documentation (including two medical certificates) provided by the petitioner, who would normally be the spouse, and would have to ensure the patient was visited at least six-monthly.[375] While these requirements offered judicial oversight of the process, Fennell notes that medical officers of asylums were able to prevent patients from being seen by judges by deeming such meetings as 'prejudicial to the patient'.[376]

Whilst the medical profession was now overseen by the judiciary, the 1890 Act offered indemnity to the profession against actions for false imprisonment so long as the documentation was completed properly and in good faith or with reasonable care.[377] The 1890 Act also set out for the first time a maximum period of detention of one year, which was renewable for a further two years on application to the Commissioners.[378] These new requirements offered both a moderating of the power of the psychiatrist and a protection, though still limited, of the Liberty of the individual patient. The

[371] ibid 249.
[372] ibid 250.
[373] Lunacy Act 1890 s 4(1).
[374] ibid s 9(1).
[375] ibid s 5.
[376] Fennell (n115) 24.
[377] SG Lushington, 'The Lunacy Act, 1890' (1890) 3 Cnty & Loc Gov't Mag 294.
[378] Fennell (n115) 24.

themes of the 1890 Act will be seen in later legislation, and the use of the judiciary in authorising detention remains an area of debate in modern mental health law.

Money

It is worth noting here too that while the focus of the 1845, 1853, and 1890 Acts were more to do with the patient and the systems of detention, care, and regulation, these statutes retained significant Chancery functions. Parts Four, Six and Seven of the 1890 Act set out the Judicial Powers over Person and Estate of Lunatics, along with the roles and duties of Chancery visitors.[379] The detail in these Parts of the 1890 Act is also telling, as there are over forty sections dealing with the management and administration of the estate, going into significant detail to protect those acting on such matters; but only twenty eight sections relating to the determination of lunacy in Part Three. While the direction of travel was positive, there remained significant focus on the importance of the assets of the patient.

Into the Twentieth Century: the consequences of war

Care, Patient Safety, and Stigma – the development of a new approach

It is in the twentieth century that we see the most significant changes in the treatment of the mentally ill from societal, medical, and legal perspectives. As noted earlier, the 1890 Act had a major impact on the practice of psychiatry; but there were unintended consequences of the new regulatory framework, with patients moved to nursing homes rather than private asylums.[380] This sidestepping of the 1890 Act led to the Nursing Homes Registration Act 1927, after the Board of Control identified the ongoing illegal

[379] Lunacy Act 1890 Parts IV VI VII.
[380] Takabayashi (n288) 250-251.

use of private nursing homes for the mentally ill.[381] It is noted that the 1890 Act requirement for certification led to increased stigma for the families.[382] As has been seen, up to the 1900s, the naming of legislation along with the reference to lunatics, feeble-minded, idiots, etc. did little to challenge this position. Even with the Victorian charitable intention, the harsh and pejorative language used in such endeavours as the launch in London in 1847 of the Charity for the Asylum of Idiots[383] continued. The situation remained unchanged in the early twentieth century with further Lunacy Acts in 1908[384] and 1922,[385] and Acts in respect of those with learning disabilities which used the phrase Mental Deficiency or Mentally Defective.[386]

However, with the mental health consequences of war on soldiers returning from the Great War, a change in attitude and political will emerged. Bogacz writes, 'The first world war fundamentally challenged inherited social and cultural ideas, including traditional views of mental illness and its treatment';[387] a view researched and confirmed by Takabayashi[388] who noted official figures of 27,000 mental health beds in military institutions in 1917. It is estimated that there were over 80,000 cases during the conflict.[389]

---

[381] ibid 251.
[382] ibid 251; It is significant that the fact of detention under the MHA 1983 still stigmatises to current times: Syeda F Akther and others, 'Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis' (2019) BJPsych Open 5 e37 1, 6.
[383] Open University, 'Timeline of learning disability history' <www.open.ac.uk/health-and-social-care/research/shld/timeline-learning-disability-history> accessed 31 August 2020.
[384] Lunacy Act 1908.
[385] Lunacy Act 1922.
[386] Mental Deficiency (Amendment) Act 1935; Mental Deficiency Act 1927; Mental Deficiency Act 1938.
[387] Ted Bogacz, 'War Neurosis and Cultural Change in England, 1914-22: The Work of the War Office Committee of Enquiry into 'Shell-Shock'' (1989) Journal of Contemporary History Apr 1989 Vol 24 No 2 Studies on War (Apr 1989) 227.
[388] Takabayashi (n288) 264.
[389] History.com, 'British soldier Harry Farr executed for cowardice' (2019) <www.history.com/this-day-in-history/british-soldier-henry-farr-executed-for-cowardice> accessed 20 September 2020.

The war poet Siegfried Sassoon wrote of the impact on servicemen in his poem Survivors:

> No doubt they'll soon get well; the shock and the strain
> Have caused their stammering, disconnected talk,
> Of course they're "longing to go out again"-
> These boys with old, scarred faces, learning to walk,
> They'll soon forget their haunted nights; their cowed
> Subjection to the ghosts of friends who died,-
> Their dreams that drip with murder: and they'll be proud
> Of glorious war that shatter'd their pride…
> Men who went out to battle grim, and glad;
> Children, with eyes that hate you, broken and mad.[390]

The response by the establishment to soldiers impacted by "shell shock" ranged from execution for desertion[391] to electric shock treatment, electric heat baths, milk diets, and hypnotism at the National Hospital for Paralysed and Epileptic, at Queen Square, London.[392] The name of the institution reflects the utilitarian approach at the time to the naming of hospitals, with other examples such as the Royal Hospital for the Incurables (later the Royal National Hospital for Neuro-Disability in Putney).[393] This use of language was also reflected in the development of a phrase that remains with us today: the term 'basket case' is used as a reference to those who have had mental health issues, and it appears that this phrase was first coined in referring to servicemen who were given repetitive tasks such as basket weaving to try to treat shell shock.[394]

---

[390] Siegfried Sassoon, *Survivors* (1917) <http://ww1lit.nsms.ox.ac.uk/ww1lit/collections/item/9686> accessed 20 September 2020.
[391] John Sweeney, 'Lest we forget: the 306 'cowards' we executed in the first world war' (1999) *The Guardian* Sunday 14 Nov 1999.
[392] Caroline Alexander, 'The Shock of War' (2010) Smithsonian Magazine September 2020 <www.smithsonianmag.com/history/the-shock-of-war-55376701/> accessed 20 September 2020.
[393] Gordon C Cook, 'Caring for "incurables": the 150th anniversary of the Royal Hospital for Neuro-Disability, Putney' (2004) Postgraduate Medical Journal 2004;80:426.
[394] Christopher Harvie, 'Basket Case' <http://ww1centenary.oucs.ox.ac.uk/?p=3364> accessed 20 September 2020.

McCartney argues that the view of the World War One soldier in British society persisted for many years as one of a hero,[395] and that a significant consequence of the experiences of those servicemen means that 'psychological injury as a result of wartime experience' is now 'part of popular consciousness'.[396] Winter states:

> The term 'shell-shock' denoted a violent physical injury, albeit of a special kind. That injury was validated by the term, enabling many people and their families to bypass the stigma associated with terms like 'hysteria' or 'neurasthenia' connoting a condition arising out of psychological vulnerability. 'Shell-shock' was a vehicle at one and the same time of consolation and legitimation.[397]

That such stigma was associated with the mental health impact of war, along with the huge numbers affected, led in 1920 to Lord Southborough putting forward a Motion to establish a committee to investigate the nature and treatment of "Shell Shock" in the Great War.[398] While this was an early recognition of the issue in Great Britain, it is interesting to note that by the time Westminster started debating such issues; India had already established improved mental health services for soldiers who had fought in the Great War.[399]

While this did not become legislation, the Ministry of Health (Miscellaneous Provisions) Bill 1920[400] was debated in both Houses. A firm advocate of the Bill was Lt. Col. Nathan Raw, MP for Liverpool Wavertree. This Bill was aimed at addressing the issue where an individual could not secure voluntary admission to a State-run asylum but could to a private asylum. Raw spoke on the Bill and noted (in respect of those detained in asylums):

---

[395] Helen B McCartney, 'The First World War soldier and his contemporary image in Britain' (2014), International Affairs 90: 2 299, 303.
[396] ibid 307.
[397] Jay Winter, 'Shell-Shock and the Cultural History of the Great War' (1995) Journal of Contemporary History Jan 2000 Vol 35 No 1 Special Issue: Shell-Shock (Jan 2000) 7, 10.
[398] Bogacz (387) 227.
[399] Manimugdha S Sharma, 'World War 1 and the beginning of modern psychiatry in India' (2014) *Times of India* 21 September 2014 <https://timesofindia.indiatimes.com/india/World-War-I-and-beginning-of-modern-psychiatry-in-India/articleshow/43101847.cms> accessed 12 September 2020.
[400] Ministry of Health (Miscellaneous Provisions) Bill 1920.

> In the meantime the families and relations of these unfortunate people are under the stigma of insanity as far as this patient is concerned. I maintain that a great amount of this hardship, which is inevitable under the existing state of the law, will be removed by the application of Clause 10. I feel certain it can do no harm to anybody, and it will do an incalculable amount of good. War, with all its horrors, has shattered the nervous system of many thousands of our soldiers. Very few of these men are insane. They are suffering from neurasthenia and a collapse of the nervous system, which in a few weeks or months may be cured.[401]

It is significant that one of the drivers here for change in mental health legislation was the stigma of mental illness starting to taint the "courageous".[402]

In 1922 the Report of the War Office Committee of Enquiry into "Shell Shock" was published noting that, unsurprisingly, there was no honourable escape thorough loss of nervous or mental control from the battlefield.[403] The Report also eliminated the term "Shell Shock" from use in such matters, recognising a wider range of conditions,[404] recommended separating treatment of such conditions from physical health conditions, and identified baths, electricity, and massage as effective treatments.[405] While this was not the most forward thinking approach it is noteworthy that dedicated military mental hospitals were established as a consequence of the Great War.[406]

---

[401] Hansard HC Deb 09 November 1920 vol 134 cc1029-148 at 1038.
[402] It is interesting to note the connection with PTSD today where the military, while keen to support veterans, are no doubt sensitive about conflating military service with mental illness: Jeffrey A Lieberman, 'Solving the Mystery of Military Mental Health: A Call to Action' (2018) Psychiatric Times December 18 2018; Alison Howell, 'Afghanistan's Price: By downplaying PTSD, our government makes soldiers and their families bear the costs of war' (2011) The Literary Review of Canada (LRC) vol 19 no 9, 1. McCartney notes there is 'current widespread acceptance, indeed expectation, that soldiers will be psychologically damaged by war: McCartney (n395) 310.
[403] Report of the War Office Committee of Enquiry into "Shell-Shock" (1922) 191 <https://wellcomelibrary.org/item/b18295496#?c=0&m=0&s=0&cv=99&z=0.4003%2C0.1794%2C0.5307%2C0.3333> accessed 20 September 2020.
[404] Report of the War Office Committee of Enquiry into "Shell-Shock" (n403) 190.
[405] ibid 191-2.
[406] Bogacz (n387) 235.

Criminal Justice and the Development of Care and Treatment rather than Punishment

1922 was also significant from the perspective of more humane treatment for the mentally ill under the criminal law. Grey notes that prior to the First World War all attempts to pass legislation in respect of maternal homicide had failed,[407] but identifies partial emancipation for women in 1918[408] as a significant driver for change.[409] Grey argues that feminism and the increasing engagement of women in the justice system was key in such progress, but notes there are also arguments that the impact of the Great War influenced such changes.[410] The Infanticide Act 1922[411] saw the recognition of maternal mental illness as a defence to murder where a mother killed her child (the child being under twelve months of age), providing for a verdict of manslaughter and thus not liable to the death penalty.

1924 saw the appointment of a Royal Commission on Lunacy and Mental Disorder. Their remit included consideration of the existing law in England and Wales and the associated administrative machinery in connection with the certification, detention and care of persons who are or are alleged to be of unsound mind. It also was to consider, as regards England and Wales, the extent to which provision is or should be made for the treatment without certification of, persons suffering from mental disorder.[412] When this Commission reported in 1926 it provided a paradigm shift in the approach to mental illness and those who experience it. Noted below are the principles as identified at the time:

[407] Daniel JR Grey, 'Women's Policy Networks and the Infanticide Act 1922' (2010) Twentieth Century British History Vol 21 No 4 2010 441, 442.
[408] Representation of the People Act 1918.
[409] Grey (n407) 444.
[410] ibid 450.
[411] Infanticide Act 1922.
[412] British Journal of Nursing, 'Royal Commission on Lunacy and Mental Disorder' (1926) September 1926 200.

> They state that there is no clear line of demarcation between mental illness and physical illness. The distinction is commonly based on a difference of symptoms and is in practice no doubt convenient, but it has had an undue influence on the development of the lunacy system. *The modern conception of mental illness calls for a complete revision of the attitude of society in the matter of its duty to the mentally afflicted. The key-note of the past has been detention; the key-note of the future should be prevention and treatment*; but the crucial difficulty lies in this, that the special nature of the symptoms of mental illness must in many cases necessitate restraint. The Commission take the view that every facility and encouragement should be afforded to the mentally ailing to submit themselves voluntarily to treatment; but *where compulsory detention is unavoidable the intervention of the law should be as unobtrusive as possible and should extend no further than is necessary to secure that the patient's liberty is not infringed longer or to a greater extent than his symptoms necessitate in his own or the public interest*. In particular, emphasis is laid on *the need for providing facilities for the treatment of incipient mental disorder without the necessity of certification, which should be the last resort in treatment and not (as is now too commonly the case) the pre-requisite of treatment*. Further, the problem of insanity is essentially a public health problem, and the administration of the lunacy code should be associated as far as possible with public health administration rather than with the Poor Law.[413]

It is hugely significant that these remain the same principles underpinning mental health legislation today.[414]

The consequence of the 1926 report was the Mental Treatment Act 1930[415] which was heralded by the British Journal of Nursing as 'A Message of Hope'.[416] The focus of the Act was closely linked to the report of the Commission and emphasised the key messages of prevention and treatment over detention; of Certification being the last resort not the pre-requisite of treatment.[417] The British Journal of Nursing welcomed

---

[413] ibid emphasis added.

[414] This can be compared with the guiding principles set out in the Welsh Assembly Government, Mental Health Act 1983 Code of Practice for Wales (2008) which state:
Alternatives to avoid the use of compulsory powers should be explored before making an application for admission, and the least restrictive options should be considered. This should include creative approaches to offer choice in service delivery and alternative means of *providing treatment and care*, subject to the need to prevent harm. This should always be balanced with *ensuring patients receive treatment appropriate to their needs* and which is aimed at preventing them from harming themselves or others (emphasis added). Welsh Assembly Government (n275) para1.8. It is interesting to note that simply in the use of language, the 1926 report was more strongly averse to the use of detention than we are today.

[415] Mental Treatment Act 1930.

[416] Bedford Fenwick, 'Editorial' (1930) The British Journal of Nursing No 1943 Vol 78 June 1930.

[417] ibid.

the earlier Nurses' Registration Act[418] of 1919 which identified a specialist role of Mental Nurse. The language used to support this reflects the time and a perhaps more austere profession:

> Closely allied with mental treatment is mental nursing, and if the best possible is to be done for the mentally afflicted, Nurses must take pains to become highly qualified for this difficult work … No class of patients need protection so much from ignorant and inefficient nurses as mental ones, and the proof that they are registered by the State should be demanded of all nurses in charge of insane persons.[419]

The 1930 Act[420] provided for voluntary admission to public / State asylums which were now renamed mental hospitals. Killaspy credits the 1930 Act with the creation of community mental health services in that it encouraged the development of out-patient services, resulting in an increase from 25 departments in 1925 to 162 by 1935.[421] The 1930 Act also forbade the use of the term *pauper,* and changed the language from *voluntary boarder* to *voluntary patient.*[422]

In addition to providing for voluntary admission, the 1930 Act provided for a non-judicial, temporary compulsion to hospital without seeking judicial certification for patients who we would now determine had limited capacity to decide whether they would be willing or unwilling to receive treatment.[423] While this may be seen as a potential way of sidestepping the judicial oversight, patients who were admitted in this way were formal patients and had to be certified after six months unless the Board of Control authorised a maximum of twelve months under this measure.[424] With the

[418] Nurses' Registration Act 1919 9 and 10 Geo V c 94.
[419] Fenwick (n416).
[420] Mental Treatment Act 1930.
[421] Helen Killaspy, 'From the asylum to community care: learning from experience' (2006) British Medical Bulletin Volume 79-80 Issue 1 June 2006 245, 249.
[422] BMJ Supplemental, 'Mental Treatment Act 1930' (1930) The British Medical Journal Sep 20 1930 Vol 2 No 3637 (Sep 20 1930) 139 41.
[423] Fennell (n115) 32.
[424] ibid 33. Fennell notes that this approach was one adopted in the Mental Health Act 1959 which will be explored further in Chapter Four.

impact too of the Great Depression in the early 1930s, Jones notes that there was a pressure on voluntary mental health beds for those who were not mentally ill, but needed 'a bed and a square meal'.[425] While this pressure was a challenge, the Depression did mean that the development of a staff group for mental health services flourished as hospitals and clinics became established.[426]

The 1930 Act was a step forward in many ways in protecting the Liberty of the patient, addressing stigma, establishing standards of care, and setting time limits for detention. By 1938 there was a dramatic increase in the number of voluntary admissions, with the consequence that the Board of Control pushed for better standards of food, accommodation, care, and even library services in hospitals.[427] The 1930s also saw the development of improved training for professionals, the construction and opening of the new Bethlem hospital, and a review of voluntary associations supporting mentally ill people.[428] The Feversham Report recognised the role of the voluntary sector, even as limited as it was at that time, and recommended that where services were not provided by local authorities, grants could be made to voluntary organisations to provide the same.[429] It is notable that the Committee brought together the three key voluntary organisations of the time, and this merging led to the creation of the National Association for Mental Health in 1946, an organisation we now know as Mind.[430]

There was however a significant unintended consequence of the new legislation. Fennell[431] believes that lobbying by the British Medical Association (BMA) among

[425] Kathleen Jones, *Asylums and After* (1993 The Athlone Press Ltd. London) 136.
[426] ibid.
[427] ibid 136-7.
[428] ibid 139.
[429] The British Medical Journal, 'Voluntary Mental Health Services: The Feversham Committee's Report' (1939) BMJ Vol 2 No 4099 (Jul 29 1939) 239-241.
[430] Jones (n425) 139.
[431] Fennell (n115) 34.

others resulted in s.16[432] of the 1930 Act which led to in a much higher threshold being established for claimants in actions against the medical profession. Fennell refers to the period 1930-1959 as the 'Age of Experimentation',[433] and reflects that,

> By the early 1930s it was clear that detained patients could be treated without consent, voluntary patients could be detained by assembling the necessary medical evidence to have them certified, and doctors felt themselves to be adequately protected from legal action. This was fertile legal soil for therapeutic experimentation.[434]

As noted in Chapter One, in the early twentieth century, psychiatrists were experimenting with what are now seen as quite horrific treatments including coma therapy either through barbiturates or insulin, and drug induced epileptiform seizures, with the intention of providing a severe shock to the system.[435] As we consider the further development of mental health legislation from the formation of the NHS in Chapter Four, we will also examine the impact and influence of the pharmaceutical industry and how medication came to play a major role.[436]

The end of the 1930s brought the Second World War, and disruption to what had been a rapidly developing mental health service; many hospitals were repurposed, and services reduced due to other demands, staff joining up, and a tuberculosis crisis.[437] War has been recognised as a catalyst for improvements in medicine,[438] and, it appears that the challenges faced in rebuilding the nation, led to both the development of the

[432] Mental Treatment Act 1930 s 16.
[433] Philip Fennell, *Treatment Without Consent* (2014 Routledge) Chapter 9.
[434] ibid128.
[435] ibid128-133.
[436] ibid129.
[437] Jones (n425) 142.
[438] Science Museum, 'Medicine in the aftermath of war' (2019) <www.sciencemuseum.org.uk/objects-and-stories/medicine/medicine-aftermath-war> accessed 25 May 2024 ; Raymond E Tobey, 'Advances in Medicine During Wars' (2018) Foreign Policy Research Institute <www.fpri.org/article/2018/02/advances-in-medicine-during-wars/> accessed 25 May 2024.

Welfare State,[439] and, despite some initial disagreements, the first signs of parity.[440] In 1945, a joint memorandum between the Royal College of Physicians, the British Medical Association and the Royal Medico-Psychological Association[441] was published. This was entitled Memorandum on the Future Organization of the Psychiatric Services, and set out reflections on psychiatry, and recommendations for much of the fundamental basis for psychiatric services as we know them today. These recognised that:

> Historically, psychiatry developed as the method of treatment of those individuals whose mental illness necessitated their segregation from the rest of society. It is now recognized that this distinction, however important socially, is medically irrelevant, for there is only a difference of degree between the majority of patients in mental hospitals and the far more numerous sufferers from less severe mental disorders…
> Moreover, the historical association of the mental hospital with severe forms of illness and with legal restraint has undoubtedly made the public reluctant to avail themselves of these institutions and has militated against the early treatment of mental illness. Although modem developments in mental health services are doing much to lessen such fears and prejudices among the public, they are still a factor to be reckoned with.[442]

This memorandum listed 51 recommendations, four of which (1, 9, 49, and 50) are still key today:

> **Scope of Psychiatry**
> 1. Psychiatry is not a limited specialty. It permeates and influences general medicine, surgery, and obstetrics and gynaecology. In particular, psychiatrists should be appointed to the staffs of general hospitals with status equal to that of other physicians and surgeons.
>
> **Administration and Staffing**
> 9. The main factors which retard progress in the treatment of mental disorder at the present time are: (1) the law, which lags behind enlightened public and medical opinion; (2) the mental hospital buildings, many of which are quite out of date, having been designed for detention and safety without sufficient vision regarding curative treatment; (3) the association of public assistance

[439] UK Parliament, 'Social Insurance and Allied Services Report by Sir William Beveridge' (1942) Cmd 6404 HMSO.
[440] Jones (n425) 143.
[441] Later to be renamed the Royal College of Psychiatrists in 1971, Royal College of Psychiatrists, 'Our History' <www.rcpsych.ac.uk/about-us/exploring-our-history/our-history/the-rmpa> accessed 26 May 2024.
[442] The Royal College of Physicians, The British Medical Association, The Royal Medico-Psychological Association, 'Memorandum on the Future Organization of the Psychiatric Services' (1945) British Medical Journal Supplement Saturday June 16 1945 111-116.

with mental hospital treatment; and (4) the numerical in adequacy of the medical staff and the numerical and professional inadequacy of the nursing staff in mental hospitals. Improvement is necessary also in the status, pay, and conditions of service of the medical staff, with greater freedom in regard to professional matters and the formation of medical committees. Increased opportunities for purely clinical work should be developed.

Delinquency

49. Psychiatric advice should be made more widely available to the courts so that greater use of it could be made by them. There should be collaboration with the legal authorities at all stages in the ascertainment, treatment, and rehabilitation of offenders.

50. A mental health service should cover at least the psychiatric requirements envisaged in the Criminal Justice Bill of 1939, and the powers of the central health authority should include at least the provision of psychiatric advice to approved schools, Borstal institutions, remand homes, and the special hospitals proposed in the Criminal Justice Bill.'[443]

The sentiment of the first recommendation seems to reflect a key phrase in the preamble to the Constitution of the World Health Organization: 'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.'[444] The other recommendations noted above are repeated on an annual basis in relation to resources[445] and engagement in criminal justice matters.[446] Despite the timing of this memorandum, the National Health Service Act in 1946[447] did not address many of these recommendations, but provided what Jones regarded as 'rather vague powers under section 28' for local health authorities.[448] These led to an increase of many of the administrative issues highlighted in the memorandum, and a lack of understanding of responsibilities.[449]

[443] ibid.
[444] United Nations International Health Conference (n37) 1.
[445] BMA, 'It's broken. Doctors' experiences on the frontline of a failing mental healthcare system' (2024) 4 <www.bma.org.uk/media/ddclsiii/bma-mental-health-report-2024-web-final.pdf?_gl=1*bp6j67*_up*MQ..*_ga*MTEwNDk1MzE0Ny4xNzE2ODIxMjM3*_ga_F8G3Q36DDR*MTcxNjgyMTIzNi4xLjAuMTcxNjgyMTIzNi4wLjAuMA> accessed 27 May 2024.
[446] John Pring, ''Deep concern' over funding for national plan to limit mental health policing' (2023) Disability News Service <www.disabilitynewsservice.com/deep-concern-over-funding-for-national-plan-to-limit-mental-health-policing/> accessed 27 May 2024.
[447] The National Health Service Act 1946.
[448] Jones (n425)144.
[449] ibid 145.

Conclusion

The two hundred years between the Vagrancy Act 1744 and the end of the Second World War saw fundamental changes to the way mental illness was perceived and addressed in the United Kingdom. Many of these changes were sadly driven by experiences of neglect, harm, and abuse, and as we will see moving forward in Chapter Four and Five, this may often be the catalyst for change. The experiences of soldiers who were both brave and now mentally ill played a significant part in changing the public perception of mental illness and created an opportunity for treatment and care to be considered rather than containment. The end of the Second World War also brought with is massive socio-economic changes, and the development of a new National Health Service. As we will see in the next chapter, the birth of the NHS was also the starting point for a period of significant change for mental health services and legislation.

Chapter Four - Mental Health Legislation in England and Wales from 1948 to the new Millenium

Introduction

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. *The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being* without distinction of race, religion, political belief, economic or social condition.[450]

This chapter starts at the turn of the year 1948; a significant year which saw the founding of the National Health Service, the United Nations Declaration of Human Rights, and the coming into force of the constitution of the World Health Organisation. Following on from Chapter Three we will consider the changes in mental health legislation, and the public attitudes and health and social care policy which led to the current state of mental health law in England and Wales. This period is a key moment in the development of health and care services in England and Wales and also the beginning of the post-war human rights focus. As explored in Chapter Three the impact and influence of war changed public, and thus political, opinion of mental illness. In reviewing the post-World War Two landscape, it will be seen that the development of a human rights focus owed much to the experiences of those persecuted by the Nazis, the coming to light of the way people with a mental illness were treated in the former Soviet Union, and a new, more liberal western approach to the understanding of mental illness.

As noted previously, the early part of the twentieth century was the 'Age of Experimentation',[451] and the mental health historian Kathleen Jones dubbed the period

[450] World Health Organisation, 'Preamble to the Constitution of WHO' (adopted by the International Health Conference New York 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States) Official Records of WHO no 2 100 entered into force on 7 April 1948. Emphasis added.
[451] Fennell (n433) Chapter 9.

1954-59 as 'years of therapeutic flux',[452] suggesting that clarity and certainty in mental health services were lacking. This uncertainty, along with the need for a review of the legislation, which was carried out by the Percy Commission,[453] created an optimal time for the development of the 1959 Mental Health Act (hereafter MHA 1959). This Act, and the Mental Health Act 1983 (hereafter MHA 1983), will form much of the discussion of the legislative focus within this chapter. The examination of both the rationale for, and the impact on, the individual of the evolving legislation which follows in Chapter Five, will identify a politicised approach to mental health services. This will be both from a populist political perspective, and also from a more ideological basis, which provides for fundamental agreement on a mode of service provision though from diametrically opposing positions. One, the populist seeking increased services to address perceived harms, the other seeking increased services to address care needs.

The influence of the European Convention on Human Rights[454] (hereafter ECHR) and the introduction of the Human Rights Act 1998 (hereafter HRA 1998), and the role it played in requiring a review of existing legislation such as the MHA 1983 will be considered alongside the relevant case law. The underpinning of the HRA 1998 in the ECHR and a broader discussion on the rights of those with disabilities, referencing the United Nations Convention on the Rights of Persons with Disabilities (hereafter UNCRPD),[455] will also be explored in assessing if and how these rights have been incorporated into national law. The development of new pharmaceutical products

[452] Jones (n425)150.
[453] Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (Percy Commission) (1957) Cmd 169 HMSO.
[454] Council of Europe (n38).
[455] United Nations General Assembly (n24).

which provided chemical restraint, the so called 'Chemical Revolution',[456] will also be considered in understanding how Autonomy and Liberty are affected not just by the action of the medicines but also by the requirement to take them.

Parity between physical and mental health is a strong driver for change in mental health services.[457] However this is a subject which, while looking for similar focus and understanding of the varying conditions, fails to recognise that it is a fundamentally flawed argument. As identified in Chapters One and Two, individuals with capacity can be detained and treated under the MHA 1983 for a mental illness but there is no comparator in the physical health arena. I will touch on this subject before returning in more detail in Chapter Seven where I contrast mental health legislation and that relating to the rules introduced during the COVID-19 pandemic.

The Post War Years – Changes at an England and Wales level

> International revulsion at the violation of human rights during World War II helped spark a global movement to define and protect individual human rights. Starting with the creation of war crimes tribunals after the war, this newfound awareness stimulated a concerted international effort to establish human rights for all, both in periods of war and peace. These endeavors [sic] resulted in a historic milestone when the United Nations adopted the Universal Declaration of Human Rights (UDHR) in 1948.[458]

[456] Benoît Majerus, 'Making Sense of the 'Chemical Revolution'. Patients' Voices on the Introduction of Neuroleptics in the 1950s' (2016) Medical History vol 60(1) 54.
[457] The King's Fund, 'Is there 'parity of esteem' between mental and physical health? Big election questions' (2017) <www.kingsfund.org.uk/publications/articles/big-election-questions-parity-mental-physical-health> accessed 2 August 2020; Gabriel Ivbijaro, 'Mental and Physical Health Parity: not a luxury but a necessity' (2012) Mental Health in Family Medicine 2012 Dec 9(4): 213-214; BMA, 'Beyond parity of esteem – Achieving parity of resource, access and outcome for mental health in England' (2020) <www.bma.org.uk/media/2099/mental-health-parity-of-esteem-report-jan-2020-2.pdf> accessed 1 August 2020; Carl Baker, Manjit Gheera, 'Achieving 'parity of esteem'' (2020) House of Commons Library 16 January 2020 <https://commonslibrary.parliament.uk/insights/mental-health-achieving-parity-of-esteem/> accessed 1 August 2020.
[458] Stewart Walters, William B Russell III, 'The World War II Era and Human Rights Education' (2012) Social Education 76 (6) 301, 301.

The development of the United Nations and the ambition that had been set in the Atlantic Charter of 1941[459] between Great Britain and the United States were not however the only drivers for societal change in England and Wales. A Labour government was elected in 1945 in a landslide, despite the leadership of Churchill through World War II, credited largely to the Labour party's commitment[460] to take forward the recommendations of the Beveridge Report.[461] This was a commitment to what we understand now as the Welfare State, providing housing, social security, health care, and the wrap around support. For a nation which had undergone such loss through the devastation of war, this ambitious plan offered a sense of hope, but also one I would argue of recognition of the personal sacrifices the citizens of the UK had made. This approach to the State accepting the responsibility for the wellbeing of the citizens rather than expecting charity or philanthropy to support those who could not support themselves, mirrored some of the changes we saw in Chapter Three in mental health legislation. A transition from services for those with the ability to pay, or charity for those unable to fend for themselves, to a more universalist approach[462] proved popular.

This period also saw men returning from war and the expectation that they would take on the roles that had been carried out by women during the war,[463] along with the

[459] US Department of State Archive, 'The Atlantic Conference & Charter, 1941' <https://2001-2009.state.gov/r/pa/ho/time/wwii/86559.htm> accessed 13 July 2024.
[460] UK Parliament, (n453); Imperial War Museum, 'How Winston Churchill And The Conservative Party Lost The 1945 Election' <www.iwm.org.uk/history/how-winston-churchill-and-the-conservative-party-lost-the-1945-election> accessed 13 July 2024.
[461] UK Parliament (n453).
[462] Morgan (n10).
[463] Striking Women, 'Gains and losses for women after WWII' <www.striking-women.org/module/women-and-work/post-world-war-ii-1946-1970#:~:text=The%20proportion%20of%20women%20in,to%20be%20'secondary%20workers> accessed 13 July 2024.

retention of rationing until 1954.[464] The development of the Welfare State though did offer roles that were seen as "women's work" as well as the development of other role less attractive to men.[465] The commitment to "full employment" in part through offering only very basic benefit for those unemployed[466] also mobilised a nation to reconstruct both physically and economically. A Welfare State though in its most simple definition recognises the needs of the citizens of the State for housing, health and welfare, and the ability to earn or be supported. This is a theme which flows through the development of the Welsh Government as will be seen later in this chapter. Post war reconstruction in the UK both in the rebuilding of the ravaged cities and also the transition to a post war economy included the passing of the National Health Service Act 1946, which led on the 5th of July 1948 to the birth of the NHS. Original proposals for this legislation had left out mental hospitals, but through pressure from groups such as the British Medical Association (BMA), this was reversed.[467] The role of professional bodies, charities, and patient groups has been key in the development of mental health law, and this will be examined in greater detail below, with particular regard to of the Mental Health Alliance in Chapter Five.

It is interesting to note that at the point where the NHS was formed, mental hospital beds in the NHS totalled almost half of the total beds available in the new NHS hospitals, at 190,000.[468] Figures for England for March 2024 show a total of 132,520

[464] Imperial War Museum. What You Need To Know About Rationing In The Second World War <www.iwm.org.uk/history/what-you-need-to-know-about-rationing-in-the-second-world-war> accessed 13 July 2024.
[465] Striking Women (n463)
[466] UK Parliament (n439) 163.
[467] Royal College of Psychiatrists, 'Through the decades: A deep dive through 75 years of NHS history' (2023) <www.rcpsych.ac.uk/news-and-features/blogs/detail/history-archives-and-library-blog/2023/07/05/through-the-decades-a-deep-dive-into-nhs-history> accessed 14th July 2024.
[468] ibid.

NHS beds with only 17,789 mental health beds.[469] Figures for Wales are available for 2022-2023 and there were a total of 10,400 NHS beds and of those only 1,285 were for mental health.[470] NHS Scotland reported that there were 3,366 mental health beds available in 2022[471] though published data on total NHS beds (13,695 for 22-23) for Scotland only refers to acute beds, excluding mental health and a few other specialities.[472] In 2023, Our Scottish Future estimated that there were a total of 13,300 beds available in Scotland,[473] but as there is no clarity on how the figures were determined, these are likely to not include other specialities as noted earlier. Northern Ireland figures show 5,804 total beds[474] in 2021/22, of which, 488 were mental health beds.[475] This indicates that the proportion of mental health beds (based on the above figures) across the four nations is around 14%, and while total NHS beds have been reduced by some 57%, mental health beds have been reduced by 88% over the same timescale.

Returning to 1948, Kathleen Jones noted that while the NHS Act 1946[476] did include mental hospitals, there were significant administrative issues as there was a lack of

---

469 NHS England, 'Bed Availability and Occupancy Data – Overnight' <www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2024/06/Beds-Open-Overnight-Web_File-Q4-2023-24-Final-1.xlsx> accessed 14 July 2024.

470 Stats Wales, 'NHS beds by organization and year, 2009-10 onwards' <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/nhsbeds-by-organisation-site> accessed 14 July 2024.

471 Scottish Government, 'Inpatient census 2022: parts one and two' (2022) <www.gov.scot/publications/inpatient-census-2022-part-1-mental-health-learning-disability-inpatient-bed-census-part-2-out-scotland-nhs-placements/pages/3/> accessed 14th July 2024.

472 Public Health Scotland, 'Acute hospital activity and NHS beds information (annual)' (2023) <https://publichealthscotland.scot/publications/acute-hospital-activity-and-nhs-beds-information-annual/acute-hospital-activity-and-nhs-beds-information-annual-annual-year-ending-31-march-2023/> accessed 14th July 2024.

473 Our Scottish Future, 'Scotland's Unsustainable Health Service' (2023) 2 <https://ourscottishfuture.org/wp-content/uploads/2023/12/Scotlands-Unsustainable-Health-Service.pdf> accessed 14 July 2024.

474 Department of Health NI, 'Hospital Statistics. Inpatient and Day Case Activity Northern Ireland 2021/22' (2023) 2 <www.health-ni.gov.uk/sites/default/files/publications/health/hs-inpatient-day-case-stats-21-22.pdf > accessed 14 July 2024.

475 ibid.

476 National Health Service Act 1946.

understanding of mental health care, and a wide variance in availability of beds by location.[477] Jones also reflected on the new ethos and culture in these hospitals, suggesting that the these were impacted upon by the increasing numbers of patients, but also the organisational approach, which she felt owed something to military experience of patients and staff.[478] In the next few years though there was little change to legislation in respect of mental health. The Criminal Justice Act 1948 permitted probation orders to stipulate mental health treatment as a condition of that probation[479] without imposing certification and forceable treatment. Offenders were to be treated as voluntary patients and could even refuse specific treatment if it were deemed reasonable to do so.[480] This Act also discontinued the language of "criminal lunatic" and "criminal lunatic asylum",[481] and made provision for patients detained in Broadmoor to be able to be treated elsewhere for medical or surgical needs before return to Broadmoor.[482] While the language amendment was positive, this did not appear to be a complete change as it continued to refer to such places as, "the Lunatic Department of Perth Prison", and "mental defectives".[483]

As noted above, 1948 also saw the United Nations Universal Declaration of Human Rights,[484] "a milestone that would profoundly influence the development of international human rights law".[485] In considering the development of mental health and human rights law in the UK, we will also be considering below the implications

[477] Jones (n425) 144-145.
[478] ibid 145-148.
[479] Criminal Justice Act 1948 s 4.
[480] ibid s 6(6).
[481] ibid s 62.
[482] ibid s 64.
[483] ibid ss 63(4) 64.
[484] United Nations General Assembly (n23).
[485] United Nations Human Rights Office of the High Commissioner, 'International Bill of Human Rights' <www.ohchr.org/en/what-are-human-rights/international-bill-human-rights> accessed 14 July 2024.

of the UN conventions that flowed from this initial work, particularly the Convention on the Rights of Persons with Disabilities.[486] 1948 also saw the founding of the World Health Organisation, and the definition of health that remains unchanged to this day, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[487] This too is a key definition when we consider the ongoing challenge of gaining parity between mental health and physical health, an area of much ambition, but limited progress.[488] Sadly, though human rights were being seen as a global area of concern, psychiatry, while having some improved access to newer pharmaceutical treatments in the immediate post war years,[489] was still actively pursuing a psychosurgery approach.[490] Indeed, in 1949, Portuguese neurologist Egas Moniz won a Nobel Prize for his work on lobotomies.[491] While there is limited psychosurgery within modern psychiatry, this is very specialised, and there are significantly greater protections, though surgery is not recommended by the National Institute for Health and Care Excellence.[492]

The political leadership of the UK changed again in 1951. The progress in legislation towards the Welfare State and the development of the NHS had been delivered, but the challenges were in maintaining the belief of the electorate.[493] Despite Atlee's

[486] United Nations General Assembly (n24).
[487] World Health Organisation (n450).
[488] Ivbijaro (n457); Royal College of Nursing, 'Parity of Esteem' <www.rcn.org.uk/clinical-topics/Mental-Health/Parity-of-esteem> accessed 14 July 2024 ; Chris Millard, Simon Wessely, 'Parity of esteem between mental and physical health' (2014) BMJ 2014; 349; Alex J Mitchell, Sheila Hardy, David Shiers, 'Parity of esteem: Addressing the inequalities between mental and physical healthcare' (2017) BJPsych Advances Vol 23 Iss 3 May 2017 196.
[489] Hugh Marston, 'A Brief History of Psychiatric Drug Development' (2013) British Association for Psychopharmacology <www.bap.org.uk/articles/a-brief-history-of-psychiatric-drug-development/> accessed 14 July 2024; Fennell (n433)129-131.
[490] Kelsey Ables, 'Now seen as barbaric, lobotomies won him a Nobel Prize in 1949' (2023) *Washington Post* October 9 2023.
[491] ibid; Fennell (n433) 141-143.
[492] Mind, 'Neurosurgery for mental disorder' <www.mind.org.uk/information-support/drugs-and-treatments/neurosurgery-for-mental-disorder-nmd/> accessed 14 July 2024.
[493] Robert Crowcroft, Kevin Theakston, The fall of the Attlee Government 1951 in Timothy Heppell,

Labour party winning the 1950 General Election, the majority was so slim (5 seats), that the King influenced Atlee to call a further election which resulted in a 17-seat majority for Churchill's Conservative Party.[494] It was this new Government which set up the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency,[495] chaired by Baron Percy of Newcastle with the following mandate:

> To inquire, as regards England and Wales, into the existing law and administrative machinery governing the certification, detention, care (other than hospital care or treatment under the National Health Service Acts, 1946–52), absence on trial or licence, discharge and supervision of persons who are or are alleged to be suffering from mental illness or mental defect, other than Broadmoor patients; to consider, as regards England and Wales, the extent to which it is now, or should be made, statutorily possible for such persons to be treated, as voluntary patients, without certification; and to make recommendations.[496]

On the face of this, the trajectory appears to continue the path of reducing compulsion, and suggests again that mental illness and mental defect are different, but Gostin noted that they were conjoined in this review and the subsequent legislation.[497] Fennell notes that the Percy Commission was established ostensibly in response to what were seen as cases of wrongful detention, but noted that the Ministries and the Board of Control had a separate reform agenda.[498] The purpose of such Commissions is to consider on a cross party, non-partisan basis, but with an expert lens.[499] Fennell is highly critical of the Board of Control during the 1950s, noting that over seven hundred patients had been wrongfully detained based upon their policy guidance.[500]

Kevin Theakston (eds), *How Labour Governments Fall: From Ramsay Macdonald to Gordon Brown* (2013 Palgrave Macmillan) 64-85.

[494] Brian Brivati, 'Every loser wins' (2005) *The Guardian* Monday 4 April 2005.

[495] Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (n453).

[496] Hansard HC Deb 22 October 1953 vol 518 cols 2153-6 at 2153.

[497] Larry Gostin, *Mental Health Services: Law and Practice* (2000 Shaw and Sons 18th Ed) para 1.07.5.

[498] Fennell (n433) 164.

[499] Joan Rapaport, Jill Manthorpe, 'Fifty Years On: The Legacy of the Percy Report' (2009) Journal of Social Work 9(3): 251, 253.

[500] Fennell (n433) 164-5.

The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 1954-1957 reported in May 1957.[501] The main conclusions and recommendations included recognising mental illness in the same way that physical illness was recognised at the time, and challenging the assumption that detention was required for treatment. The Commission recommended that,

> [T]he law should be altered so that wherever possible suitable care may be provided for mentally disordered patients with no more restriction of liberty of legal formality than is applied to people who need care because of other types of illness, disability or social difficulty.[502]

This was also supported by the recommendation that admission for a mental illness should not result in the diminution of a patient's rights or status, even if that admission was compulsory.[503] Other recommendations included nuancing terminology in relation to mental illness and mental defective, but it remains astonishing to see a government report, less than 70 years old, referring to the "feeble minded", "moral defectives", or "idiots".[504]

The Commission's report did however give reference to a new grouping of patients, those in "psychopathic states", who, "have seriously aggressive characteristics".[505] Highly significant though was the recommendation to change the existing "certification" approach, which at that point meant that a magistrate was required to authorise detention, to one requiring the agreement of two doctors.[506] In post-war Britain, it was therefore recommended that detention could now be approved *without* judicial involvement, with any oversight provided through the setting up of Mental

[501] Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (n453).
[502] ibid para 7, 3-4.
[503] Gostin (n497) para 1.08.3.
[504] Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (n453) paras 9-11, 4.
[505] ibid para 15, 5.
[506] ibid para 42, 11.

Health Review Tribunals.[507] Gostin noted that this, if taken up, meant for the first time since 1774 that there were to be no pre-detention judicial controls.[508]

When we consider the post-war experience, it should be noted that while this recommendation suggested reducing judicial oversight, in Germany this was a very different matter and indeed the direction of opposite travel continues today. Detention for mental health conditions in Germany is strictly monitored, and it has been said that:

> Because the courts are involved in the process, the degree of adherence to these laws in Germany is probably very high. Medical doctors who do not follow these rules and admit or even treat patients against their will without obtaining the appropriate court permission would be subject to severe legal punishment'. with detention very much a legal process in Germany.[509]

Where German law has sought to ensure avoidance of historical atrocities, and reinforces the need for legal protections before detention, in the UK this was a journey from legal protections to detain to one where the medical profession make the decision. As Miller noted, '(M)odern Germany's historical encounters with violent authoritarian, anti-democratic, and terrorist movements have endowed it with a wealth of constitutional experience in balancing security and liberty.'[510] The experience of World War Two has led to legislation focussed on the patient's rights, motivated by restricting medical and family powers.[511]

---

[507] ibid para 42(vii), 14.
[508] Gostin (n497) para 1.08.2.
[509] Jürgen Zielasek, Wolfgang Gaebel, 'Mental health law in Germany' (2015) BJPsych International Vol 12 Number 1 February 2015 14, 15.
[510] Russell A Miller, 'Balancing Security and Liberty in Germany' (2010) Journal of National Security Law & Policy Vol 4:369.
[511] Hanns Rüdiger Röttgers, Peter Lepping, 'Treatment of the mentally ill in the Federal Republic of Germany' (1999) Psychiatric Bulletin 23 601.

In 1949, the Federal Republic of Germany passed the Basic Law for the Federal Republic of Germany.[512] Article 104 sets requirements for judicial involvement in any deprivation of liberty, and the Civil Code requires that the sixteen different State laws however can only provide for compulsory treatment by means of a court order. This requires the involvement of the city council, a doctor (who does not take part in the decision-making), and the patient. Such applications are usually made by the local police or the treating doctor and the only grounds for enforced hospitalisation are that, 'there is a danger to his health that cannot otherwise be dealt with'. There are no powers held by medical or nursing staff to impose compulsion.[513] Such detention is very limited and does not provide for compulsory treatment against the patient's will, with Röttgers and Lepping noting that the German Supreme Court[514] upheld the patient's right to suffer an illness so long as it does not represent an immediate danger. Indeed, they refer to this as, '"the right to be ill", and to maintain a mental illness'.[515] This approach has been further clarified in the German Federal Constitutional Court in 2 BvR 882/09, which notes that:

> Coercive medical treatment administered to achieve the confinement's objective is only permissible if, due to illness, the confined person lacks the mental capacity for insight into the necessity of medical treatment or for acting upon this insight. Coercive medical treatment may only be used as a last resort, and only if the prospects of success in respect of the objective of the treatment justifying the measures are good and if it does not burden affected persons disproportionately to the benefit that car reasonably be expected. [516]

[512] Basic Law for the Federal Republic of Germany in the revised version published in the Federal Law Gazette Part III classification number 100-1 as last amended by the Act of 19 December 2022 (Federal Law Gazette I p 2478).
[513] Röttgers (n511) 602.
[514] ibid.
[515] ibid.
[516] BVerfG, Order of the Second Senate of 23 March 2011 - 2 BvR 882/09 - paras 1-82

Fennell,[517] Jones,[518] and Unsworth[519] welcomed the medicalisation approach taking over from the legalistic management of existing legislation recommended in the Percy Report, but it appears to me that this had the unintended consequences creating a power imbalance. Doctors treating patients would hold the decision-making powers for detention, potentially resulting in a "do as doctor says, or else" risk to patients who may disagree with treatment options. It also seems that there was a failure to recognise the potential for harm to therapeutic relationships by placing the powers with the doctors who patients would need to trust with their liberty. This is a theme which we will also explore in the development of legislation through the latter part of the twentieth century and into the twenty first, in this chapter and in Chapter Five.

Incidentally, before the Percy Commission Report was debated in Parliament, the Homicide Act 1957 set out the criteria for diminished responsibility:

> (1) Where a person kills or is a party to the killing of another, he shall not be convicted of murder if he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts and omissions in doing or being a party to the killing.
> (2) On a charge of murder, it shall be for the defence to prove that the person charged is by virtue of this section not liable to be convicted of murder.
> (3) A person who but for this section would be liable, whether as principal or as accessory, to be convicted of murder shall be liable instead to be convicted of manslaughter.[520]

This provided for a partial defence to murder on the basis of a recognised medical condition of 'abnormality of mind', providing an additional defence to that of insanity, though this in itself poses questions as to the motive for such an option.[521]

---

[517] Fennell (n115) 38.
[518] Jones (n425).
[519] Clive Unsworth, *The Politics of Mental Health Legislation* (1987 Clarendon Press Oxford) 230-231.
[520] Homicide Act 1957 s 2.
[521] It has been noted that the insanity defence is perceived negatively by the public as an opportunity for the defendant to avoid paying for their crimes, Chioma Ajoku, 'The Insanity Defense, Public Anger,

The Percy Commission Report though did lead to Parliament bringing forward the 1959 Mental Health Act which was based almost entirely on those recommendations.[522] This was new legislation, in so far as it was intended to repeal 15 Acts in full and 37 Acts in part.[523] This contrasts significantly with attempts at modernising mental health legislation in the early twenty first century as will be discussed later in this chapter. The main principles underpinning the 1959 Act were:

> 1. That such treatment as possible, both in hospital and outside, should be given on a voluntary and informal basis.
> 2. That proper provision should be made for the residual category of cases where compulsion was necessary, either in the interests of the patient, or in the interests of society.
> 3. That the Act as a whole should be seen against the background of the desirability of shifting the emphasis in mental cases as far as possible from institutional care to care within the community.[524]

The introduction to the Mental Health Act 1959 took on board the principles of the Percy Commission,[525] with the Act having eight key impacts:

1. It provided a single legal code for all types of mental disorder
2. It provided a definition of 'Mental Disorder'
3. It abolished the Board of Control, providing for local health authorities to take on the role of inspection and review
4. It set out what services might be included under s.28 of the National Health Service Act 1946[526]
5. It Provided for Mental Health Review Tribunals on a regional basis to act as the 'watchdog'
6. There were to be no formalities associated with admission to hospital and so long as the patient did not positively object to the detention, they did not need to be detained[527]

---

and the Potential Impact on Attributions of Responsibility and Punishment' (2015), PhD Submission to The City University of New York <https://academicworks.cuny.edu/cgi/viewcontent.cgi?article=1844&context=gc_etds> accessed 16 November 2024 1-3. This is clearly and area which offers significantly more opportunity for debate but is included here to identify further the challenges faced by the mentally ill when engaging with the law.

[522] Claire Hilton, 'Changes between the 1959 and 1983 Mental Health Acts (England & Wales), with particular reference to consent to treatment for electroconvulsive therapy' (2007) History of Psychiatry 2007 18 (2) 217, 219.

[523] Hansard HC Deb 26 January 1959 vol 598 cols 704-840 at 704.

[524] National Archives, 'Ministry of Health: Mental Health Act 1959' General Policy Registered Files (95,200 Series) Ref MH 140 <https://discovery.nationalarchives.gov.uk/details/r/C10978> accessed 14 July 2024.

[525] Gostin (n457) para 1.08.5.

[526] National Health Service Act 1946 s 28

[527] This approach to considering admission as voluntary where a patient may lack capacity to positively object is worth noting for consideration when we discuss the *Bournewood* case *HL v UK* 45508/99 [2004] ECHR 471 later in this chapter.

7. There were three kinds of compulsory admission which conformed with existing practice, other than they no longer required a magistrate's certificate
8. Informal patients could discharge themselves at any time, and detained patients would be discharged when an order lapsed without renewal.[528]

The Mental Health Act 1959 still forms the basic framework of modern England and Wales mental health legislation.[529]

Throughout the 1950s and onwards, psychiatrists continued with experimental treatments and new medications. These included electroconvulsive therapy (ECT),[530] Largactil[531] (chlorpromazine, referred to by the Daily Mirror as "Liquid Cosh"[532]), and haloperidol.[533] These new medications provided for significant improvements in treated patients but soon these patients experienced debilitating side effects.[534] As noted in Chapter One, ECT continues today as does the use of haloperidol and chlorpromazine,[535] despite the concerns over these forms of treatment.

The 1960s and 1970s – More conflicts, challenges, and the growth of the rights movement

There was little legislative change in the 1960s in relation to mental health. Of note, the Suicide Act 1961 meant that suicide was no longer a crime, though it retained the phrase "commit suicide" with all the stigma associated with the commission of an offence.[536] The Sexual Offences Act 1967, introduced by Welsh MP and lawyer Leo Abse, decriminalised homosexuality, and, through ss.1(3)(4), extended protection to

[528] Jones (n425) 156-157.
[529] Fennell (n115) 37.
[530] Nicholas Bakalar, '1940: Electroshock Therapy' *The New York Times* 21 July 2024.
[531] Winston W Shen, 'A History of Antipsychotic Drug Development' (1999) Comprehensive Psychiatry Vol 40 No 6 407, 408.
[532] BMJ, 'The "liquid cosh" libel' (1983) Vol 286 8 January 1983,153.
[533] Shen (n531) 409.
[534] ibid.
[535] British National Formulary 2024 <https://bnf.nice.org.uk/> accessed 21 July 2024.
[536] Suicide Act 1961 s 1.

male patients detained under the Mental Health Act 1959 from sexual assault perpetuated by male staff, where previously this only related to female patients.

1964 saw the formation of the Welsh Office with initial responsibility for housing, local government, and roads, and 1969 saw the start of the Northern Ireland conflict. The financial situation in the UK became dire with deflation and devaluation of the pound.[537] It was more however the political changes in the UK that impacted on mental health, with 1961 seeing the announcement by the Minister for Health Enoch Powell that mental hospitals were to be abolished, and half the mental health beds cut.[538] Powell set out in this speech an intention to transition such services to the community but suggested that this would be the responsibility of local health and welfare authorities to develop.[539] Unsworth views this as both an opportunity to reduce public spending, and one of demonstrating more right leaning vision by expecting self-reliance and the importance of the family.[540]

The changes that followed provided the foundations of what is understood as Community Care, including industrial therapy, day centres, social work involvement in mental health, and therapeutic communities.[541] There was a significant reduction in beds and bed occupancy between 1954 and 1969 with a 15% reduction in bed availability and a 23.6% reduction in bed occupancy.[542] However, the period 1968-1977 also saw multiple scandals, tragedies, and issues of neglect, one of which led to

[537] Nuffield Trust, 1968-1977: Rethinking the National Health Service <www.nuffieldtrust.org.uk/chapter/1968-1977-rethinking-the-national-health-service-1> accessed 20 July 2024.
[538] Jones (n425) 158; J Enoch Powell, 'Address to the National Association of Mental Health Annual Conference' (9 March 1961) <www.nuffieldtrust.org.uk/sites/default/files/2019-11/nhs-history-book/58-67/powell-s-water-tower-speech.html> accessed 21 July 2024.
[539] Powell (n538).
[540] Clive Unsworth, *The Politics of Mental Health Legislation* (1987 Clarendon Press Oxford) 262.
[541] ibid 262-263.
[542] Nuffield Trust (n537).

the Ely Report in March 1969.[543] In 1967, Ely Hospital in Cardiff became the focus of national news when a Nursing Assistant made allegations of misconduct against other staff in respect of their treatment of patients.[544] An inquiry was set up and chaired by Geoffrey Howe,[545] later Lord Howe of Aberavon,[546] which found that most of these allegations were true,[547] and identified systemic failures for the treatment of the 'mentally subnormal'.[548]

Mark Drakeford, former First Minister of Wales, wrote, as the constituency Assembly Member, in 2012 of how in his view, the Ely Hospital inquiry had a profound impact on the care of people with learning difficulties.[549] Drakeford reflected on the impact of the community care approach resulting in mental health system changes having the unintended consequences of diminishing care for those with learning difficulties.[550] This was the view too of the Richard Crossman, Secretary of State for Social Services at the time:

> I hope the House will permit me one further general observation. We are in the midst of a medical revolution in the treatment of the diseases of old age and mental illness. As the span of life is extended, long-term, often permanent, hospitalisation, which only 20 years ago was the norm for these patients, is being replaced by intensive treatment given in short spells in hospital. In planning the Health Service of the future, therefore, we are able to assume a massive reduction in the proportion of hospital beds—and of long-stay hospitals—required for geriatric and mentally ill patients.
> Unfortunately, this does not apply to anything like the same extent to the mentally subnormal. For the foreseeable future many thousands of them will need resident hospital care for very long periods; and this means that there is

[543] ibid.
[544] Department of Health and Social Security, 'Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff' (March 1969) Cmnd 3975 Introduction.
[545] Susanna Shapland, 'Scandal that led to hospital closures' (2022) Community Living Winter 2022 <https://communitylivingmagazine.com/scandal-that-led-to-hospital-closures/> accessed 20 July 2024.
[546] 'Lord Howe of Aberavon' (2024) UK Parliament MPs and Lords <https://members.parliament.uk/member/872/career> accessed 21 July 2024.
[547] BMJ (1969), 'Mental Hospital Commissioners' Br Med J 1969;2:6.
[548] Hansard HC Deb 27 March 1969 vol 780 cols 1808-20 Col 1810.
[549] Mark Drakeford, 'Why the Ely inquiry changed healthcare forever' (2012) *WalesOnline* 6 Feb 2012 <www.walesonline.co.uk/news/health/ely-inquiry-changed-healthcare-forever-2041200> accessed 20 July 2024.
[550] ibid.

> no prospect of doing without this class of hospital, which I am afraid still remains a deprived area within the Health Service as, indeed, it was long ago when the Service came into being. The advice issued by my Department in 1965 to stimulate improvements, which this Report commends, was a good beginning. It shows what can be done. These hospitals must be given their fair share of manpower and money, even if this means, as it will mean, a reallocation of resources within the Health Service.[551]

Drakeford suggests that commentators attribute the closure of long stay hospitals and the resettlement approach to the events at Ely,[552] but Ely was not alone in providing poor care or indeed abusing patients. From 1965 and well into the 1970s saw a pattern of catastrophic failures of care.[553]

In 1969, Richard Crossman, now as Secretary of State for the Department of Health and Social Services, established the Health Advisory Service as an independent inspectorate.[554] While many of these issues were clearly based on evidence and dreadful experiences, Jones also suggests that there was a period of 'moral panic' in the 1970s fuelled by popular journalism.[555] Nevertheless, this did have the impact of drawing attention to a system where people with what we now consider as having intellectual disabilities and those with mental illness was failing as a consequence of the restructuring plans set out by Powell.[556] The mid-1970s was also where Mind[557] published the work of Larry Gostin in his role as their legal officer which Fennell[558] believes significantly influenced the development of the Mental Health Act 1983.

[551] Hansard (n548).
[552] Drakeford (n549); Louise Hide, Mental hospitals, social exclusion and public 'Scandals', in George Ikkos, Nick Bouras, (eds), *Mind, State and Society: Psychiatry and Mental Health in Britain 1960-2010* (2022 Cambridge University Press) 60, 66.
[553] Hide (n552) 64.
[554] ibid 65.
[555] Jones (n425) 188-189.
[556] Powell (n539).
[557] Mind at this point was still known as the National Association for Mental Health.
[558] Fennell (n115) 43.

1975 saw both a review of progress of these plans, and minor amending legislation[559] to clarify the definition of psychopathy, and to address some of the difficulties in the 1959 Act[560] in respect of age limits.[561] The report from the Department of Health and Social Security identified that no hospital had closed, admissions were rising, and both staffing and facilities had some way to go.[562] 1975 also saw the publication of the Butler Report[563] which considered the treatment of mentally disordered offenders without consent. While this is not the focus of this thesis, it is of note however that Mind submitted evidence suggesting that irreversible treatment should be subject to approval by the Mental Health Review Tribunal.[564] Additionally, Fennell notes that Mind argued that there was a requirement to ensure that any such treatment without consent must comply with Article 3 of the European Convention on Human Rights,[565]an approach ahead of its time. The Butler Report also focussed significantly on 'The concept of dangerousness',[566] which it noted should not be applied without qualification as it depends upon the personality and the circumstances the individual experiences.[567] This is a useful point to note for discussions which will follow in relation to the use of Dangerous Severe Personality Disorder as a label introduced by the Labour Party in 2001 ahead of their attempts to develop new mental health legislation.[568]

[559] Mental Health (Amendment) Act 1975.
[560] Mental Health Act 1959.
[561] John Finch, 'Mental Health (Amendment) Act 1975' (1976) The Modern Law Review 39(1) 70, 70–76.
[562] Jones (n425) 190-191.
[563] Home Office, Report of the Committee of Mentally Abnormal Offenders (HMSO 1975) Cmnd 6244.
[564] Fennell (n433) 172-173.
[565] ibid 173.
[566] Home Office (n563) 56.
[567] ibid 56-57.
[568] Connor Duggan, 'Dangerous and severe personality disorder' (2011) British Journal of Psychiatry. 2011;198(6):431.

Returning to the review of the Mental Health Act 1959, Barbara Castle, Secretary of State at the Department for Health and Social Services introduced a White Paper entitled 'Better Services for the Mentally Ill'.[569] This supported the direction of travel of the intention behind the 1959 Act,[570] suggested even greater reductions in inpatient provision, the development of a therapeutic team, and integrated community care.[571] This also appears to be the point at which there was a more significant recognition of the medical and social models of care for the mentally ill in that there was to be a combined team, though as Jones notes, there were a number of assumptions made.[572] These assumptions included a view that beds could be cut to one seventh of those available in 1961, there would be sufficient skilled staffing, and that the administrative split between health and social services was of little concern.[573] All three of these assumptions, when we consider matters today, appear excessively ambitious, but at the time, the paper was referred to as "Castles in the Air" in reference to the Minister and the lack of groundedness.[574]

Jones reflects that the discord between the medical and social models of care provided opportunities for politicians to use which ever model suited them to reduce mental health spending.[575] The timing of this was remarkably unhelpful, with the change of government in 1979 to a Thatcher administration leading to a period of turmoil in industrial relations, and a new form of economic policy which sought to reduce the

[569] Department of Health and Social Services, Better Services for the Mentally Ill (London HMSO 1975) Cmnd 6233.
[570] Mental Health Act 1959.
[571] Jones (n425) 190-191.
[572] ibid.
[573] ibid 191-192.
[574] Geoffrey Rivett, 'Castles in the air' (2010) Health Service Journal 20 October 2010.
[575] Jones (n425) 192.

cost of the Welfare State.[576] 1979 also saw a referendum on St David's Day to establish a new elected body for Wales with devolved powers; this referendum was rejected by a majority of 4-1.[577]

The 1980s – Thatcherism, and a new Act

Important context for the changes in both legislation and practice in the 1980s should start with noting the impact of the change of government at the end of the 1970s. In 1979 Margaret Thatcher's Conservative government took office and it was clear early on that the intention was to follow through with the policies that the earlier Heath government had failed to deliver having been defeated by the unions.[578] The country was in recession, and unemployment high.[579] While the Thatcher government did not, as some expected, privatise the NHS, it did introduce a business management culture and the development of personal choice and competition in health care.[580] During the 1980s, there were many power battles between general management and doctors and nurses,[581] despite the 1983 Griffiths report recommending that clinicians should be more closely involved in decision making.[582]

[576] Alex Scott-Samuel, and others, 'The Impact of Thatcherism on Health and Well-Being in Britain' (2014) International Journal of Social Determinants of Health and Health Services Vol 44 Iss 1 53, 54.
[577] Senedd Cymru, 'History of Devolution' (7 October 2020) <https://senedd.wales/how-we-work/history-of-devolution/> accessed 11 August 2024.
[578] Scott-Samuel (n576) 55.
[579] Thomas Weston, 'The UK economy in the 1980s' (2004) UK Parliament House of Lords Library 29 May 2024 <https://lordslibrary.parliament.uk/the-uk-economy-in-the-1980s/#:~:text=The%20upshot%20of%20all%20of,time%20since%20the%20interwar%20depression> accessed 28 July 2024.
[580] Scott-Samuel (n576) 61.
[581] The Health Foundation, 'Griffiths report on management in the NHS' <https://navigator.health.org.uk/theme/griffiths-report-management-nhs> accessed 28 July 2024.
[582] The King's Fund, 'The changing role of managers in the NHS (2010) <www.kingsfund.org.uk/insight-and-analysis/articles/changing-role-managers-nhs> accessed 28 July 2024.

In terms of the development of legislation, a new focus on civil rights, often bled over from the work in the United States, and this, supported by the strengthening role of Larry Gostin at Mind, carried great weight[583] in the debates around mental health legislation in the UK. The acceptance by the Royal College of Psychiatrists and the DHSS[584] that change was necessary, led[585] to the Mental Health (Amendment) Act 1982, though the legislation itself was not well received by Mind or the Royal College of Psychiatrists.[586] The legislative changes included in the 1982 Act[587] excluded sexual deviancy, and alcohol or drug dependency in isolation, from being considered a mental disorder.[588] There were also a number of clarifications around the use of treatment without consent,[589] and the duty on managers of hospitals to refer the use of detention to the Mental Health Review Tribunal, even if the patients has not done so.[590] A major change too was the requirement for 'second opinion doctors'[591] where there was consent from the patient, but the nature of the treatment was such that it may have permanent effect.[592] The 1982 Act also established the Mental Health Act Commission to oversee the use of the statute and the care and treatment of those detained,[593] and under s.16 introduced what later became the Approved Social Worker function.

In 1983, the Mental Health Act 1959 and the Mental Health (Amendment) Act 1982 were consolidated[594] into a new Act, the Mental Health Act 1983 (MHA 1983), an Act

[583] Hilton (n522) 221-225.
[584] Department for Health and Social Services
[585] Hilton (n522) 225.
[586] Larry Gostin, Derek R Davies, 'Consent to psychiatric treatment' (1982) Letter to the BMJ Vol 284 (6333): 1945 Jun 26 1982; Hilton (n522) 225.
[587] Mental Health (Amendment) Act 1982.
[588] Mental Health (Amendment) Act 1982 s 2(2).
[589] ibid ss 3-8.
[590] ibid s 40.
[591] Mental Health Act 1983 Part IV.
[592] Mental Health (Amendment) Act 1982 Part VI.
[593] ibid s 56.
[594] Hilton (n522) 225.

which owed much to the work of Gostin and Mind.[595] Fennell notes that the MHA 1983 gave both additional protections in relation to detention and increased flexibility in the use of detention.[596] Jones also reflected that the introduction of the new MHA 1983 resulted in the need for considerable clarification and interpretation.[597] What was clear though was that this new legislation used the terminology 'mental health', where in fact its key powers were in relation to the deprivation of liberty of patients, and treatment without consent, under the guise of protection of the public. There were protections for the detained patient, but no guarantee that the treatment they were detained to receive would be available: a theme that was subsequently picked up in the review of the MHA 1983[598] by Genevra Richardson.[599] Jones was critical of the MHA 1983 in so far as how it impacted on providing effective community-based services,[600] but the legislation itself was not new, did not seek to set treatment or patient outcomes, nor did it address service structures.

Post Griffiths Report[601] - The 1990s and into the new Millennium

In 1988, Griffiths produced his report recommending effective targeting of resources, voice and choice for the consumer, and a focus on enabling people to remain in their own homes.[602] There is little to disagree with in such principles, though when we consider Rhodri Morgan's Clear Red Water[603] speech, individual choice in public

[595] ibid 225-226.
[596] Fennell (n115) 127.
[597] Jones (n425) 206.
[598] Mental Health Act 1983.
[599] Department of Health (n7) 1-2.
[600] Jones (n425) 213.
[601] Sir Roy Griffiths, 'Community Care: Agenda for Action. A report to the Secretary of State for Social Services' (1988) London: HMSO.
[602] David J Hunter, 'Griffiths and community care: meeting the challenge' (1988) Kings Fund Institute, London <https://archive.kingsfund.org.uk/concern/published_works/000002255?locale=es#?cv=9&xywh=-50,146,886,506> accessed 28 July 2024.
[603] Morgan (n10) "The Assembly Government attaches a positive value both to diversity and innovation and also to responsiveness to the needs of users of public services. We firmly believe, however, that such receptivity is best achieved through strengthening the collective voice of the citizen".

services is seen as less important that universalism and the collective voice of the citizen. Such divergence of perspectives will be discussed in further detail in relation to why Wales offers an opportunity to provide patients with greater rights in line with a citizenship approach. The Griffiths Report was followed by a White Paper, 'Caring for people: community care in the next decade and beyond',[604] which led to the National Health Service and Community Care Act 1990. This introduced the concept of contracting out of non-clinical services, and the creation of the purchaser provider split between GP and service providers.[605] I worked in the first NHS Trust body in Wales in Pembrokeshire, an organisation that became the subject of an independent review into the impact of the changes. This review found that at least three quarters of a million pounds per year had been diverted from health care into management and administration which had increased by 90 per cent over two years, and increased management salaries.[606]

The legislation was focussed on moving away from the State necessarily providing all services and created the principle of the funds following the patient, allowing patients to be treated wherever their referring GP might wish to send them.[607] This also resulted in the separation of services previously provided free as part of NHS provision, and now moved into the ambit of local authorities who could charge individuals for their social care.[608] Such changes also included services for people with mental illness, with the exception of those patients who, having previously been detained under ss.3, 37,

[604] Department of Health, Caring for People: Community Care in the Next Decade and Beyond (HMSO 1989) Cm 849.
[605] Scott-Samuel (n576) 62.
[606] UK Parliament, 'Financial Crisis in Pembrokeshire NHS' Early Day Motion EDM 1186 (9 May 1994).
[607] Department of Health, 'Working for Patients' (1989) HMSO.
[608] John Lister, 'When Margaret Thatcher Privatised Social Care', (2020), The Tribune 10.12.2020 <https://tribunemag.co.uk/2020/12/when-margaret-thatcher-privatised-social-care> accessed 28 July 2024.

45A, 47, or 48, fell under s.117 of the MHA 1983.[609] Community care was not a new concept; as noted earlier, it was a main driver for Enoch Powell in the Water Tower speech which led up to the Mental Health Act 1959.[610] The challenge was that the lack of resources over many years, poor communication, and conflicting care management systems, joined up care in the community was not guaranteed.[611]

This was a key finding in the case of the homicide of Jonathan Zito at the hands of schizophrenia patient Christopher Clunis in 1992.[612] Clunis pleaded not guilty to murder but guilty to manslaughter, and this was accepted, with disposal under ss. 37/41 of the Mental Health Act 1983.[613] Jeremy Laurance, health editor of The Independent was provided with a Joseph Rowntree Foundation Journalist's Fellowship to conduct an investigation into the state of mental health care for his book *Pure madness: how fear drives the mental health system*.[614] In this work he discussed how risk avoidance has impacted on the care of the severely mentally ill while reflecting that proportion of individuals who may pose a serious risk are around 1:10,000 of the whole population.[615] In considering the impact of the Clunis case, and the subsequent inquiry, Laurance highlights a particular focus. He notes that while:

> community care policy…worked well for the vast majority of mentally ill people, [the inquiry] warned that there was a serious risk that repeated violent attacks by mental patients would discredit the policy and 'exceptional means' were required to prevent them.[616]

[609] Mental Health Act 1983 s 117 After-care.
[610] Powell (n539).
[611] Alan Simpson, Carolyn Miller, Len Bowers, 'The history of the Care Programme Approach in England: Where did it go wrong?' (2003) Journal of Mental Health (October 2003) 12 5 489.
[612] Coid (n40) 449-452.
[613] Jean Ritchie, 'The Report of the Inquiry into the Care and Treatment of Christopher Clunis' (1994) HMSO 103.
[614] Jeremy Laurance, *Pure madness: how fear drives the mental health system*, (2003 Routledge), p. x.
[615] ibid xiv.
[616] ibid xv.

He attributes one sentence from the Inquiry Report that led to a more coercive approach to mental health services: "The serious harm that may be inflicted by severely mentally ill people to themselves or others is a cost of care in the community which no society should tolerate."[617]

The Clunis case was followed soon after by that of Ben Silcock, who also had schizophrenia, and in 1992 climbed into the lion enclosure at London Zoo carrying two turkeys to share with the animals.[618] Silcock required significant treatment, and the subsequent furore again focussed on the need to hospitalise the mentally ill, blaming care in the community for this incident.[619] It is however interesting to note that 10 similar incidents occurred in London, Amsterdam, Washington, Germany, and South Africa, all of which can hardly be the fault of the UK community care approach.[620] This did not however reduce the appetite for the media for such lurid stories, nor for those who felt that asylums were the best place for people to be cared for.[621] Jayne Zito, Jonathan Zito's widow set up the Zito Trust which campaigned for improvements to mental health services; but unlike other such organisations, Zito advocated for greater use of detention and compulsory medication.[622]

Around this time, and likely in response to such cases, new legislation was proposed to provide a legal route to recall patients who may pose a risk on discharge from their

[617] ibid xv.
[618] Marjorie Wallace, 'Ben's Life outside the lions' den' (1993) *The Times* Dec 31 1993 16.
[619] Judy Jones, 'Care in the community: Ben Silcock's mauling by a lion at London Zoo has highlighted the plight of the mentally ill. Judy Jones examines the theory and practice behind closing psychiatric hospitals' (1993) *The Independent* Sunday 10 January 1993.
[620] Bennett (n41) 565-566.
[621] Laurance (n614) xvi.
[622] Owen Bowcott, 'Jayne Zito: why it's time to end campaign' (2009) *The Observer* Sun 17 May 2009.

detention.[623] The Mental Health (Patients in the Community) Act 1995 provided for aftercare under supervision, a forerunner of what we know as Community Treatment Orders (CTOs) under the Mental Health Act 2007. Both of these measures appeared to be political in nature,[624] and indeed, the recent Independent Review of the MHA 1983 stated that, 'CTOs are in the "Last Chance Saloon"'.[625]

This period in the mid-1990s was the beginning of a period where every case of homicide involving mental health services came under even greater scrutiny,[626] and further high profile cases were almost celebrated in the press in a way not seen elsewhere.[627] 1996 saw two high profile cases, one of which involved a class of children and their teacher, Lisa Potts, attacked by Horrett Campbell who had paranoid schizophrenia;[628] the other the Russell murders.[629] This last case seemed to offer a new opportunity to justify increasing the scope of detention as Michael Stone, who was convicted of these murders, was considered to have a personality disorder[630] which could not be treated, and was thus not detainable.[631] This led to the introduction of the Dangerous and Severe Personality Disorder (DSPD) Programme.[632] This became a significant part of the rationale for the planned amendments to the Mental Health Act 1983[633] which were developed in the early 2000s and will be discussed later.

---

[623] Nigel Eastman, 'The Mental Health (Patients in the Community) Act 1995: A clinical analysis' (1997) British Journal of Psychiatry 1997;170(6):492, 492-493.
[624] ibid 492; Simon Lawton-Smith, John Dawson, Tom Burns, 'Community treatment orders are not a good thing' (2008) British Journal of Psychiatry (2008) 193 96, 96.
[625] Department of Health and Social Care (n50).
[626] Laurance (n614) xviii.
[627] ibid xviii.
[628] BBC, 'Lisa Potts: Freedom of Wolverhampton honour for machete heroine' (2002) <www.bbc.co.uk/news/uk-england-birmingham-60592123> accessed 5 August 2024.
[629] Sirin Kale, 'The Russell murders: is Michael Stone in prison for a brutal crime he didn't commit?' (2023) *The Guardian* Wed 22 Nov 2023.
[630] Andy Davies, 'Dangerous offenders scheme to be axed' (2010) *Channel 4 News* 15 Feb 2010 <www.channel4.com/news/dangerous-offenders-scheme-to-be-axed> accessed 5 August 2024.m
[631] Laurance (n614) xviii.
[632] Duggan (n568) 431.

Earlier in 1996, Alan Milburn, who later became the Secretary of State for Health, commented on the report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People,

> It is all too common for psychiatrists to have to spend hours on the telephone desperately trying to find an acute bed for someone who is severely mentally ill. Quite simply, there are not enough appropriate beds available for patients when they need them. There are not enough facilities in the community. The Audit Commission, in its recent report "Finding a Place", argued that comprehensive mental health care facilities in the community had been slow to develop. As a consequence, in too many parts of the country the cart has been put before the horse. There was a rundown in acute provision before the introduction of appropriate community facilities. There must be a balance in provision to deal with the serious concerns that have been highlighted both in today's debate and in yesterday's report.
> There is need for emergency action to deal with the shortfall in provision and the issues of public confidence that have been raised. I have four brief suggestions. First, there should be a moratorium on further acute bed closures pending the development of an appropriate community infrastructure. Secondly, there should be immediate implementation of the care programme approach in all parts of the country. There has been yet another delay in implementation--with the latest deadline now being the end of March--yet the programme was due to be implemented in April 1991. Thirdly, there must be urgent action to deal with the problem of staff shortages, which is compromising patient care. Fourthly, over time, there should be changes to the mental health funding allocation formula so that cash ends up going where it is most needed. We all know that the inner cities experience a particular problem. Without urgent action, I fear that, before too long, the House will again be debating the same issues, but also a new round of tragedies involving mentally ill people.[634]

Contrasting Milburn's 1996 remarks with those as Secretary of State in 2000, it seems that despite him suggesting that his government had invested significantly in and reformed the NHS to the tune of £330M to provide reform, public protection was the real priority.[635]

> Public confidence in care in the community has been undermined by failures in services and failures in the law.
> The policy lost public confidence because, in too many cases, neither services nor the law properly protected either patients or the public. There have been no requirements for local health and social services to exchange relevant information about patients. Services have too often worked in isolation from one another. Too often, severely ill patients have been allowed to drift out of contact with mental health services altogether. Many patients have failed to

[634] Hansard HC Deb 17 January 1996 vol 269 cols 655-73 at 670.
[635] Hansard HC Deb 20 December 2000 vol 360 cols 361-75 at 362.

> comply with treatment. Clinicians have been in the absurd position of having to wait until patients in the community become ill enough to require admission to hospital. That prevented early intervention to reduce the risks to both patients and the public. In particular, existing legislation has failed to provide adequate public protection from those whose risk to others stems from a severe personality disorder.[636]

His predecessor as Health Secretary had been even more blunt. Frank Dobson in 1998 told Parliament that "care in the community has failed",[637] going on to state:

> [T]here is a small group of people with an untreatable psychiatric disorder, which makes them dangerous. At present, neither law nor practice are geared to cope with them. They cannot be taken into a mental hospital if they will not respond to treatment, and they cannot be put in prison unless they have committed an offence. If they are sent to prison, they can be a danger upon their release. Therefore, the Home Secretary and I are considering proposals to create a new form of renewable detention for people with a severe personality disorder who are considered to pose a grave risk to the public.[638]

This statement from the Health Secretary in the same year that the Human Rights Act 1998 (HRA 1998) came into force appears remarkable. Both Health Minister and Home Office Minister sought to find a way to detain people who have not committed an offence, by claiming they have a legitimate psychiatric condition, thus allowing detention compliant with the HRA 1998[639] which gave effect to the ECHR. Ethically, treatment must be in the patient's best interests,[640] and an approach where it is considered to be in the patient's best interests to detain them in order to protect others, relies heavily on extrapolating the impact of such a consequence for the patient.

With the new HRA 1998, it was clear that detention without obtaining a conviction for individuals who had not yet caused harm but were considered dangerous, would fall

[636] ibid.
[637] Hansard, HC Deb 8 December 1998 vol 322 cols 145-58 at 146.
[638] ibid.
[639] Lisa Wootton, Tom Fahy, 'Dangerous severe personality disorder: beyond the ethical boundary of psychiatry' (2007) Psychiatry Volume 6 Issue 2 2007 52.
[640] ibid 54.

foul of Article 5 (see further discussion in Chapter Five). Up to this point, the MHA 1983, was deemed compliant with the European Convention for the Protection of Human Rights[641] (which the UK signed in 1950), following the *Winterwerp*[642] judgement. This judgment confirmed that,

> except than in an emergency, the detention of a person of unsound mind will be lawful only if:
> - The person detained is reliably shown to be of unsound mind (that is, by objective medical experts).
> - The Relevant mental disorder is of a kind or degree warranting compulsory confinement, *and*
> - There is a persistence of such a disorder to justify continuing detention.'[643]

The MHA 1983 did in 1998 require these criteria to be met, so it was thus lawful under Article 5(1)(e) of the European Convention on Human Rights.[644] The emergency detention had also been tested in relation to a UK case of recall under a hospital order to Broadmoor and found compliant with Article 5(1)(e), though not with Article 5(4) as there was no right to judicial determination.[645]

The White Paper that followed Milburn's statement, Modernising Mental Health Services[646] set out a plan for the reform of mental health services, increased investment, and increased control over patients.[647] Included in these plans was the commissioning of a review of the existing legislation, the review was chaired by Professor Genevra Richardson.[648] The committee were tasked with undertaking a 'root

[641] Council of Europe (n16).
[642] *Winterwerp v. Netherlands* 6301/73 [1979] ECHR 4.
[643] W-C Leung, 'Human Rights Act 1998 and mental health legislation implications for the management of mentally ill patients' (2002) Postgrad Med J 2002; 78: 178, 178-179.
[644] Council of Europe (n16).
[645] *X v UK* 7215/75 [1982] ECHR 6 para 55
[646] Department for Health (1998) Modernising mental health services: safe, sound and supportive. London Department for Health. <https://webarchive.nationalarchives.gov.uk/ukgwa/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4046660.pdf> accessed 6 August 2024.
[647] Max Marshall, 'Modernising mental health services' (1999) BMJ 1999 Jan 2; 318(7175): 3, 3.
[648] Department of Health (n7) 11.

and branch review which will consider all the major issues that must be addressed and to make clear recommendations on how to deal with them in legislative terms.'[649] The expectation from government was that the committee recognise that:

> On some of the more difficult issues it is important that we are not bogged down by stock responses from the past. You will need to adopt a fresh approach and find innovative solutions, which will address our new policy requirements.[650]

Though at this point it was also clear that the government wanted the review to make recommendations that supported the perspective of increasing the ability to force compliance:

> But if there is a responsibility on statutory authorities to ensure the delivery of quality services to patients through the application of agreed individual care plans, so there is also, increasingly, a responsibility on individual patients to comply with their programmes of care. Non compliance can no longer be an option when appropriate care in appropriate settings is in place. I have made it clear to the field that this is not negotiable.[651]

This seems to suggest that there is a requirement on patients to comply on the basis that there would be a delivery of quality individualised patient care, this is a significant point that will be considered later in this chapter in relation to reciprocity.

The Richardson Review set out key general principles for any new legislation,[652] focussed significantly on reciprocity,[653] and the need to provide clarity on the use of compulsion[654] and raised the issue of capacity in treatment without consent.[655] The Reviewers had also considered the challenges that the *Bournewood*[656] case brought, though this case had not yet been concluded in the European Court of Justice. At this

[649] ibid Speech by Mr Paul Boateng – then Parliamentary Under Secretary of State for Health 140-145 para 16.
[650] ibid para 29.
[651] ibid para 11.
[652] Department of Health (n7) 19-25.
[653] ibid 23, 27-31.
[654] ibid 44-76.
[655] ibid 94.
[656] *R v Bournewood Community and Mental Health NHS Trust ex parte L* (Secretary of State for Health and others intervening) [1998] 3 All ER 289.

point, the challenge was that the UK did not have specific legislation addressing capacity issues, and it was presumed that the MHA 1983 would provide protections for those detained under it if they did not have capacity. Unfortunately, for individuals who did not resist admission to a mental hospital and as such were informal patients, they were not protected by the MHA 1983. The House of Lords ruled that such cases would fall under what was now s.131(1) of the MHA 1983[657] where informal admissions were permitted without capacity, or as was found, the protection from what we now consider a deprivation of liberty.[658] In cases where the individual wanted to leave, such detention therefore fell under the common law doctrine of necessity, and this was referred to as the Bournewood Gap.[659] This is notable, but is not the focus of this thesis, and would form several volumes in itself, so will not be explored in any further significant manner save to say that this gap was closed by amendment to the Mental Capacity Act 2005.[660]

Conclusion

The period from 1948 to the end of the twentieth century was remarkable in so much as the nation rebuilt, and recovered from war, we saw the creation of the National Health Service, providing universal health care for all, and the beginnings of Human Rights. While it is clear from the discussions above that Human Rights scrutiny appears as a final check, or compliance matter with legislation to this point, the HRA 1998 and giving effect to the ECHR offers much for the development of rights-based legislation. The MHA 1983 by the year 2000 was almost old enough as those who

[657] Mental Health Act 1983 s 131(1)
[658] *R v Bournewood Community and Mental Health NHS Trust ex parte L* (Secretary of State for Health and others intervening) [1998] 3 All ER 289 Steyn LJ [308 b-h].
[659] Nigel Eastman, Jill Peay, 'Bournewood: an indefensible gap in mental health law' (1998) BMJ 1998 Jul 11; 317(7151): 94-95.
[660] Neil Allen, 'The Bournewood Gap (As Amended?)' (2010) Medical Law Review 18 Winter 2010 78, 78.

were eligible to vote for the first time, and with Welsh devolution and a new Labour administration for the first time in a generation, the scene was set for change. Chapter Five will examine the developments in legislation, policy, and government from the Richardson Review through to the King's Speech of 2024.

Chapter Five - Mental Health Legislation in England and Wales in the new Millenium

The early years of the twenty first century saw the development of separate health policy in England and Wales which followed the creation of the Welsh Assembly in 1999 and the transfer of functions from the Welsh Office to the National Assembly.[661] This period was also the lead up to the draft Mental Health Bills of 2002,[662] 2004,[663]and 2006,[664] which ultimately led to the development of the Mental Health Act 2007 (hereafter MHA 2007). During this time the Mental Capacity Act 2005 (hereafter MCA 2005) was developed. The application of the MCA 2005 in relation to Deprivation of Liberty Safeguards, and the crossover with the MHA 1983 in respect of detention while a person is capacitous is considered later in this Chapter. As noted in Chapters One and Two, capacity and the ability to make 'bad' decisions are key issues in Liberty and personal autonomy. As such, we will explore whether mental health legislation provides for a State arbiter function of moral behaviour.

In this chapter, I will examine the changes which were eventually made to the MHA 1983 after three attempts to change the legislation between 2002 and 2007, and how that was heavily influenced by public perception of mental illness. This was also a period of fundamental change in Welsh governance with the development of the National Assembly for Wales, and the impact of devolution will be considered in relation to mental health law. The Welsh Code of Practice for the MHA 1983[665] includes the requirement that any course of action under the Act should always

[661] National Assembly for Wales (Transfer of Functions) Order 1999, SI 1999/672.
[662] Department of Health, Draft Mental Health Bill & Mental Health Bill: consultation document (June 2002) Cm 5538.
[663] Department of Health, Draft Mental Health Bill (2004) Cm 6305-1.
[664] Mental Health Bill [HL] 2006, Bill 76 54/2.
[665] Welsh Government, Mental Health Act 1983 Code of Practice for Wales Revised (2016) 8.

consider the guiding principle of 'least restrictive option and maximising independence'; this will be developed in considering the impact of such decisions on human rights. As will be explored below, the development of human rights legislation has had a huge impact on the ability to challenge such detention, and also may provide a less complex route to seek redress.

This chapter will also provide background to the current legislative landscape in Wales following the devolution of health and social care policy, and limited legislative competence to the National Assembly for Wales. By mapping out the divergence of Welsh mental health policy and guidance from that developed in England at the Department for Health, the rationale for choosing the subject for this thesis will become apparent. With devolved powers, continuous Labour administration since the inception of the Senedd,[666] and an increasing appetite for the increased use of law-making powers,[667] an opportunity exists for change. From there a route will be drawn to develop a new Welsh approach to support the rights of the mentally ill in Chapters Seven, Eight and Nine.

The process of challenge to, and amendment of the legislation are detailed below, and consider the recommendations of the Richardson Review,[668] the development of the Mental Health Alliance, and the public and governmental fear following high profile homicides.[669] This period of change at Westminster, and in Cardiff Bay provided an

[666] Including the minority pact with the Liberal Democrats and the One Wales coalition with Plaid Cymru.
[667] BBC News, 'Welsh referendum analysis: Wales 'united in clear vote'' (2011) <www.bbc.co.uk/news/uk-wales-12653025> accessed 13 October 2024.
[668] Department of Health (n7).
[669] Laurance (n614) xiv.

opportunity to influence both the Westminster Government controlled Mental Health Act 1983, and a new, and ambitious Welsh Assembly Government. This was a period where I personally played a very active role in the campaigning work of my organisation in relation to the reform of the MHA 1983, and in the development of the first Welsh mental health law since Hywel Dda. In this chapter, the Welsh policy context and the development of Welsh policy and practice will be used to highlight why Wales offers a unique opportunity to develop a more humane way to support the seriously mentally ill.

Contextualising Developments – My Involvement in Patient Advocacy

As noted above, I was particularly involved at this time in the patient advocacy groups response to the debate around mental health legislation, and I should declare my own perspectives on MHA 1983 detention in principle. While I do not argue that detention under the MHA 1983 should cease, it is worth clarifying here the concerns I have to the current approach to detention under the MHA 1983 in order to provide some context for my reform proposals in Chapter Nine.

I understand and accept that society needs to take action to prevent foreseeable harm to an individual, or by them to others, due to a mental disorder for so long as it is necessary to properly address the issues in question. It is in the determination of an individual's capacity to make decisions, and the subsequent detention and treatment that might occur that starts to blur the boundaries. An individual who has delusional thoughts and wishes to act on these, which either intentionally or consequentially causes harm to others, clearly needs to be prevented from doing so. If these delusional thoughts mean that the individual lacks capacity to make treatment decisions about

themselves, and their condition can be improved by treatment, I can both understand and accept that treatment without consent may be appropriate. Note, I refer to treatment without consent here rather than treatment against the wishes of a capacitant individual.

The key issues here are, first, in the detention of individuals which may occur because there has been a failure to provide early intervention (see Chapter Eight), and the individual's condition deteriorates to the point where they have to be detained. To me, as a nurse, this appears fundamentally at odds with the principles of patient-centred care.[670] When contrasting this approach with physical health, it would be seen as outrageous if, for example, an individual who, despite asking for a review of their insulin treatment for diabetes, only received it because they had fallen into a diabetic coma and required hospitalisation. However, as shocking as this example may seem, this can be the very experience of those who are detained under the MHA 1983 (see Chapter Six).

Secondly, I have concerns around the patient experience under the MHA 1983 in relation to their capacity in making decisions about their treatment. For example, as highlighted in Chapters One and later in Chapter Seven, individuals detained under the Public Health (Control of Disease) Act 1984 are treated differently when compared to those detained under the MHA 1983 in relation to capacity. Although the assumption of capacity remains per the MCA 2005, capacity may be overridden in relation to

[670] Mohsen Khosravi, Ghazaleh Azar, Reyhane Izadi,' Principles and elements of patient-centredness in mental health services: a thematic analysis of a systematic review of reviews' (2024) BMJ Open Quality 2024; 13: e002719 doi:10.1136/ bmjoq-2023-002719 1, 6-7 <https://pmc.ncbi.nlm.nih.gov/articles/PMC11227821/pdf/bmjoq-2023-002719.pdf> accessed 7 September 2025.

patients detained under the MHA 1983, but not under the Public Health (Control of Disease) Act 1984 (see further Chapter Seven).

I accept that people who have a mental disorder and pose a risk to the health and safety of themselves or others may need to be detained for assessment. If the individual has capacity and the risk is to themselves, this becomes a question of individual choice (see Chapters One, Two, and in Chapter Four in relation to the 'right to be ill'), and we should be very reluctant to continue the detention. If the individual poses risks to others, then, as this is attributed to a mental disorder, I believe that detention may need to be extended until that risk has passed. This may require treatment, but if the individual has capacity and wishes to refuse the treatment, this again poses a challenge for me as we should not go against a capacitous individual's wishes. This may result in individuals being detained for some time, but they have the option of accepting treatment which will speed their release.

Finally, I find it somewhat draconian where we have legislation in the MHA 1983 which allows for a person to be detained for the purposes of receiving treatment[671] but that treatment is not necessarily available. This was a key feature of the recommendations of the Richardson Review[672] who called for a reciprocal duty to the power to detain which would mean that the appropriate therapeutic treatment would be available if an individual was detained to receive it. Sadly, this recommendation was not included in the Mental Health Act 2007, which amended the MHA 1983, and

[671] Mental Health Act 1983 s 3.
[672] Department of Health (n7) 27-31.

as a result demonstrates a continued power imbalance which leads to my objection to the use of detention in such situations.

Richardson Unheeded

As discussed in Chapter Four, the Richardson Committee had produced a comprehensive report[673] as requested by the UK Government, setting out the priorities for new mental health legislation. Sadly, despite this being very much focussed on reciprocity, much of it was not in keeping with the Labour administration's ambition for new legislation which had a public protection agenda.[674] The Richardson Committee had proposed underlying principles including:

- Non-discrimination – that wherever possible the principles governing mental health care should be the same as those which govern physical health.[675]
- 'Patient Autonomy - any new legislation must be expressly concerned with the recognition and enhancement of patient autonomy. Activities under the legislation should be concerned with preserving or (where possible) restoring autonomy, or (where not possible) protecting those with impaired autonomy. Patient autonomy should only be disregarded in well defined circumstances set out by law.
- Informal care - Wherever possible care, treatment and support should be provided without recourse to compulsion.
- Least restrictive alternative - Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account of the safety of other patients, carers and staff.
- Consensual care - Programmes of care, treatment and support should as far as possible reflect the preferences of the service user, even where intervention in the absence of consent is expressly permitted by law.
- Reciprocity - Where society imposes an obligation on an individual to comply with a programme of treatment and care it should impose a parallel obligation on the health and social care authorities to provide appropriate services, including ongoing care following discharge from compulsion.

---

[673] Department of Health (n7).
[674] David Brown, 'Draft Mental Health Bill receives frosty reception from professionals' (2002) Community Care July 4 2002 <www.communitycare.co.uk/2002/07/04/draft-mental-health-bill-receives-frosty-reception-from-professionals/> accessed 5 August 2024.
[675] Department of Health (n7) 20.

- Respect for diversity - Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds, and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.'[676]

The key principles here for this thesis are the expectation of parity, the least restrictive approach, and reciprocity. Parity was discussed in Chapter Four in relation to how mental health systems may be more greatly influenced for change when compared to the treatment for physical health (further discussion on parity and how the current lack of it in both law and services is examined in relation to fairness in Chapter Seven).

The least restrictive approach for me in this context should not simply relate to the experience in treatment but should be a system wide approach focussed on avoiding any reason for restriction in the first place. Early support and / or treatment at the request of a patient must be fundamental to avoiding any impingement on liberty or freedom, and this is where I differ from the principle of reciprocity set out in the Richardson Committee report.[677] It is unarguable in my view that should an individual have a condition leading to detention under the MHA 1983, there should be a corresponding duty to provide the services necessary to treat the condition post detention. Reciprocity should however go further, as will be discussed in more detail in Chapters Seven and Eight, and should balance the power of the State to detain with a right to treatment to avoid the need for such detention.

[676] ibid 20-23 emphasis added.
[677] Department of Health (n7).

The Three Bills – the role of the Mental Health Alliance, and the Mental Health Act 2007

Having failed to take onboard the reciprocity recommendations of the Richardson Committee,[678] the Westminster Government continued to pursue a replacement for the MHA 1983. Sadly, the first draft Mental Health Bill in 2002[679] was as oppressive as had been feared by patient and professional groups, and a major campaign followed, bringing together patients, charities, and Royal Colleges.[680] The key issues in the 2002 Bill are summarised well by Zigmond[681] and are predominantly related to loss of rights, removal of independent process, and broadening the criteria for compulsion. Similarly, Thornicroft and Szmukler were critical:

> The manner in which the principle of safety is given salience in the Bill is likely to reinforce common and stigmatising stereotypes that associate mental illness and violence. This conflicts with the principles of participation, autonomy and empowerment, and dignity.[682]

At this point, the proposed new legislation to follow the 2002 Bill risked becoming draconian and sought to move away from a therapeutic treatment approach to a confinement and "Minority Report"[683] type law.

There were of course some positive proposals including the improvement of access to advocacy, tribunals, and a mandatory care plan for those detained, and it was said that

---

[678] ibid.
[679] Department of Health (n662).
[680] The Guardian, 'Protest against 'draconian' mental health bill' (2002) Wed 23 Oct 2002; Anselm Eldergill, 'IS ANYONE SAFE? Civil Compulsion under the Draft Mental Health Bill' (2002) Journal of Mental Health Law Dec 2002 331; Tony Zigmond, 'A new Mental Health Act for England and Wales' (2004) Advances in Psychiatric Treatment 2004;10(3):161.
[681] Zigmond (n680) 161.
[682] Graham Thornicroft, George Szmukler, 'The Draft Mental Health Bill in England: without principles' (2005) Psychiatric Bulletin (2005) 29, 244, 247.
[683] Philip K Dick, *Minority Report* (Gollancz 2009 London) This novel imagines a pre-crime programme which detects crimes before they are committed and thus arrests people for offences they have not committed but it is believed that they will offend.

the intention of the 2002 Bill was to align with human rights legislation.[684] This was also the point where I had joined the National Schizophrenia Fellowship Cymru, the forerunner of Hafal, and latterly Adferiad. The engagement of almost all those involved in patient charities, psychiatry, social work, nursing, and law was remarkable, and is well documented by Rowena Daw, Vice Chair of the Mental Health Alliance at the time.[685]

The response to the draft 2002 Bill was sufficient to cause the Government to rethink, and in 2004 an amended draft Mental Health Bill[686] was produced. Both the 2002 and 2004 Bills were intended to replace the MHA 1983, (which had not fundamentally changed the legislation from the earlier Mental Health Act 1959), so that it would be more compatible with the European Convention on Human Rights.[687] This amended Bill was accompanied by the setting up on a Joint Parliamentary Scrutiny Committee in June 2004 to examine the draft Mental Health Bill and report back to both Houses.[688] The Committee, having taken extensive evidence, produced a report which Daw[689] highlights as a key factor in the abandonment of the 2004 draft Bill.[690]

I led a seminar at the Palace of Westminster with Welsh MPs and Peers including Hywel Williams MP for Arfon, a former Social Worker, and Lord Carlisle, the Chair of the Scrutiny Committee, and a Trustee of a partner charity to Hafal during this time.

---

[684] Parliamentary Office of Science and Technology, 'Reform of Mental Health Legislation' (Postnote, October 2003 Number 204) 2 <www.parliament.uk/globalassets/documents/post/pn204.pdf> accessed 8 August 2024.
[685] Rowena Daw, 'The Mental Health Act 2007 – The Defeat of an Ideal' (2007) Journal of Mental Health Law November 2007 131-148.
[686] Department of Health (n663).
[687] Department of Health, Government Response to the Report of the Joint Committee on the Draft Mental Health Bill 2004 (2005) Cm 6624 7.
[688] House of Lords and House of Commons, Joint Committee on the Draft Mental Health Bill HL Paper 79-I HC 95-I (2005) The Stationery Office.
[689] Daw (n685) 131-148.
[690] ibid 132.

I also supported two members of Hafal to give evidence to the Committee which they did in person on the 10th of November 2004.[691] This experience of being directly involved in the law making, or in this case the stopping of an unfair law was a key point for my understanding of the impact the voice of patients and carers have in comparison with employed staff in organisations. The Committee's report was broadly in line with both the recommendations of the Richardson Committee, and the Mental Health Alliance.[692] This provoked a UK Government response which disagreed with many of these recommendations, and in particular reset the battle lines in relation to the emphasis on public safety.[693] Indeed, in its response the Government stated:

> The great majority of people with a serious mental disorder are more likely to harm themselves than others, and it is wrong to paint a picture of a government or society obsessed with public safety. The Government's and society's concern is to protect very vulnerable people from harming themselves or, much more occasionally, others. And the concern to ensure that people can get the treatment they need to protect them from harming themselves or others is balanced by a concern to respect patients' rights to make decisions for themselves.[694]

The suggestion that the perception of the Government's intentions was incorrect is remarkable when this was the focus of speeches and directions given by Milburn, Dobson, and Boateng (as noted earlier in Chapter Four).

The emphasis on public protection, the broadening of the criteria for detention, and the focus on Dangerous Severe Personality Disorder (DSPD) was also contrasted with the approach in Scotland where powers were already devolved. The Scottish Mental Health (Care and Treatment) Act 2003 was far more in line with the recommendations

[691] UK Parliament, 'Joint Committee on the Draft Mental Health Bill Minutes of Evidence' (2004) Wednesday 10 October 2004 <https://publications.parliament.uk/pa/jt200405/jtselect/jtment/79/4111014.htm> accessed 8 August 2024.
[692] Daw (n685) 133.
[693] Department of Health (n687) 3.
[694] ibid 4 para 12.

of the Richardson Committee[695] and introduced a right to an assessment of needs for community care services.[696] It also included guiding principles along the lines of Richardson,[697] set out a new definition of mental disorder[698] including personality disorder and learning disability, but also required any assessment for detention to consider ability to understand treatment decisions.[699] Scotland had also passed earlier legislation in relation to capacity, the Adults with Incapacity (Scotland) Act 2000, again some five years ahead of the UK Government passing the Mental Capacity Act 2005. The Joint Committee on the Draft Mental Health Bill also considered the issue of capacity and the definition of mental disorder, and recommended that the Scottish approach be considered for capacity,[700] and a tightening of the definition of mental disorder.[701] Lord Rix, a member of the Committee, and Angela Browning MP sought unsuccessfully to exclude those with learning disabilities from the definition of mental disorder.[702] This extension of compulsory powers to this group of patients has led to some confusion[703] in the application of the MHA 1983 and the Mental Capacity Act 2005.

Specialist Legal advisor to the Committee, Professor Phil Fennell, whilst recognising his bias, wrote an article critical of the Government's response to the Parliamentary Scrutiny Committee.[704] Fennell reflected upon the priority the Government had set itself in the public protection area, the misinformation about the nature of the risk

[695] Daw (n685) 133.
[696] Scottish Mental Health (Care and Treatment) Act 2003 Part 14.
[697] ibid s 1.
[698] ibid s 238.
[699] ibid s 36 (1).
[700] Department of Health (n7) 11.
[701] ibid 16.
[702] Daw (n685) 135.
[703] ibid.
[704] Philip Fennell, 'Protection! protection! protection! deja vu all over again: the Government response to the Joint Parliamentary Scrutiny Committee' (2005) Journal of Mental Health Law (Nov) 110-122.

posed by those with mental illness in homicide research,[705] and the failure to see legislation as a way of improving services.[706] He noted the rationale for scrutiny as it, 'gives the key 'stakeholders' in draft legislation, to use Government parlance, the opportunity to voice their views on its workability and desirability'.[707] Disappointingly and quite correctly, he closed his paper by saying:

> The Government's somewhat grudging approach to the Scrutiny Committee recommendations reflects its commitment and determination to pursue the public safety agenda above all others, and this is to be regretted. If things go wrong there will be no shortage of people in a position to say 'We told you so.'[708]

Despite the Government taking such a stern approach, there was significant opposition to the draft Mental Health Bill 2004[709] and it was not taken forward in the Queen's Speech for the 2005/6 session, despite earlier plans for this to happen.[710] This left the MHA 1983 unamended, and the Government plans to address risk in tatters, some seven years after they announced their intention to act. There had of course been an attempt in 2003 to address the 'dangerousness' argument for those individuals convicted of an offence and were considered to be 'dangerous', through the passing of the Criminal Justice Act 2003. This legislation introduced the concept of imprisonment for public protection sentences,[711] which resulted in individuals being convicted of less serious offences being detained for many years with no automatic release and subject to recall.[712] This type of sentence was scrapped in 2012 though there has been

[705] ibid 114-115.
[706] Department of Health, Government Response to the Report of the Joint Committee on the Draft Mental Health Bill 2004 (2005) Cm 6624 para 10 cited in Fennell (n704) 114-115.
[707] Fennell (n704) 110.
[708] ibid 122.
[709] Department of Health (n663).
[710] Peter Lepping, 'Ethical analysis of the new proposed mental health legislation in England and Wales' (2007) Philosophy, Ethics, and Humanities in Medicine 2007 2:5 1, 1.
[711] Criminal Justice Act 2003 Ch 5.
[712] Jacqueline Beard, 'Sentences of Imprisonment for Public Protection' House of Commons Library Research Briefing (2023) 6086

much public concern over those still subject to these sentences who have not yet been released, despite serving many more years than the minimum term.[713]

In 2005 the Mental Capacity Act[714] was passed with the presumption that every person must be assumed to have capacity unless established otherwise,[715] and that unwise decisions are not a reason to treat an individual as lacking capacity.[716] This key principle seems at odds with mental health legislation where doctors can override a patient who has capacity, and suggests further the lack of parity in mental health which is discussed further in Chapter Seven. As noted earlier, while the MCA 2005 is critical to protect people whose decision-making status may be in question, this thesis is focussed predominantly on mental health legislation, so will not necessarily include broader issues relating to capacity law.

In 2006, the Government abandoned the earlier two draft Bills, and published a third, the Mental Health Bill 2006.[717] This was brought forward in the House of Lords with the intention of amending the Mental Health Act 1983 and the Mental Capacity Act 2005 to address concerns in relation to the human rights implications of the legislation on mentally disordered persons.[718] The amendment to the Mental Capacity Act 2005 was required, as noted in Chapters One and Four, as in passing the original Act, the Government had not believed that they would lose the *Bournewood*[719] case at the

<https://researchbriefings.files.parliament.uk/documents/SN06086/SN06086.pdf> accessed 24 April 2023.

[713] Antonia Matthews, 'Man still in jail 20 years after laptop robbery' (2024) *BBC News* <www.bbc.co.uk/news/articles/c1e5154j4z0o#:~:text=A%20prisoner%20who%20has%20served,(IPP)%20sentence%20in%202005> accessed 5 August 2024.

[714] Mental Capacity Act 2005.

[715] ibid s 1(2).

[716] ibid s 1(4).

[717] Mental Health Bill [HL] 2006, Bill 76 54/2.

[718] Hansard, HL Deb 16 November 2006 vol 687 cols 19-100 at 19.

[719] *HL v UK* 45508/99 [2004] ECHR 471.

European Court of Human Rights.[720] This had now become a piece of amending legislation rather than a whole new Act as was intended for both the 2002 and the 2004 Bills.[721]

The Headline Changes

Key provisions included broadening the definition of mental disorder,[722] changing the definition of treatment,[723] and introducing Community Treatment orders,[724] and a new role of Approved Mental Health Practitioner.[725] There were also changes to the nearest relative provisions,[726] and the creation of the Mental Health Review Tribunal for Wales.[727] This new Bill however was again criticised as, 'draconian and risked deterring vulnerable people from seeing *[sic]* help.'[728] It required a number of amendments again as it had not been clear enough in how young people might end up in adult wards, and the amount of control a psychiatrist would have in relation to where someone lived.[729] The most dramatic changes here related to the inclusion of sexual disorders as a condition liable for compulsory treatment, the ability to count basic habilitation as 'appropriate treatment',[730] and the ability to require compliance with treatment in one's own home.[731] The Bill did however clear both Houses and gained

[720] Fennell (n704) 114.
[721] Simon Lawton-Smith, 'Mental Health Act 2007 Briefing' (2008) The King's Fund (2008) 1 <https://assets.kingsfund.org.uk/f/256914/x/6c4339a9f2/mental_health_act_2007.pdf> accessed 11 August 2024.
[722] Mental Health Bill [HL] 2006, Bill 76 54/2, ss 1-3.
[723] ibid ss 4-6.
[724] ibid ch 4.
[725] ibid ss 17-19.
[726] ibid ch 3.
[727] ibid s 31(2)(1).
[728] David Batty, 'Opposition calls for new changes to mental health bill' (2007) *The Guardian* Mon 18 Jun 2007.
[729] ibid.
[730] John Crichton, Rajan Darjee, 'New mental health legislation' (2007) BMJ 2007 Mar 24; 334(7594): 596-597.
[731] Community Treatment Orders have conditions that patients must follow, and if they do not, they can be recalled to hospital. Rethink Mental Illness, 'Community Treatment Orders (CTOs)' <www.rethink.org/advice-and-information/rights-restrictions/mental-health-laws/community-treatment-orders-ctos-made-under-the-mental-health-act-1983/> accessed 8 August 2024.

Royal Assent in July 2007, becoming the Mental Health Act 2007, and amended the MHA 1983. Previously, the rationale for detention under the MHA 1983 was clear that detention for treatment could only be authorised if, 'such treatment is likely to alleviate or prevent a deterioration of his condition'.[732] Under the amended MHA 1983 detention for treatment is authorised so long as, 'appropriate medical treatment is available for him'.[733] Such appropriate medical treatment is referenced as:

> In this Act, references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to 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.[734]

While this suggests that there is a duty to provide, and thus perhaps a 'right' to receive appropriate medical treatment if detained,[735] the very nature of what is 'appropriate' is itself left deliberately vague in s.3(4) of the amended Act.[736] Phull and Bartlett explored this issue in 2012[737] noting that despite the relevant Codes of Practice referencing an almost identical copy of the previous treatability test, there remains little clarity in the definition of appropriate medical treatment.[738] As found in *Munjaz*,[739] the Code of Practice may be departed from so long as those doing so can demonstrate that they had a good reason for doing so.[740]

Case law remains limited on challenges to the appropriateness of available treatment. A case involving a Welsh hospital appears to highlight the challenges in continuing

[732] Mental Health Act 1983 s 3(2)(b) original text.
[733] Mental Health Act 1983 as amended, s 3(2)(d).
[734] ibid s 3(4).
[735] Lawton-Smith (n721) 3.
[736] Mental Health Act 1983 as amended, s.3(4)
[737] Jaspreet Phull, Peter Bartlett, ''Appropriate' medical treatment: what's in a word?' (2012) Medicine, Science and the Law Vol 52 April 2012 71-74.
[738] ibid 72.
[739] *Regina v. Ashworth Hospital Authority (now Mersey Care National Health Service Trust) (Appellants) ex parte Munjaz* (FC) (Respondent) [2005] UKHL 58.
[740] ibid para 97.

detention for an individual considered to be unsafe to discharge but making no progress in their treatment.[741] In this case, Knowles J,[742] seems to suggest that they favour the approach of Sullivan J, in an earlier case, in that:

> The matter has to be looked at in the round, including the prospect of future in-patient treatment, but there will come a time when, even though it is certain that treatment will be required at some stage in the future, the timing of that treatment is so uncertain that it is no longer "appropriate" for the patient to continue to be liable to detention. It is the tribunal's function to use its expertise to decide whether the certainty, or the possibility, of the need for in-patient treatment at some future date makes it "appropriate" that the patient's liability to detention shall continue.[743]

This suggests that even where the responsible clinician gives evidence that there is no benefit to the patient as in *WH*,[744] the Tribunal may gaze into the future and decide to affirm the detention on the basis that some treatment may become available.

There are differences here in interpretation too from the Codes of Practice in England and in Wales, noting that each nation has a separate Code of Practice following devolution of powers on health and social care.[745] Interestingly, while both Codes include guidance that nursing may be considered appropriate treatment, they do not define what nursing would mean in this context.[746] The Welsh Code is unique however in that expects that any treatment being offered, 'should always be grounded in and guided by best practice, e.g. NICE Guideline documents'.[747] The Welsh Code also differs from the English Code in that it specifically identifies that:

> The appropriate medical treatment test therefore requires a clinical judgement about whether an appropriate package of treatment for mental disorder is

[741] *WH v Llanarth Court Hospital (Partnerships in Care)* [2015] UKUT 695 (AAC).
[742] ibid paras 57-58.
[743] *R (on the application of Epsom and St Helier NHS Trust) v Mental Health Review* Tribunal [2001] EWHC Admin 101 para 52.
[744] *WH v Llanarth Court Hospital (Partnerships in Care)* [2015] UKUT 695 (AAC).
[745] Welsh Assembly Government (n35) 1.
[746] Welsh Government (n665) paras 23.2, 23.9; Department of Health, Mental Health Act 1983: Code of Practice (2015) The Stationery Office paras 23.2, 23.17.
[747] Welsh Government (n665) para 23.5.

> available and accessible for the individual within the setting in which they are receiving that treatment.[748]

In the case of *WH*[749] the medical opinion was clear that there was not appropriate medical treatment available to the patient at the hospital, but Knowles J, considered that the Tribunal is not obliged to accept such evidence in isolation.[750] In reading the judgment, what appears to be of more importance is the consideration that the patient could not be discharged safely due to risk, and that such risk was being given significant weight despite this being about the availability of treatment.[751] There was however confirmation on the detention itself not being appropriate medical treatment.[752] While this is not a key part of the thesis, it is worthy of discussion as the broadening of the definitions of mental disorder, and the lack of clarity on the reasons for detention are further restrictions on patients with a serious mental illness.

The Mental Health Act 2007 thus amended the existing MHA 1983, which meant that there needed to be consideration of how this impacted in Wales, with devolved powers for health. It must be noted that the retention of criminal justice powers by the Westminster Parliament means that the MHA 1983 must be applied by police forces under two separate codes, causing challenges for the College of Policing.[753] I was part of a working group which developed the latest Welsh Code,[754] and there was a heavily focused desire to ensure that the patient experience, and that of their families, ran throughout the Code. This approach will also be reflected when we discuss the development of Welsh mental health laws and policy below. Both Codes of Practice

---

[748] ibid para 23.12.
[749] *WH v Llanarth Court Hospital (Partnerships in Care)* [2015] UKUT 695 (AAC).
[750] ibid para 46.
[751] ibid paras 6-9.
[752] ibid para 39.
[753] Michael Brown, 'Timing is Everything' (2017) MentalHealthCop November 4 2017 <https://mentalhealthcop.wordpress.com/2017/11/04/timing-is-everything/> accessed 11 August 2024.
[754] Welsh Government (n665).

are now somewhat outdated following the Policing and Crime Act 2017. This amended the MHA 1983 in respect of ss.135/136 and prohibited the use of police custody cells as a place of safety for under 18s and restricted the use for adults except in exceptional circumstances.[755]

Compatibility with the ECHR

This thesis seeks to highlight the impact that detention and subsequent involuntary treatment may have on an individual's ability to make choices, how they live their private and family life, and how they are able to be autonomous individuals in order to argue for an alternative approach. In Chapter One I highlighted the effect that detention may have on both negative and positive Rights. Before moving on from the MHA 2007 it is worth taking some time to clarify the legal difference between Rights being infringed, and Rights being engaged but not infringed, despite the serious effect this has on an individual's personal autonomy (as set out in Chapter Six). The current position is that the ECtHR[756] has deemed that detention under the MHA 1983 is compatible with the ECHR so long as the *Winterwerp*[757] criteria is met. The Joint Committee on Human Rights has explained the ambit of this criteria in relation to the MHA 1983 in the following terms:

> The *Winterwerp* criteria for a lawful psychiatric detention require objective medical evidence of a true mental disorder. This is provided for by the reports from a psychiatrist and another doctor (section 12), which are presented to the competent authority which is the managers of the relevant hospital (section 6). The mental disorder must be of a nature or degree making treatment in hospital appropriate, and it must be the case that treatment cannot be provided without detention (sections 2 and 3), treatment must be necessary for the patient's health or safety or for the protection of other persons. We consider that these

[755] Home Office, 'New Rules Restricting the Use of Police Cells as Places of Safety Come into Effect' (Press release 11 December 2017) <www.gov.uk/government/news/new-rules-restricting-the-use-of-police-cells-as-places-of-safety-come-into-effect> accessed 11 August 2024.
[756] HL v UK 45508/99 [2004] ECHR 471.
[757] *Winterwerp v. Netherlands* 6301/73 [1979] ECHR 4.

> procedures appear broadly to comply with the case law on Article 5(1)(e) of the Convention.[758]

It is worth noting that in *Winterwerp*[759] while the ECtHR found that detention was lawful under Article 5(1), there had been an infringement of Article 5(4) as at the time there was no requirement in Dutch national legislation requiring periodic review of the need for the detention.[760] Further, in 2006, the ECtHR has also held in *Wilkinson*[761] that *compulsory treatment* under the MHA 1983 is compatible with the ECHR so long as it was necessary and proportionate. In *Munjaz*[762] the ECtHR recognised that while seclusion from others as an interference with Article 8(1), so long as this was in accordance with the law, this was, on the facts, justified.

To that end, whilst there is potential for interference with the Rights of the individual detained, or the subject of involuntary treatment, the ECtHR has found that this, in the appropriate circumstances, can nevertheless be compatible with the ECHR. The discussion in Chapter Six reflects the interference with the Rights of my fictional amalgam patient 'P' through detention but recognises that there are minimal routes of challenge available so long as the process has been followed properly. Within this thesis, my focus is on the impact detention has on the individual's ability to live their lives and is more than merely the impact on Article 5 Rights in relation to the physical Liberty through 'sectioning' under the MHA. The interference in other Rights that this detention may cause is developed further in Chapter Six and it is this that led me to this study. The justification for detention under national law and the ECHR has been

[758] House of Lords House of Commons, 'Joint Committee on Human Rights – Fourth Report' (2007) 2.16 <https://publications.parliament.uk/pa/jt200607/jtselect/jtrights/40/4002.htm> accessed 6 August 2025 original emphasis.
[759] *Winterwerp v. Netherlands* 6301/73 [1979] ECHR 4.
[760] ibid 54-61.
[761] *Wilkinson v. UK (No. 1)* 14659/02 [2006] ECHR 1171 21.
[762] *Munjaz v UK* 2913/06 [2012] ECHR 1704 [87]-[96].

set out above. It is the impact detention has on the individual, especially where such detention may have been avoidable if services were provided in a timely manner, which is key to the discussions in the next chapter.

Devolution and the Dual Landscapes of England and Wales

For context and a broader understanding of the Welsh health landscape, this short section reviews the development of the Welsh Government and highlights key points in the policy and legislative development in Wales since Devolution. This is not intended as a historical record of Welsh Devolution, but more a journey through many of the key markers in mental health policy and practice during this period. While the history of Welsh law making goes as far back as Hywel Dda (see Chapter Three), and a number of attempts to devolve powers to Wales have been made over the last five centuries,[763] this discussion will consider relevant matters from the 1979 referendum. This referendum was held despite strong opposition from within the Labour party and movement, who were in power at the time in Westminster but with only a small and vulnerable majority.[764] This referendum attracted a turnout of 58.8%, with only 20.3% in favour of devolution, and the impact of the failure led to the collapse of the Callaghan Government,[765] which was succeeded as noted earlier by the Thatcher administration. The experience in Wales of many years of the Thatcher and subsequent Conservative Governments appeared to change the views of the Welsh public towards devolution,[766] and the newly elected Blair administration acted quickly in office. The 1996 landslide for Labour meant that there were no Welsh Conservative MPs, and on

[763] Senedd Cymru (n42).
[764] BBC Wales Referendum, 'The 1979 Referendums' <www.bbc.co.uk/news/special/politics97/devolution/wales/briefing/79referendums.shtml> accessed 11 August 2024.
[765] ibid.
[766] David Broughton, 'The Welsh Devolution Referendum 1997' (1998) Representation 35:4 200, 200.

the back of their commitment in the Labour manifesto, the White Paper on Welsh Devolution[767] was published in July 1997.[768] This was not however an easy journey, and a strong NO campaign including the support of Lord Tonypandy and concerns raised by several Labour MPs[769] saw a very close result, with a turnout of 50.2%[770] and a majority of less than 7,000 carrying the YES vote.[771]

Health Structures in Wales following Devolution

The Government of Wales Act 1998 established the National Assembly for Wales and a range of other administrative bodies and functions. The powers initially devolved were those previously held by the Welsh Office and related to secondary legislation and executive functions. Within these powers though was the ability now to set strategies and delivery plans for health, and in particular mental health, and in 2001 the Welsh Assembly Government (as was) published their first Adult Mental Health Strategy.[772] This was followed by a National Service Framework,[773] which was revised in 2005.[774] These strategies and frameworks were distinct in that they were specifically focussed on Welsh issues, involved Welsh patients, professionals, and charities in understanding the local issues, and promoted ambitious aims for quality care. I was involved in the Implementation Advisory Group for the National Service Framework on a few occasions, including a meeting where the Minster Jane Hutt MS announced

[767] Welsh Office (1997), A voice for Wales Cm 3718 HMSO.
[768] Broughton (n766) 201.
[769] ibid 204.
[770] UK Parliament, 'Welsh Devolution' Early Day Motion EDM 178 (7 December 2023).
[771] Broughton (n766) 206.
[772] Welsh Assembly Government, Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness, Efficiency, Strategy Document (2001).
[773] Welsh Assembly Government, Adult Mental Health Services: A National Service Framework for Wales (2002) <www.wamhinpc.org.uk/sites/default/files/adult-mental-health-nsf-april-02.pdf> accessed 11 August 2024.
[774] Welsh Assembly Government, Raising the Standard: The Revised Adult Mental Health National Service Framework and an Action Plan for Wales (2005) <www.wamhinpc.org.uk/sites/default/files/adult-mental-health-raising-the-standard-oct-05.pdf> accessed 26 August 2024.

the creation of 22 Local Health Boards coterminous with 22 local authorities. This meant scrapping the existing five Health Authorities.[775] There has been a strong drive since devolution in the development of Welsh citizenship and local determination of service provision priorities, most obviously in the creation of these 22 local health boards and 22 local authorities. This approach, intended no doubt to demonstrate greater local accountability, was not one that succeeded, and has since been restructured on a number of occasions. Indeed, while the number of local health boards in Wales have since reduced from 22 to 7,[776] further changes have followed with both name and areas of responsibility coming under review.[777] As will be seen later in this chapter, the need to reform mental health service delivery has led to the commissioning of two important reviews into the provision of mental health services in Wales and included a proposal for a single Welsh mental health board.

The NHS in Wales at that time followed the same structure in England of having an internal market with a provider/purchaser split. This meant that the Local Health Boards commissioned health providers such as the NHS Trusts to provide services to the population of that Health Board area. My concerns at this time were that this structure now required expertise in commissioning mental health services in 22 separate governmental bodies, and that such expertise was likely to be lacking. In 2005, the Auditor General for Wales published a baseline review of adult mental health

[775] Roger Dobson, 'Wales to scrap health authorities' (2001) BMJ 2001 Feb 10; 322(7282): 318.
[776] Hywel Griffith, New health boards to control NHS, *BBC News* (1 October 2009) <news.bbc.co.uk/1/hi/wales/8283265.stm> accessed 26 October 2024.
[777] Cwm Taf University Health Board, Bridgend Boundary Change – Joint Transition Board (23 April 2019) <https://ctmuhb.nhs.wales/about-us/our-board/committees/bridgend-boundary-change-joint-transition-board-jtb/#:~:text=On%20the%2014%20June%202018,Board%20(ABMUHB)%20to%20Cwm%20Taf> accessed 26 October 2024.

services in Wales.[778] The report was damning of the way in which adult mental health services were 'planned, organised and funded'.[779] This report also highlighted that in 16 of the 22 areas, there was a 'lack of capacity and resource' resulting in failure to implement the National Service Framework set by the Welsh Government, and a need to provide earlier intervention to prevent crisis.[780] Despite or perhaps because of the Welsh Government's decision to create more local commissioning bodies, the report highlighted a significant variation of service availability across Wales,[781] sadly a postcode lottery for those most in need. This report was revisited in 2011 and the findings of this will be considered in the next section. In this next section we begin to see the divergence of Welsh policy and the creation of Welsh mental health law.

From 2007 to the King's Speech 2024: the development of Welsh law and practice, and the opportunity for further change.

In 2007, Labour had entered a coalition with Plaid Cymru which relied upon the One Wales agreement which set out plans to dismantle the internal market in the NHS.[782] The 22 Local Health Boards (LHBs) did not last, as in 2009, the Local Health Boards (Establishment and Dissolution) (Wales) Order[783] dissolved all but Powys Health Board and created 6 further merged Boards. This second major reorganisation did not go smoothly, and there was significant resentment when the Government undertook to protect the salaries of over 100 managers to the tune of £700,000 per year.[784] Some

[778] Wales Audit Office, Adult Mental Health Services in Wales: A Baseline Review of Service Provision (2005) <https://senedd.wales/media/2wqdavkr/bus-guide-n00000000000000000000000000038346-english.pdf> accessed 31 August 2024.
[779] ibid 7.
[780] ibid.
[781] ibid 69.
[782] Welsh Government, 'Written Statement – The One Wales Delivery Plan 2008-2011' (2011) <www.gov.wales/written-statement-one-wales-delivery-plan-2008-2011> accessed 11 August 2024.
[783] The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009, WSI, 2009/778 (W.66).
[784] BBC, 'Welsh NHS pays £700k to managers who lost posts' (2011) 7 November 2011 <www.bbc.co.uk/news/uk-wales-15605671> accessed 11 August 2024.

fifteen years on, the performance of these Local Health Boards in Wales does not reflect the promised improvements, with one in special measures, three in targeted intervention, and the other three in enhanced monitoring.[785] The powers to make these changes came from the Government of Wales Act 2006 which ceded greater powers to Wales, including the passing of Assembly Measures on devolved matters which hold the status of primary legislation.[786]

In 2007, as part of the new powers, Jonathan Morgan AM, the Shadow Minister for Health and Social Services won a Member's ballot and chose to seek legislation in relation to mental health.[787] The progress of this proposal will be followed below as the timescale covered a range of other activities at the Senedd and will need to be considered in that light. Morgan's decision was influenced greatly by hearing from a Hafal service user, Lee McCabe,[788] and as will be discussed later in this chapter, I and Lee McCabe gave evidence to both the Senedd and Westminster on the need for this legislation.

During this third Assembly, 2007-2011, reviews of mental health services in Wales were commissioned by Edwina Hart, the then Minister for Health and Social Services,

[785] Mark Palmer, 'Welsh government: Three health boards under increased scrutiny' (2024) *BBC News*, 23 January 2024 <www.bbc.co.uk/news/uk-wales-68074515#:~:text=This%20means%20Betsi%20Cadwaladr%20University,in%20targeted%20intervention%20for%20performance> accessed 11 August 2024.

[786] Welsh Government, 'Government of Wales Act 2006' (2021) Law Wales <https://law.gov.wales/constitution-and-government/constitution-and-devolution/government-wales-act-2006> accessed 11 August 2024.

[787] National Assembly for Wales, The Record of Proceedings (3 October 2007) 51 <https://senedd.wales/archive/votes-and-proceedings/03-10-2007-votes-and-proceedings/> accessed 12 October 2024 .

[788] Senedd Wales, 'Assembly Member's First Clear Route to Better Mental Health Provision in Wales' (2010) <https://prep.senedd.wales/senedd-now/news/assembly-member-s-first-clear-route-to-better-mental-health-provision-in-wales/> accessed 26 August 2024.

with a reputation for having a 'no-nonsense', and 'tough talking' approach.[789] The Mental Health Act 2007 provided Wales with the opportunity to develop a Code of Practice that reflected the Welsh policy and practice that had been developing since the Government of Wales Act 2006, and these reviews were part of that approach. These included the 2007 Burrows Greenwell Review which sought to identify, "how services could help to restore service users' dignity and respect for their individual rights".[790]

This review proposed further structural changes in planning and administration of mental health services, including the greater involvement of service users and carers in planning services.[791] It also recommended[792] that all primary care services in Wales adhere to the Mental Health Declaration developed by the Wales Mental Health in Primary Care Network[793] which states:

> As individuals in Wales we all:
> • Have a responsibility for our own and others' mental health and wellbeing.
> • Need to be able to develop the understanding and gain the skills so that we can recognise signs of mental ill health in others and ourselves.
> • Need to be able to access services easily that will support recovery and empowerment, leading to the promotion of independence and to the facilitation of self-management and maintenance of mental health and wellbeing.
> As members of society, the people of Wales must accept responsibility within their own communities, workplaces and families to address those relationship issues that impact on all aspects of our day-today lives.[794]

---

[789] WalesOnline, 'Is Hart Really the Most Stylish?' (30 November 2005) <www.walesonline.co.uk/news/wales-news/hart-really-most-stylish-2370227> accessed 18 August 2024.
[790] Mary Burrows, Stuart Greenwell, 'The Other End of the Telescope: A Refocusing of Mental Health and Wellbeing for Service Users and Carers, Report of All Wales Review of Mental Health Services' (2007) 3 <https://webarchive.nationalarchives.gov.uk/ukgwa/20160426082522/http:/gov.wales/topics/health/publications/health/reports/2279017/?lang=en> accessed 26 August 2024.
[791] ibid 8.
[792] ibid 9.
[793] My own organisation was a member of this network.
[794] Wales Mental Health in Primary Care Network, 'The Welsh Declaration for Mental Health and Well-being' (2007) 2 <www.wamhinpc.org.uk/sites/default/files/5_%20Declaration%20-%20English%20Edition.pdf> accessed 26 August 2024.

This focus on early access and independence is clear as is the suggestion that individuals have responsibility for managing their own health. Citizenship has been a focus throughout this thesis, and when we consider the citizenship in further detail in Chapter Eight, the Welsh perspective offers a further rationale as to why Wales offers a key opportunity for reciprocity. The expectation of personal responsibility within a community is all well and good, and while this is accompanied by the recognition of a need for early intervention, for true recognition of the duties and benefits of citizenship, reciprocal rights should flow. The idea that citizens owe the State a duty to manage their health, but the State has no duty to support them in this fundamentally undermines the role of the State or any social contract.

The following year Professor Michael Williams produced a report which proposed a dramatic change of structure and focus for Welsh mental health services, by suggesting that there should be a single statutory body for mental health.[795] This proposal split opinion[796] but had offered greater clarity on how mental health services could be prioritised. Greater Manchester has a population of 2.868M,[797] around 92% of that of Wales (3.108M),[798] but there is one main provider for adult mental health services for

[795] Michael Williams, 'Iechyd Meddwl Cymru, A Well Being and Mental Health Service Fit For Wales' (2008) 3 <https://webarchive.nationalarchives.gov.uk/ukgwa/20090711092025/http:/www.wales.nhs.uk/sites3/page.cfm?orgid=201&pid=32302> accessed 26 August 2024.

[796] WalesOnline, 'Stigma Warning over Single Mental Health Trust' (2008) <www.walesonline.co.uk/news/wales-news/stigma-warning-over-single-mental-2160110> accessed 26 August 2024; Bridgend County Borough Council, 'Response of Bridgend County Borough Council to Professor Michal Williams' Report 'A Well-being and Mental Health Service Fit for Wales'' <https://democratic.bridgend.gov.uk/Data/Cabinet/200808121430/Agenda/$051866.doc.pdf> accessed 26 August 2024; MentalHealthWales, 'Hart rejects all Wales mental health organization' (2008) <https://mentalhealthwales.net/2008/10/hart-rejects-all-wales-mental-health-organisation/> accessed 26 August 2024.

[797] Greater Manchester Combined Authority, Census 2021 Briefing Total Population (2023) <www.greatermanchester-ca.gov.uk/media/7869/230514_population_final.pdf> accessed 26 August 2024.

[798] Office for National Statistics, 'Population and Household Estimates, Wales: Census 2021' <www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/populationandhouseholdestimateswales/census2021#:~:text=2.-,Population%20growth%20of%20Wales%20between%202011%20and%202021,through%20a%20census%20in%20Wales> accessed 26 August 2024.

that population.[799] Whilst this did not ultimately result in the reconfiguration of mental health services in Wales separately from general health services, this was a period where mental health was seen as a priority in both policy and delivery focus. The Welsh Government undertook to ring-fence NHS mental health funding from 2008,[800] and following an independent review by PricewaterhouseCoopers in 2016,[801] this continues to 2024.

In February 2009 the Health, Wellbeing and Local Government Committee, chaired by Jonathan Morgan AM, Shadow Minister for Health and Social Services, commenced an inquiry into community mental health services in Wales.[802] The findings and response to this review will be noted below in this chapter, but in the meantime, Morgan was still pursuing his ambition for Welsh mental health law. By 2009, there had been cross party support for this, and indeed, the Assembly approved the Legislative Competence Order (LCO) in December 2009.[803] Morgan noted,

> The draft LCO could be a watershed—not for devolution, but for those in Wales, such as Lee,[804] who deserve better services that are responsive to their needs, and that offer an early assessment of those needs, individualised care and access to advocacy.[805]

The power of Lee McCabe's story and the influence it had on Jonathan Morgan is discussed further in Chapter Nine, The Welsh Paradigm.

---

[799] Salford City Council, 'Commissioning Mental Health Services' <www.salford.gov.uk/health-and-social-care/strategies-and-policies/integrated-commissioning/commissioning-mental-health-services/> accessed 26 August 2024.
[800] Wales Audit Office, 'Adult Mental Health Services Follow Up Report' (7 July 2011) 1 para 32 <www.audit.wales/sites/default/files/Adult_Mental_Health_Services_-_Follow_up_Report_English_2011_14.pdf> accessed 18 August 2024.
[801] Welsh Government, Written Statement – Welsh Government Response to PricewaterhouseCoopers Review of the Financial Ring Fencing Arrangements for Mental Health Services in Wales (2016) <www.gov.wales/written-statement-welsh-government-response-pricewaterhousecoopers-review-financial-ring-fencing> accessed 26 August 2024.
[802] National Assembly for Wales, Health Wellbeing and Local Government Committee Proposed Inquiry into mental health services in the community (2009) Committee Ref: HWLG (3)-03-09 5 February 2009.
[803] The National Assembly for Wales, The Record of Proceedings, Wednesday, 9 December 2009, p45.
[804] Lee McCabe.
[805] The National Assembly for Wales (n803) 64.

The Government of Wales Act 2006[806] permitted the Assembly to pass legislation but this followed a rather tortuous route where, even when matters fell within the devolved settlement, both Houses of Parliament in Westminster had to approve.[807] I gave evidence to the Welsh Affairs Westminster Committee in July 2009 with Lee McCabe, and it is significant that the Chairman, Hywel Francis, thanked Lee in particular 'for giving an authentic account of your own experiences'.[808] The experience of giving evidence in such circumstances is challenging when sitting in the Palace of Westminster. I would suggest that if such a requirement for interested parties to give evidence to a Westminster Government Committee were still required for the Westminster Government to approve Welsh Law it would likely mean limited citizen participation. This approach though has been amended following a further referendum where almost two thirds of the electorate supported greater law-making powers for the National Assembly for Wales,[809] and such approval is no longer required for devolved matters.[810] Legislative Competence Orders were the format that National Assembly legislative proposals had to follow. These, once approved, became Measures of the Assembly rather than Acts.[811] The Wales Act 2017 also made the Assembly, the Welsh Ministers, and Welsh legislation permanent, unless decided upon by the people of Wales.[812]

---

[806] Government of Wales Act 2006 Part 3.
[807] National Assembly for Wales, The Constitution – Legislative Competence Orders, Members' Research Service: Quick guide, (2009) 2 <https://senedd.wales/media/aytkg1yl/qg07-0058-english.pdf> accessed 26 August 2024.
[808] UK Parliament, Welsh Affairs Committee, Proposed National Assembly for Wales (Legislative Competence) (Health and Health Services and Social Welfare) Order 2009, Fourteenth Report of Session 2008-09 HC 778 Examination of Witnesses Ev 12 9 July 2009.
[809] Paul Bowers, House of Commons Library, Referendum in Wales (2011) SN/PC/05897 <https://researchbriefings.files.parliament.uk/documents/SN05897/SN05897.pdf> accessed 26 August 2024.
[810] UK Government, Devolution Settlement: Wales <www.gov.uk/guidance/devolution-settlement-wales> accessed 26th August 2024.
[811] Senedd Research, The UK Parliament and law-making in Wales (2024), <https://research.senedd.wales/research-articles/the-uk-parliament-and-law-making-in-wales/> accessed 26 August 2024.
[812] Wales Act 2017 Part A1.

Finally, the Mental Health (Wales) Measure 2010 (MH(W)M 2010) became law in Wales, and Welsh qualifying patients (including those cared for in English hospitals but funded by Wales) had a right to advocacy, and a Care and Treatment Plan (CTP).[813] The MH(W)M 2010 has four main parts setting out how services will engage with patients, plus two further parts setting out interpretation and regulatory details. Part One sets out the duty to provide assessments and services in primary care, Part Two provides for Care and Treatment Planning, Part Three for reassessment as will be discussed in Chapters Seven and Nine, and Part Four a right for advocacy.[814] Part Four extended the right to advocacy to patients who were not detained in hospital,[815] and Part One sought to ensure there was provision of mental health services at an earlier stage.[816] The development of Part One services, providing counselling and support to those individuals who may never have even approached their GP, was intended to reduce pressure on specialist services[817] so they could be focussed more on those most in need.

Both the Interim and Final Duty to Review Report[818] found a huge uptake of these services, and indeed, the development of services where people do not even have to go through their GP to seek the service.[819] However, the question remains whether those individuals who are qualifying patients, and either are subject to the Mental Health Act 1983 or are receiving specialist services, have seen corresponding improvements in their care? In 2016, the Final Report noted that there were still issues

[813] Welsh Assembly Government, Mental Health (Wales) Measure 2010 Implementing the Mental Health (Wales) Measure 2010 (2011) WAG 10-11316, 11.
[814] Mental Health (Wales) Measure 2010 Parts 1,2,3,4.
[815] ibid s 33.
[816] ibid s 2.
[817] Welsh Government, The Duty to Review Interim Report, Post-Legislative Assessment of the Mental Health (Wales) Measure 2010 (2014) WG21588, 5.
[818] ibid 4.
[819] ibid 14.

with compliance with Parts Two and Three of the MH(W)M 2010, and that accessibility to Part Three reassessment remained variable.[820] This does suggest that those who are most likely to be subject to the MHA 1983, the qualifying patients, are not receiving the same degree of benefit from this legislation as those who are less likely to be detained. This again indicates additional unfairness and disadvantage within the system and needs to be addressed, and how the system should be held to account for failing to provide what is set out in legislation or policy.

In 2009 the National Assembly Health Wellbeing and Local Government Committee commenced the 'Inquiry into mental health services in the community' in part to consider both current provision, and the impact on services of the new MH(W)M 2010.[821] My organisation (Hafal as was), submitted written evidence that mental health promotion would fail to recognise the needs of those most affected by serious mental illness, and that there was an absolute need for comprehensive care planning.[822] I gave oral evidence to the Committee for almost an hour, highlighting the importance of providing specialist services using an integrated care plan to people with serious mental illness to prevent them from needing to be hospitalised.[823] Such care planning

[820] ibid 15.
[821] National Assembly for Wales, Members Research Service, Health Wellbeing and Local Government Committee, Proposed Inquiry into mental health services in the community (2009) HWLG(3)-03-09 <https://business.senedd.wales/Data/Health,%20Wellbeing%20and%20Local%20Government%20Committee%20-%20Third%20Assembly/20090212/Agenda/HWLG(3)-04-09%20Paper%201%20Committee%20Inquiry%20into%20Community%20Mental%20Health%20Services%20-%20Scoping%20paper%20(Pdf,%2071kb).pdf> accessed 28 August 2024.
[822] Hafal, Evidence to the Health Wellbeing and Local Government Committee, (2009), HWLG(3)-05-09 paper 1 <https://business.senedd.wales/Data/Health,%20Wellbeing%20and%20Local%20Government%20Committee%20-%20Third%20Assembly/20090226/Agenda/HWLG(3)-05-09%20-%20Paper%201%20-%20Committee%20Inquiry%20into%20Community%20Mental%20Health%20Services%20-%20Evidence%20from%20Hafal%20(26-02-2009).pdf> accessed 28 August 2024.
[823] The National Assembly for Wales, The Health, Wellbeing and Local Government Committee, Committee Inquiry into Community Mental Health Services (2009) 8 at para 35 <https://business.senedd.wales/Data/Health,%20Wellbeing%20and%20Local%20Government%20Committee%20-%20Third%20Assembly/20090226/Agenda/HWLG(3)-05-09%20Transcript%20(PDF,%20117kb).pdf> accessed 28 August 2024.

is the fundamental requirement in Part Two of the MH(W)M 2010, but as noted above, even though it is in legislation, the performance is far from what should follow. Such examples of legislation not being followed, and care not delivered to the standard set in the law is a key driver for the Welsh Paradigm in Chapter Nine.

The Minister, Edwina Hart, also gave evidence to the Committee and recognised that even ahead of the MH(W)M 2010, 'an effective and co-ordinated programme of care and treatment for all service users referred to specialist mental health services was a priority.[824] The Committee reported in September 2009, and included in their findings was a reference to the view I expressed in my evidence session in relation to accountability for service delivery under the National Service Framework:

> There was an implementation advisory group to drive aspiration, but no-one ever said, 'Actually, you are not delivering what the national service framework outlines, so we are going to do something about it'. It is still left to local commissioners to make priorities. If mental health is to be a priority for the Assembly Government, it needs to say that this is the new NSF—namely the one that is currently in development—and that this is what its *[sic]* expects to see and that people will be held to account on that.[825]

The Committee also noted that, 'stronger and closely monitored incentives are clearly needed if full implementation is to be achieved and we agree with Hafal's conclusion.'[826]

The overall conclusions of the Committee included:

> Our overall impression is that the availability and quality of these services varies considerably across the country. And whilst there have been some

[824] National Assembly for Wales, 'The Minister for Health and Social Services, Evidence to the Health Wellbeing and Local Government Committee' (2009) HWLG(3)-12-09 paper 2, 2 <https://business.senedd.wales/Data/Health,%20Wellbeing%20and%20Local%20Government%20Committee%20-%20Third%20Assembly/20090514/Agenda/HWLG(3)-12-09%20-%20Paper%202%20-%20Committee%20Inquiry%20into%20Community%20Mental%20Health%20Services%20-%20Evidence%20from%20the%20Minister%20for%20Healt%20(14-05-2009).pdf> accessed 28 August 2024.
[825] The National Assembly for Wales (n823) 11 at para 52.
[826] ibid 7.

> improvements in recent years there is some way to go before services achieve consistently acceptable standards throughout Wales.
> We heard that the Adult Mental Health National Service Framework, the key mechanism for improving community mental health services, has not been properly implemented and that its achievements have been limited.
> Incentives to implement the Framework are weak and targets have been missed. Urgent action is now needed to ensure that the Framework is fully implemented.
> We also have concerns that, in the new Local Health Boards, responsibility for mental health services is to be given to Vice Chairs and Directors who are also responsible for primary and community health services. There is a danger that these other services will be so demanding that mental health services will not get the attention they deserve - this must not be allowed to happen.[827]

Disappointingly, this was foreseeable, and despite such expressions of priority setting, accountability, and service expectation, as will be seen in the discussion of performance under the MH(W)M 2010 in Chapters Seven and Eight below.

The following year saw the introduction of the MH(W)M 2010 and as a side note, Hafal was involved in the development of a training package in partnership with Lincoln University and funded by the Welsh Government.[828] Sadly, as I noted in a paper presented at a Public Law conference in Cardiff in 2012, the training provided on how to deliver the MH(W)M 2010 Care and Treatment Plan was not mandatory for Care Coordinators, who held the duty to complete these plans[829] The issue of accountability for poor practice noted earlier is clearly one much harder to apportion when training is not intrinsically linked to the role. As noted earlier, the Wales Audit Office reviewed the impact of the changes in structures in 2011 and found:

> Our overall conclusion is that since our baseline review there has been clear progress in improving adult mental health services, although some important gaps and inequalities in the services provided remain.
> This reflects the mixed success that the Welsh Government, NHS bodies, and

[827] ibid Chair's Foreword.
[828] Eve Piffaretti, Alun Thomas, Getting the Measure of Mental Health, Public Law Conference paper (2012) presented 4 April 2012 slide 27 <https://publiclawproject.org.uk/resources/getting-the-measure-of-mental-health/> accessed 28 August 2024.
[829] ibid.

> councils have had in removing key barriers to change. These organisations face new challenges in further developing services.[830]

The tone of this report is significantly different from the original baseline, and despite clear areas of concern in the report around the achievement of targets including crisis resolution, assertive outreach, and care planning,[831] it seems less critical. This arguably does not assist patients or citizens of Wales when the Wales Audit Office appears to offer more praise for a system which received significantly more funding[832] but still fails to meet even the most basic of targets.[833] In Chapters Seven and Eight we consider the performance against MH(W)M 2010 targets and Chapter Nine suggests how compliance with such targets may be financially incentivised.

The United Nations Convention on the Rights of Persons with Disabilities and the latest review of Mental Health Act 1983

The end of the first decade of the new millennium also saw the ratification by the UK Government of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).[834] Whilst ratified, this does not have direct effect and has not been incorporated into domestic law in relation to the powers to detain under the MHA 1983.[835] There is however a variance of views as to whether the prohibition of

[830] Wales Audit Office (n800) 8 para 14.
[831] ibid 62-68.
[832] ibid 67 para 4b.
[833] ibid 67-68.
[834] Laura Abreu, 'The UN Convention on the Rights of Persons with Disabilities: UK Implementation' (House of Commons Library Research Briefing 2022) CBP07367 <https://researchbriefings.files.parliament.uk/documents/CBP-7367/CBP-7367.pdf> accessed 1 September 2024.
[835] Royal College of Psychiatrists, 'The Convention on the Rights of Persons with Disabilities (CRPD): Implications for Psychiatrists and Mental Health Law' <www.rcpsych.ac.uk/docs/default-source/about-us/who-we-are/schr-convention-on-the-rights-of-persons-with-disabilities-q-and-a.pdf?sfvrsn=c8d1db87_2> accessed 1 September 2024.

detention under Article 14(2)[836]of the UNCRPD would be a positive approach. The UK Government designated the Equality and Human Rights Commission and national bodies in Scotland and Northern Ireland as the United Kingdom Independent Mechanism to promote, protect and monitor implementation of the UNCRPD across the UK.[837]

In their 2018 progress report, they noted progress in the commissioning of the Independent Review of the Mental Health Act,[838] but noted significant challenges with the use of detention under the MHA 1983.[839] This review of the MHA 1983 however quite deliberately failed to consider implementing the UNCRPD[840] with Wessley stating,

> Implementing our proposals will go a substantial part of the way to addressing the concerns motivating the CRPD Committee. But in rejecting the last steps that they propose - the abolition of all mental health legislation, whether a Mental Health or Mental Capacity Act, I wish to be clear. It is true that we do not currently have the legislative space that would be required for such a radical step. But to use this as a reason would be disingenuous. The reason is simpler – I don't agree with it, and I am far from sure that is what most service users want either, as well as many others.[841]

[836] United Nations Department of Economic and Social Affairs, Convention on the Rights of Persons with Disabilities (2006) Article 14 – Liberty and security of person, <https://social.desa.un.org/issues/disability/crpd/article-14-liberty-and-security-of-person> accessed 1 September 2024.
[837] Equality and Human Rights Commission, 'Disability Rights in the UK: UK Independent Mechanism Updated Submission to the UN Committee on the Rights of Persons with Disabilities in Advance of the Public Examination of the UK's Implementation of the UN CRPD' (2017) 4, 4 <www.equalityhumanrights.com/sites/default/files/2021/disability-rights-UK-july-2017.pdf> accessed 1 September 2024.
[838] Department of Health and Social Care (n50).
[839] Equality and Human Rights Commission, 'Progress on Disability Rights in the United Kingdom: UK Independent Mechanism Update Report to the UN Committee on the Rights of Persons with Disabilities' (2018) 15-17 <www.equalityhumanrights.com/sites/default/files/2021/progress-on-disability-rights-in-the-uk-crpd-shadow-report-2018.pdf> accessed 1 September 2024.
[840] Department of Health and Social Care (n50) 12.
[841] ibid 13-14.

Wessley supported this view with the writing of Freeman et al,[842] though the interpretation by psychiatric practitioners of the UNCRPD and its practicability could well be skewed in what is currently a power relationship in their favour.

The UN Office of the High Commissioner has made it clear that even where there are national laws which allow detention, these are, "incompatible with Article 14 as interpreted by the jurisprudence of the CRPD committee".[843] Bartlett suggests that the view of the CRPD committee should be read in the context of outdated mental health legislation and services, and forms a:

> 'demand that support be provided to people with mental disabilities, to access services appropriate to their needs and that they are prepared to accept. This is certainly a significant departure from the legal structure we have now, but it is also similar to how we provide other medical services. If we are looking to a model of equal citizenship, that would be a mark in its favour.[844]

I would agree with Bartlett in this regard as while I believe that the use of compulsion is too widespread, is damaging, and lacks sufficient scrutiny, there are still likely cases where people will require treatment without consent. The key I think though is that this should be based on the capacity to make decisions, but that is for other researchers with a specific interest in the MCA 2005 and falls outside of the focus of this thesis. What I strongly support though is the idea that is there was much greater pressure on the State to provide services that people wanted and at a time where this was needed, the need for detention would lessen.

---

[842] Melvin Colyn Freeman and others, 'Reversing Hard-Won Victories in the Name of Human Rights: A Critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities' (2015) Lancet Psychiatry 2(9) July 2015.

[843] United Nations Human Rights Office of the High Commissioner, Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities, Committee on the Rights of Persons with Disabilities Fourteenth Session (2015) <www.ohchr.org/Documents/HRBodies/CRPD/14thsession/GuidelinesOnArticle14.doc#:~:text=Article%2014%20of%20the%20Convention%20is%20in%20essence%20a%20non,on%20disability%20in%20its%20exercise> accessed 28 August 2023.

[844] Paul Gosney, Peter Bartlett, 'The UK Government should withdraw from the Convention on the Rights of Persons with Disabilities' (2020) BJPsych 216 296, 298.

As noted above, the ECtHR found in *Winterwerp*[845] that detention for a mental illness is compatible with Article 5 of the ECHR so long as three tests are met and that the detention is in accordance with a procedure prescribed by law. These tests are that i) there must be an objective medical diagnosis, ii) the disorder must be sufficiently serious to justify detention, and iii) the disorder must persist throughout the period of detention.[846] These requirements differ from those set out in the UNCRPD and in particular the test under Article 14(1)(b) which sets an additional challenge to the use of detention in mental health law, namely:

> 1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
>
> a)…
>
> b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, *and that the existence of a disability shall in no case justify a deprivation of liberty*.[847]

This differentiates the UNCRPD from the ECHR in that despite having a legal framework, this is not sufficient, disability itself cannot be grounds for detention.

In 2012, Bartlett suggested that 'As currently interpreted, this does not mean simply that disability cannot be the only ground for detention; it means that disability cannot be a factor in determining detention at all.'[848] More recently he has suggested that compliance with Article 14 offers more opportunity for system change:

> The CRPD approach would instead ban compulsory detention, based in whole or in part on disability: the adequacy of process would become largely irrelevant, since detention with any process would constitute a violation of the CRPD. Instead, appropriate alternatives would be required so that the people now in the institutions would have real options. Certainly, that would include accommodation in the community and support arrangements that would meet the person's needs as he or she understood them. Those might well include

[845] *Winterwerp v The Netherlands* (1979) 2 EHRR 387.
[846] ibid [39].
[847] United Nations General Assembly (n24) emphasis added.
[848] Peter Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) Modern Law Review Vol 75 No 5 (September 2012):752, 772.

> education, habilitation and rehabilitation, promotion of employment possibilities, and a variety of policies to encourage participation in cultural and similar activities, since meaningful community integration means more than simply accommodation in the community. It would also include a duty to protect the individual from violence and abuse in the community. That is a significant shift from the older requirements of providing procedural protections.[849]

This suggests that the MHA 1983 whilst compatible with the ECHR, cannot be compatible with the UNCRPD as the detention relies upon the individual having a disability and as such detention for a mental illness should not occur. Indeed, if such an approach led to a change in the way we deliver services for the seriously mentally ill in the way Bartlett suggests above, this would surely be a more humane system.

The view of incompatibility with the UNCRPD is not however a universal view. In evidence to the Joint Committee on the Draft Mental Health Bill, Simon Wessely, the Chair of the Independent Review of the Mental Health Act set out a different perspective in so far as interpreting the UNCRPD and the need for mental health legislation:

> The principles that we endorse and wish to see on the front of the Act, which we will come back to, are basically the ones that use the least coercive measures for the shortest possible time and with the least possible interference in choice and autonomy, which are all CRPD principles as well. All of that is what we endorse, but we do not endorse changing the word "least" to "none". That is where we are drawing the line. I think that goes for most people and, from what you have just said, you agree with that as well. The principles are fine, but we think that some of the interpretations made go too far. Joint Committee on the Draft Mental Health Bill. There is no getting round it. It is an intellectually tenable position to say that we should have no mental health or capacity legislation at all, but I just do not think it is a good idea. I cannot put it any better than that.[850]

[849] Peter Bartlett, 'Beyond the liberal subject: challenges in interpreting the CRPD, and the CRPD's challenges to human rights' (2025) Human Rights Law Review 2025 25 1, 6-7 original references omitted.

[850] House of Lords, House of Commons, 'Joint Committee on the Draft Mental Health Bill, Oral evidence' (26 October 2022) HC 696, 9-10.

That said, Bartlett suggests that legislation could be developed which would permit detention for care and treatment or to prevent harm, but this would have to be without any link to the disability.[851]

As I explored in Chapter One, the Public Health (Control of Disease) Act 1984 s.45G permits a magistrate to order the detention of a person if they are infected or suspected of being infected with a pathogen which presents or could present significant harm to human health. This is subject to there being a risk that they may infect others, and that the detention itself is necessary to remove or reduce that risk. This legislation relates to the management of a risk of transmission to others, not of the impact of the pathogen on the individual and arguably is not therefore linked to a disability.

However, there is of course a risk that individuals with a disability may be more disproportionately affected by such legislation, and indeed during the COVID-19 pandemic, public health legislation was used to modify some of the safeguards within the MHA 1983 and the MCA 2005.[852] While this is legislation that relates to the risk of transmission rather than the management of a disability, I do not believe it is a model fit for adaptation to prevent detention on mental health or disability grounds. This is because it may have the unintended consequences of being applied more often to those groups who may require greater support to comply with restrictions before detention, and unless the support is provided, the application may occur because of the disability. That said, the principle that the detention is based upon risk, that there is significant judicial oversight, and that there can be no involuntary treatment to a capacitant patient

[851] Bartlett (n848) 773.
[852] Coronavirus Act 2020 s 10.

does seem to follow the route of a fusion approach as developed in Northern Ireland (discussed in further detail later in this chapter).

Consideration of the UNCRPD was a factor in the Bamford Review which led to the Mental Capacity (Northern Ireland) Act 2016, and this suggests that there are opportunities to protect patients and the public without falling foul of the UNCRPD.[853] Development of such legislation however would need to ensure that patients do not fall through the gaps and that protections are in place for times where patients lack the understanding and capacity to make critical decisions or may need support to make those decisions. Supported decision making has its own challenges which are discussed further in Chapter Eight. The Committee on the Rights of Persons with Disabilities, are the monitors of State implementation (including that of the UK) of the UNCRPD. This Committee defines mental capacity as the 'decision-making skills of a person', and as such suggests the abolition of substituted decision-making.[854] Eminent clinicians raised concerns that the interpretation in the General Comment on Article 12 of the UNCRPD would result in greater risks to patients and called for further debate with clinical groups, patients, families, and advocacy groups.[855]

This future dialogue prior to any such fundamental change to mental health legislation is crucial in light of the long history of conflict between lawmakers, patient groups, professional bodies, and others in the development of mental health legislation in England and Wales (see Chapters Four and Five). The purpose of this thesis is not to re-

[853] Gavin Davidson and others, 'The Fusion Approach to Mental Capacity Law in Northern Ireland: Possibilities and Challenges' in Camillia Kong and others (eds), *Capacity, Participation and Values in Comparative Legal Perspective* (Bristol University Press 2023) 51-53.
[854] Freeman (n842) 844-850.
[855] ibid.

engage those discussions on the MHA 1983 but rather to identify a Welsh approach to improve the experience of people with a serious mental illness in Wales.

The Wessley review[856] was followed by yet another Draft Mental Health Bill,[857] and my colleague Jo Roberts, a mental health campaigner for many years, submitted Adferiad's response to the Joint Committee on the Draft Mental Health Bill. I had previously supported Jo to give evidence to the UK Parliamentary Scrutiny Committee on the 2004 Draft Mental Health Bill, and her evidence was supported then by a call for reciprocal rights.[858] In the response to the 2022 Draft Bill, the call for reciprocal rights was again at the forefront of the evidence submitted by Jo,[859] and indeed, the call for compatibility with the UNCRPD was noted by the Committee.[860] Disappointingly, the Draft Bill offered little new to Welsh patients as advocacy, and Care and Treatment Plans were already in place under the MH(W)M 2010.

While there were important proposals in respect of the disproportionate use of the MHA 1983 on black people and addressing the challenges around capacity and mental health and therapeutic benefit,[861] the Bill remained one tinkering around the edges. In the end this did not matter as the Bill was not included in the final King's Speech in 2023.[862] It was however included in the first King's Speech of the new Labour

[856] Department of Health and Social Care (n50) 12.
[857] Department for Health and Social Care (n47).
[858] House of Lords and House of Commons, Joint Committee on the Draft Mental Health Bill, HL Paper 79-II HC 95-II (2005) The Stationery Office 256-257.
[859] Jo Roberts, 'Written evidence submitted by Ms Jo Robers supported by Adferiad Recovery' (MHB0036) (2022) <https://committees.parliament.uk/writtenevidence/111575/pdf/> accessed 1 September 2024.
[860] House of Lords and House of Commons, Joint Committee on the Draft Mental Health Bill 2022, HL Paper 128 HC 696 (January 2023) 13-14.
[861] ibid 5-6.
[862] Mithran Samuel, 'Mental Health Act reform ditched, King's Speech confirms' Community Care, <www.communitycare.co.uk/2023/11/07/mental-health-act-reform-ditched-kings-speech-confirms/> accessed 1 September 2024.

administration in 2024,[863] with an ambition of parity, and a Mental Health Act 'fit for the twenty first century'. We do appear though to be reverting back to the approach by the Labour administration in 2001. Tragically, there have been a number of recent serious failings in mental health services, and one in particular, the Valdo Calocane case, has led Wes Streeting, Secretary of State for Health, to again focus on the public protection agenda rather than the rights agenda.

The Care Quality Commission Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust was published shortly after the 2024 general election. This had a particular focus on the actions of the Trust leading up to and relating to the tragic homicides of three people at the hands of Valdo Calocane.[864] The review found concerns with:

- assessing and managing risk in the community
- the quality of care planning, and the engagement and involvement of families
- poor quality discharge planning.

It has also identified additional patient safety concerns at NHFT around:

- medicines management and reviews
- managing people who find it difficult to engage with services
- clinical decision making around detaining patients under the Mental Health Act.

Our review suggests that in VC's[865] case there was no single point of failure, but a series of errors, omissions and misjudgements in all these areas.[866]

Clearly there were multiple system failures in Valdo Calocane's case. This reminds me of the issues faced in the 2002 and 2004 Draft Mental Health Bills and the case of

[863] House of Lords, The King's Speech 2024 <www.gov.uk/government/speeches/the-kings-speech-2024> accessed 1 September 2024.
[864] Jessica Murray, 'Nottingham attacks: series of errors led to Valdo Calocane being discharged, review finds' *The Guardian* 13 August 2024.
[865] Valdo Calocane.
[866] Care Quality Commission, Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2 Conclusions 40 <www.cqc.org.uk/publications/nottinghamshire-healthcare-nhsft-special-review-part2> accessed 1 September 2024.

Clunis,[867] where the government was more focussed on public safety rather than the provision of services as noted in Chapter Four. We now appear to be heading in that direction with the press suggesting that Streeting has said that reform will now be delayed so that he may hear more from families and victims of such homicides.[868] It would appear that the system is already badly broken, but yet again, the knee jerk reaction to the public protection agenda will triumph over practical matters affecting patients.

A Short Reflection on Northern Ireland and the Bamford Review

While the Westminster Government was considering the 2002 and 2004 Draft Mental Health Bills and the MCA 2005, Northern Ireland took a significantly different approach. During this period a review of mental health and learning disabilities was undertaken in Northern Ireland, chaired by Professor David Bamford (the Bamford Review).[869] The Bamford Review was set up in October 2002[870] and reported in 2007. It considered both service delivery and the Mental Health (Northern Ireland) Order 1986, and identified that, as there was no separate capacity legislation in Northern Ireland, the legislation was not compliant with principles of 'autonomy, justice, benefit, and least harm'.[871] These 'overarching principles' were proposed by Bamford on the basis that, ' A sound ethical base for legislation is the cornerstone around which

[867] Laurance (n614) x.
[868] Jessica Murray, 'Ministers to 'slow down' mental health changes after Vlado Calocane report' *The Guardian* 13 August 2024.
[869] Department of Health for the Northern Ireland Executive, 'Bamford Review of Mental Health and Learning Disability (Northern Ireland), A Comprehensive Legislative Framework' (2007) <www.health-ni.gov.uk/sites/default/files/publications/dhssps/legal-issue-comprehensive-framework.pdf> accessed 13 July 2025; Health and Social Care Public Health Agency Northern Ireland, 'Implementing Bamford: Knowledge from Research' (2011) 2 <https://research.hscni.net/sites/default/files/Bamford_Summary_Report.pdf> accessed 13 July 2025.
[870] Department of Health for the Northern Ireland Executive (n869) ii.
[871] Gerard Lynch, Catherine Taggart, Philip Campbell, 'Mental Capacity Act (Northern Ireland) 2016' (2017) BJPsych Bulletin (2017) 41 353, 353.

specific proposals should be formed', to 'recognise and support the dignity of the person. They form the basis of the Review's proposals for legislative reform.'[872]

The Bamford Review's recommendations included:

> A rights-based approach is proposed as the guiding principle for reform of legislation which should respect the decisions of all who are assumed to have capacity to make their own decisions. Grounds for interfering with a person's autonomy should be based primarily on impaired decision-making capacity. New legislative solutions are, therefore, required for issues posed by the effects of disorder of the brain or mind on an individual's decision-making capacity and which affects his/her own personal health, the need for care and treatment, safety and the welfare or the safety of others.

And:

> The Review proposes that the provision of care and treatment for mental disorder in relation to offenders or suspected offenders, and also their protection from abuse or exploitation, should be dealt with under the same legislation as that which applies to nonoffenders.[873]

This cross-over with the management of offenders/suspected offenders with a mental disorder was possible as policing and justice functions were devolved to the Northern Ireland Assembly and Executive in 2010[874] - unlike in Wales, where such powers are reserved to Westminster. The Welsh Government believes that justice should be devolved to Wales,[875] but despite engagement with UK Government,[876] this remains as an ambition. While this ambition is focussed initially on youth justice and probation,[877] the UK Government Prisons Minister stating that devolution is not 'a priority' due to the current state of the system in the UK.[878]

---

[872] Health and Social Care Public Health Agency Northern Ireland (n869) 4.
[873] Department of Health for the Northern Ireland Executive (n869) 26 4.7-4.9.
[874] The Northern Ireland Act 1998 (Devolution of Policing and Justice Functions) Order 2010.
[875] Welsh Government, 'Delivering Justice for Wales' (2022) 3 <www.gov.wales/sites/default/files/publications/2022-06/delivering-justice-for-wales-may-2022-v2.pdf> accessed 31 August 2025.
[876] Welsh Government, 'Written Statement: Preparing for the devolution of justice' (2025) <www.gov.wales/written-statement-preparing-devolution-justice-0> accessed 31 August 2025.
[877] ibid.
[878] Mark Palmer, David Deans, 'Not priority to devolve probation says UK Minister' (2025) BBC Wales News <www.bbc.co.uk/news/articles/c86gd41z39yo> accessed 31 August 2025.

The development of such fused legislation, promoted by researchers such as Dawson, Szmukler, Daw, McCallion, and O'Hare,[879] has been the subject of debate for over twenty years.[880] Whilst detailed consideration of the motivations underpinning the Northern Ireland approach is beyond the focus of this thesis, in part due to the UK Government's approach to having separate mental health and mental capacity legislation, the fused approach is worthy of some exploration. The Mental Capacity Act (Northern Ireland) 2016 sought to address some of the issues in relation to compliance with the UNCRPD[881] (highlighted throughout this thesis but see especially Chapter Five). As noted above, this Northern Irish approach sought to place mental and physical health on the same footing when it related to capacity and the ability to exercise rights, and as such sought to align with the principles of the UNCRPD, and the 'spirit of the Human Rights Act 1998'. [882]

The approach in Northern Ireland was to create a single Act to incorporate the legislative needs for capacity legislation and one which recognises the need to address mental illness related detention and involuntary treatment through a capacity based approach.[883] Capacity is addressed in the same way for an individual with a mental illness as any other patient under this legislation.[884] This relies upon two tests:

1. A diagnostic test – there must be an impairment of, or a disturbance in, the functioning of the mind or brain, and;
2. A functional test – the person is unable to understand the information relevant to the decision, to retain the information long enough to make the decision, *to appreciate the relevance of that information* and use or weigh

[879] George Szmukler, Rowena Daw, John Dawson, 'A model law fusing incapacity and mental health legislation' (2010) Journal of Mental Health Law 20:9; Maura McCallion, Ursula O'Hare, 'A new legislative framework for mental capacity and mental health legislation in Northern Ireland: an analysis of the current proposals' (2010) Journal of Mental Health Law 20:84.
[880] Davidson (n853) 51-52.
[881] Colin Harper, Gavin Davidson, Roy McClelland, 'No Longer 'Anomalous, Confusing and Unjust': The Mental Capacity Act (Northern Ireland) 2016' (2016) International Journal of Mental Health and Capacity Law (22) 57 65-66.
[882] Department of Health for the Northern Ireland Executive (n869) 3.
[883] Lynch (n871) 356.
[884] Mental Capacity (Northern Ireland) Act 2016 ss 3-4.

> the information as part of the process of making that decision, and communicate the decision.
>
> There must be a causal link between the two tests - the person is unable to make a decision because of impairment or disturbance in the brain or mind.[885] (*emphasis added)*

This is not simply about understanding what is being said but is about the ability to apply the information in making a decision. This approach provides for detention and/or involuntary treatment in situations where a formal capacity assessment is made (where the patient is represented by a nominated person throughout[886]) and a suitably qualified person provides a written statement of incapacity.[887] Such treatment though is limited and is authorised only following a review and decision from a trust panel[888] who must consider the relative risks to the patient or others and the nature of those risks.[889]

This approach appears to be far more aligned with the principles under Articles 12 and 14 of the UNCRPD in that there is a more universal approach to mental health and physical health, and in particular, Article 14(1)(b) which refers specifically to detention and disability. The Mental Capacity (Northern Ireland) Act 2016 is intended to be a replacement for the Mental Health (Northern Ireland) Order 1986 for those over 16 years, but sadly, despite the implementation of phase 1 of the Act in 2019, this has not yet progressed to address the Mental Health (Northern Ireland) Order 1986.[890]

---

[885] Lynch (n871) 354.
[886] Mental Capacity Act (Northern Ireland) 2016 ss 9, 12,13,15,16,17,19, 20, 24, 26, 28, 30.
[887] Lynch (n871) 355.
[888] As set out in The Mental Capacity (Deprivation of Liberty) (No.2) Regulations (Northern Ireland) 2019 Part 4.
[889] Mental Capacity (Northern Ireland) Act 2016 Chapter 4.
[890] Department of Health Northern Ireland, 'Mental Capacity Act Background' <www.health-ni.gov.uk/articles/mental-capacity-act-background> accessed 5 August 2025.

Ultimately the Bamford Review led to a divergent course of action in the legislation in Northern Ireland (when contrasted with England and Wales), thereby illustrating the opportunities devolution offers for alternative approaches. This Northern Irish route aligns better with the concerns raised around detention for a mental illness earlier in this chapter and would offer a less discriminatory approach to addressing the challenges faced by an individual experiencing serious mental illness. When there is full implementation in Northern Ireland it will be possible to more fully assess the potential efficacy of this approach, how it affects the individual, and whether it has any impact on public safety. This does however highlight that there may be opportunities for Wales to consider an alternative approach.

Is there a Welsh Solution?

'Wales has a long and distinctive history of placing justice at the centre of its culture and society',[891] and this offers an opportunity for a 'test bed' type approach for more humane legislation and person-centred care. Whilst policing and criminal justice is still not yet devolved, and as such, the MHA 1983 itself remains with Westminster, Wales and Welsh governance has some unique features which lead me to consider a Welsh solution.

In considering the current legislative, and policy 'perfect storm', and the unique Welsh position in respect of population, policy, and the Welsh 'citizenship' approach, there are significant opportunities for Wales to steer its own course. As noted earlier, the journey from Welsh Assembly to Senedd Cymru and the accompanying increase in ability to legislate offers much to a brave Government. The impact of the COVID-19

[891] The Commission on Justice in Wales, 'Justice in Wales for the People of Wales' (2019) 6.

pandemic and the need the find a 'new normal' can allow a transition to a model where services are more responsive to needs at an earlier stage, so long as the chance to make a change is embraced, and this is considered in further detail in Chapters Seven and Eight. While there are arguments that Wales cannot develop primary legislation to replace the MHA 1983 as criminal justice matters are not devolved, there is another view. There is now experience of creating law[892] or regulations[893] in Wales that require a different policing approach to that in England, and this suggests that we should seek to find alternative approaches.

There is also the question as to whether the Welsh Government has the legislative competence or indeed the appetite to develop a Welsh alternative to the MHA 1983. As far as appetite, at the time of writing there is less than a year to go to an election where the Labour Party is heading for its worst result since devolution itself.[894] There are continuing challenges in the NHS in Wales,[895] and the relationship with UK Labour is creaking, with the First Minister identifying a "red Welsh Labour way", somewhat reminiscent of the Clear Red Water approach from Rhodri Morgan.[896] The current administration has no time - even if it had the energy or inclination - for a Welsh specific Mental Health Act. Further, if there was the appetite, there are legislative challenges to be overcome.

[892] Children (Abolition of Defence of Reasonable Punishment) (Wales) Act 2020.
[893] The Health Protection (Coronavirus Restrictions) (No.3) (Wales) Regulations 2020, WSI 2020/1149 (W.261).
[894] George Thompson, 'Welsh Labour could slump to historic low in 2026 Senedd elections, poll finds (2025) Independent 6 May 2025 <www.independent.co.uk/news/uk/home-news/plaid-cymru-welsh-government-senedd-welsh-labour-b2745861.html> accessed 7 July 2025.
[895] Adrian Masters, 'First Minister accused of 'refusing to acknowledge a crisis in NHS'' (2025) ITVNews 21 January 2025 <www.itv.com/news/wales/2025-01-21/first-minister-accused-of-refusing-to-acknowledge-crisis-in-nhs> accessed 7 July 2025.
[896] David Deans, 'Wales' Labour first minister says she'll call out Starmer' (2025) BBC Wales News 6 May 2025 <www.bbc.co.uk/news/articles/cy9v7gn9729o> accessed 7 July 2025.

The Wales Act 2017 sets out those matters which Westminster has reserved to the UK Government and thus cannot be legislated upon by the Senedd. These include the single legal jurisdiction of England and Wales,[897] which includes sentencing in criminal proceedings.[898] The MHA 1983 has specific sentencing provisions for offenders with a mental disorder[899] and as such, it would suggest that the MHA 1983 would fall within reserved matters to the Westminster Government. Additionally, the Wales Act 2017 also provides for prisons and offender management to remain reserved matters, including specifically referencing prisoners subject to ss. 47 to 49 of the MHA 1983.[900]

As criminal justice matters are not devolved, this indicates that Wales cannot currently develop primary legislation to replace the MHA 1983. However, these is perhaps a more pragmatic approach that could be explored. Since 2020, there is now a track record in Wales of creating law[901] or regulations[902] that require a different policing approach to that in England. Accordingly, should there be an appetite to do so, the Welsh government could seek alternative methodologies which could mean developing Welsh law in a way that does not fall foul of the reservations within the Wales Act 2017, and allows for additional rights and services within devolved matters. This has previously been achieved in the provision of independent mental health advocates under the MH(W)M 2010;[903] and should there be political will, legislation such as the MH(W)M 2010, or the Social Services and Wellbeing (Wales) Act 2014,

[897] Wales Act 2017 Sch 7 Part 1 s 8.
[898] ibid s 8(1)(c).
[899] Mental Health Act 1983 ss 37/41/45A/49.
[900] Wales Act 2017 Sch 7 Part 2 Section L11 s 175.
[901] Children (Abolition of Defence of Reasonable Punishment) (Wales) Act 2020.
[902] The Health Protection (Coronavirus Restrictions) (No.3) (Wales) Regulations 2020, WSI 2020/1149 (W.261).
[903] Mental Health (Wales) Measure 2010 Part 4.

offers routes for similar innovation. The Welsh Government could choose to legislate to impose specific duties in relation to mental health to counter the draconian nature of the MHA 1983, and this is what I propose in Chapter Nine, The Welsh Paradigm. The Welsh Paradigm will set out a pragmatic approach to the Senedd for a more humane and rights-based approach to mental health law in Wales.

Conclusion

In almost a quarter of a century since the millennium, we have seen five Mental Health Bills (including drafts), a new Act,[904] the MCA 2005, and the first Welsh mental health law since the 10th Century, but the power imbalance persists. The coming of the HRA 1998 and the ratification of the UNCRPD have sadly meant little to individuals subject to the MHA 1983 in so far as an improvement in their right to early, and quality healthcare. The latest Mental Health Bill 2024, for those in Wales, offers little more than already exists under the MH(W)M 2010, and appears to be yet another missed opportunity to provide a reciprocal right to treatment to counteract the damage of detention.

The development of new mental health law will likely again be influenced by stigma and fear, magnified by lurid press stories, and put forward as a public protection priority. In Wales, while it is unlikely that primary powers will be available for replacing the MHA 1983 with a purely Welsh Act, there is the opportunity to apply Welsh policy, and secondary legislation to improve the rights of the seriously mentally ill. Chapter Six provides us with some understanding of the need for this Welsh perspective but offering a journey through the challenges a patient faces in accessing

[904] Mental Health Act 2007.

treatment in a system which does not prioritise early responses to avoid detention. This will lead us onto the consideration of a Welsh solution in Chapters Seven, Eight, and Nine.

Chapter Six – A fictional amalgam of experiences shared with me by patients and families

Introduction

As outlined in the introduction chapter, the stories of the personal experiences of many individuals when they encounter the mental health system in Wales acted as the driver for this thesis. As part of my role with a mental health charity, I have heard the experiences of people across Wales who have felt let down and abandoned by a system which seems to them as acting only for public protection rather than a therapeutic intervention. Early intervention is a keystone in high quality mental health services,[905] and can often avoid both expensive long-term care, and trauma and deterioration in the health and wellbeing of the patient.[906]

My desire to undertake this thesis was prompted in large part[907] by the experiences of Richard[908] as shared with me before Richard's untimely death in 2009. My understanding of the challenges faced by Richard and his family are strong themes throughout this thesis, and while the story below is not that of his situation, the impact on patients and families noted is strongly influenced by this understanding. Richard

---

[905] Rethink Mental Illness, 'Briefing: Early Intervention in Psychosis (EIP') <www.rethink.org/campaigns-and-policy/campaign-with-us/resources-and-reports/briefing-early-intervention-in-psychosis-eip/#:~:text=Reduced%20suicide%20rates%20%E2%80%93%20EIP%20services,on%20supporting%20people's%20physical%20health> accessed 22 September 2024; Pennsylvania Psychiatric Institute, 'The Power of Early Intervention in Mental Health: A Pathway to Wellness and Recovery' <https://ppimhs.org/newspost/the-power-of-early-intervention-in-mental-health-a-pathway-to-wellness-and-recovery/> accessed 22nd September 2024.

[906] Pennsylvania Psychiatric Institute (n905).

[907] Certain details have been omitted which are not relevant and are very personal, but the information included is accessible in newspaper and online news stories where Richard gave interviews about his personal experience in order to improve the lives and experience of others.

[908] BBC News, 'Mental health patients 'let down'' 19 July 2006 <http://news.bbc.co.uk/1/hi/wales/5193188.stm> accessed 22 September 2024; Madeleine Brindley Health Correspondent (September 10 2002 Tuesday) MENTAL HEALTH GROUPS OPPOSE DRAFT BILL; NHS: CRITICS OF OVERHAUL FEAR TREATMENTS WILL BE IMPOSED ON PATIENTS WITH CAPACITY TO CHOOSE FOR THEMSELVES, *Western Mail* <https://advance.lexis.com/api/document?collection=news&id=urn:contentItem:46ST-YY80-015B-331Y-00000-00&context=1519360> accessed 9 November 2024.

was a great supporter of Hafal, the organisation managed by the author, and he spoke openly about the struggles he faced in getting support for his mental health, and how, despite being referred for specialist support he only received help from the police when he was in crisis. Often, the police may be the only agency to respond to an individual in mental health crisis,[909] and this manifests in the use of sections 135/136 of the MHA 1983 which permit them to detain individuals for assessment. A snapshot of the quarter from April 2024 to June 2024 shows that of 551 people detained in Wales under s.136, 155 received ongoing inpatient care, 288 received ongoing support and treatment, with less than 20% discharged with no support.[910] From this we can see that 80% of those who come into contact with the police for their mental health via the s.136 route required either inpatient or specialist care.

In this chapter, I have created a fictional amalgam of many such experiences shared with me which will examine the routes of admission to services, the priority given by the current system for accessing therapy, and the accessibility of inpatient beds. I will then consider how the routes via the criminal justice system impact on the patient and their family. At each stage, this chapter will consider how failure to provide prompt treatment may form the basis to establish a potential course action (taking into account the broad range of duties to treat on the NHS and similar bodies). I will finally consider a determination of harm predominantly in relation to Articles 3, 5, 6, 7, 8, and 14 of the HRA 1998. The consideration of Article 14 will relate to the duty of the UK as a

[909] Senedd Wales, 'Police response to people in mental health crisis' Senedd Research (2020) <https://research.senedd.wales/research-articles/police-responses-to-people-in-mental-health-crisis/> accessed 22nd September 2024.
[910] StatsWales, 'Section 135 and 136 Detentions by local health board, assessment outcome and quarter' <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/Detentions-under-Section-135-and-136-Mental-Health-Act/section135136-by-lhb-outcomeofassessment-quarter> accessed 22nd September 2024.

signatory to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)[911] not to discriminate on grounds of a disability.[912]

It should be noted that while the patient experience detailed below was a key factor in my choice to develop this thesis, the issues raised in relation to access to treatment are not those that I will eventually address in Chapter Nine, the Welsh paradigm. This is because my initial thoughts were to develop the argument that this thesis should be focussed on identifying a route to address the access from primary care to specialist services, to seek to reduce emergency admissions[913]. In carrying out this research and reviewing what I now believe to be a pragmatic approach to changing Welsh Government policy and practice, I will be focussing on patients already known to specialist services. The fictional amalgam below though is a helpful journey through the difficulties faced by patients and families where services fail to act in a reasonable time. I will explain in more detail in Chapter Eight why I have considered this different route.

The Crisis[914]

A 40-year-old married woman (P) with a job in a government agency has had a fairly unremarkable health record up to the point where she receives devastating family news which causes a rapid decline in her mental health. She becomes increasingly anxious, depressed, and withdrawn, and her husband persuades her to visit her family doctor. The family doctor suggests some counselling. Such services are available for low level

[911] United Nations General Assembly (n24).
[912] United Nations Human Rights Office of the High Commissioner (n843).
[913] See footnote 20, p.14 for a further explanation.
[914] While this fictional amalgam is based on experiences shared with me over some 20 years, it has been updated to take cognisance of changes to service provision, legislation, practice, and health board structures since the original events.

mental health issues within 28 days in Wales,[915] but the services are achieving less than 80% compliance with these targets. [916] Nevertheless, P accesses support within 28 days. The counselling provision offered is for six sessions and P undertakes all six sessions over three weeks but remains distressed and is becoming increasingly unwell.

P visits the family doctor again who prescribes anti-depressant medication and makes a referral to secondary mental health services for assessment. Secondary mental health services are under pressure, and despite the referral highlighting the lack of progress, it takes 8 weeks for P to be assessed,[917] by which time she has been signed off from work, and the situation at home is deteriorating. The standard expected for a routine assessment is 28 days.[918] P is expressing suicidal thoughts and is feeling paranoid. P is called for an appointment with a consultant psychiatrist after a further 3 weeks,[919] and following a medication review is referred for Eye Movement Desensitization and Reprocessing (EMDR) via the Community Mental Health Team (CMHT). The CMHT do not currently have an EMDR practitioner in the area that P lives[920] and P will be waiting for several months for this treatment.[921] P continues to experience dark

[915] NHS Wales, 'Waiting Times' <https://111.wales.nhs.uk/Waitingtimes/> accessed 30 December 2021.
[916] StatsWales, Waiting times for a therapeutic intervention, by LHB, age and month June 2024 <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/Mental-Health-Measure/Part-1/waitingtimesforatherapeuticinterventiont-by-lhb-month> accessed 22 September 2024.
[917] Royal College of Psychiatrists, 'Hidden waits force more than three quarters of mental health patients to seek help from emergency services' (2022) <https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2022/10/10/hidden-waits-force-more-than-three-quarters-of-mental-health-patients-to-seek-help-from-emergency-services> accessed 22 September 2024.
[918] Welsh Government, Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010 (2012) WG14643, 50.
[919] Royal College of Psychiatrists (n917).
[920] This is not an uncommon feature where psychological services are provided by CMHTs as the availability of therapies depends upon the team members, A Lewis, A Beck, A Clark, 'Psychological Therapies Review in North Wales' (2019) <https://bcuhb.nhs.wales/news/updates-and-developments/updates/archived-updates/psychological-therapies-review-in-north-wales/psychological-therapies-review/bcuhb-psychological-therapies-review/> accessed 5 January 2022.
[921] Mind, 'Hundreds of people in Wales wait more than a year for help with their mental health' (2021) <www.mind.org.uk/news-campaigns/news/hundreds-of-people-in-wales-wait-more-than-a-year-for-help-with-their-mental-health/> accessed 22 September 2024.

thoughts, and has now been called to a fitness review with her employer, where she is informed that her employment is at risk if she is not able to return to work in the foreseeable future. As P is unable to determine when the therapy will start, she is left in limbo and becomes more fearful for her future.

Ten days later, P's daughter contacts the CMHT to seek support as P is talking about means of taking her life, and she has expressed the view that her husband would be better off without her. She is very concerned, and the CMHT increase P's medication and confirm that they are seeking EMDR treatment via another CMHT. Four months after the referral for EMDR, police are called to the docks area where P is sitting on a parapet in tears. She expresses suicidal intent, but the police are able to persuade her to move to a safe place, and at this point they detain P under s. 136 MHA 1983 to move her to a place of safety for an assessment of her mental state by a registered medical practitioner. P is transported to the local mental health hospital, and the need for her admission to hospital is confirmed by two medical officers and an Approved Mental Health Practitioner (AMHP), and she is detained under s.2 MHA for up to 28 days for assessment.[922]

For the first two weeks of her detention, P is tearful and under continuous observation: her mental state is poor, and she is not eating or sleeping. Family are worried about her, but with their agreement with clinical staff, limit visiting to twice a week so as to reduce the guilt expressed by P to family for her admission. A medication review significantly changes the regime, and a referral is made for EMDR as an inpatient. Inpatient treatment times are long, and it is expected that P will wait for at least three

[922] For the purposes of the case study, it is taken that P meets the criteria for detention and there are no challenges in relation to either the police or health detentions and that all necessary hospital manager hearings and Tribunals are managed appropriately.

months before the specialist treatment is available. As her suicidal thoughts and low mood continue, she is further detained under s.3 MHA 1983 for a period of 6 months. P's sick pay has been exhausted, and the family are facing financial problems. Three months into the s.3 MHA 1983 detention, P starts undergoing EMDR therapy: she receives 8 sessions over 8 weeks and is making progress. Her mood has lifted, she is able to rationalise her thoughts, and, while she remains deeply disturbed by the nature of the family matters, she finds himself more able to discuss this with the team. Her family see the difference in her, and following a multidisciplinary team meeting, it is agreed that P will be discharged from s.3 MHA 1983 and can go home with a s.117 MHA 1983 aftercare package. This will include ongoing outpatient EMDR treatment, assistance with finances, support to get back to work, and support from the CMHT. P returns home and continues to receive support. Her health does not improve sufficiently in the short term, and with the support of her trade union she retires on ill health grounds from her role. Over the next two years P becomes well enough to volunteer and eventually to work in a mental health support worker role as a peer mentor.

Identifying Potential Causes of Action

As outlined in the Introductory Chapter, this thesis is intended to identify whether Welsh law currently satisfies the role of protecting the rights of the mentally ill or if not, can it be reasonably further developed to protect and / or enhance the rights of the mentally ill. Chapters Four and Five identified the Human Rights drivers for mental health in the HRA 1998, the UNCRPD, and ECHR, but is there a right to assessment and treatment, and indeed to have a guarantee of mental health?

In considering this question I was fortunate enough to attend a lecture by Mr Justice MacDonald, now the Hon Mr Justice MacDonald, which considered mental health as a right for children. MacDonald noted that, 'It is well established that the right to respect of private life under Art 8 of the ECHR encompasses the concept of mental health',[923] and he highlighted the shared perspective of the House of Lords and the ECtHR thus:

> In *Bensaid v United Kingdom*, in comments endorsed in the House of Lords by Lord Bingham in *R(Razgar) v Secretary of State for the Home Department*, the ECtHR observed as follows:
> "Mental health must also be regarded as a crucial part of private life associated with the aspect of moral integrity. Article 8 protects a right to identity and personal development, and the right to establish and develop relationships with other human beings and the outside world…The preservation of mental stability is in that context an indispensable precondition to the enjoyment of the right to respect for private life."
> *This sounds very much like a right to mental health,* albeit one that is an element of, and derived from another, wider substantive right, *namely the right to respect for private life. At the very least, the right to respect for private life is a right that seeks to protect and preserve the mental health of the individual.*[924]

He went on to note:

> Further, in accordance with well-established general principle and as made clear in *YF v Turkey*, Art 8 encompasses a positive right to protection of physical and psychological integrity. The positive obligations inherent in Art 8 have, traditionally, been relatively widely drawn. In *Stubbings v United Kingdom* as follows:
> "It is to be recalled that although the object of Art 8 is essentially that of protecting the individual against arbitrary interference by the public authorities, it does not merely compel the state to abstain from such interference: there may, in addition to this primary negative undertaking, be positive obligations inherent in an effective respect for private or family life. These obligations may involve the adoption of measures designed to secure respect for private life even in the sphere of relations of individuals between themselves."
> Within the context of mental health, this positive duty has found expression in compelling State parties to act in a manner that will prevent actions and events

[923] Mr Justice MacDonald, 'Do Children have a Right to Mental Health?' Annual lecture of the Wales Observatory on Human Rights of Children and Young People at the College of Law and Criminology Swansea University (2017) (5) <www.swansea.ac.uk/media/2017-Observatory-Annual-Lecture-MR-JUSTICE-MACDONALD.pdf> accessed 14 January 2018.
[924] ibid (6) emphasis added by Mr Justice MacDonald; *Bensaid v United Kingdom* (2001) 33 EHRR 205; *R(Razgar) v Secretary of State for the Home Department* [2004] 2 AC 368.

> that may give rise to mental trauma, such as ensuring effective criminal and civil sanctions against child abuse.[925]

The argument that follows from this reflection is predominantly one that P's Article 8 Right to a private and family life is engaged by her detention, which is arguably a consequence of the failure to prevent her mental health crisis.

In order to fully explore how this potential right may be supported currently, and what changes may be necessary to Welsh legislation to enhance and consolidate the position, it will be helpful to examine potential causes of action under current legislation and common law. This will allow a 'gap analysis' of the current legislative framework and provide clarity for any proposed changes. Samuels[926] has considered the broader issues of how the NHS in England 'rations' treatment, and identifies cost, human rights implications, medical effectiveness, differentiation between the roles of social care and healthcare, and local prioritisation policies as the key factors in decision making. These are helpful markers to consider in the case of P and will be explored in further detail in relation to each contact or request for help so as to determine whether the outcomes were reasonable in the circumstances. The relevant Welsh legislation in considering the treatment of P will include the Mental Health Act 1983 (as amended), the National Health Service (Wales) Act 2006, the NHS Redress (Wales) Measure 2008, the Mental Health (Wales) Measure 2010, the NHS the Social Services and Well-being (Wales) Act 2014, and the Health and Social Care (Quality and Engagement) (Wales) Act 2020. This is not an exhaustive list. Negligence will also be considered in respect of potential tortious conduct.

---

[925] MacDonald (n923) (6); *YF v Turkey* (2004) EHRR 715 para 33; *Stubbings v United Kingdom* (1996) 23 EHRR 213 [60].
[926] Alec Samuels, 'The NHS refuses treatment' (2019) Medico-Legal Journal 2019 Vol 87 (1) 23-26.

Establishing a Cause of Action in Tort or Negligence

Primary Care Responsibilities

In P's case there are several points where help was requested from the National Health Service (NHS), whether as a service provision from a Local Health Board, national provision of specialist services, or indeed as a consequence of policy and resourcing from the Welsh Ministers as the duty holder for the NHS in Wales.[927] The NHS, tasked by the Welsh Ministers with the delivery of such services, operates through seven local health boards, three trusts, and a national shared service arrangement for highly specialist services, procurement, legal and other matters.[928] The issues to be considered relate initially to the provision of services / provision of services in a timely manner - appropriate mental health services in the community or availability of specialist therapy services in the community or as an in-patient. As a consequence of the initial issues, the impact on the human rights of P through detention and whether that was a proportionate response or indeed justifiable form an additional set of issues for consideration. If it can be shown that there was a duty, and that duty was breached, the impact of any unnecessary detention will form part of a claim for damages. This chapter will consider individual episodes for establishing potential causes of action in the patient experience of P at each stage.

Taking each of the interactions with the NHS in turn, the initial engagement with the family doctor is the first contact with a potential duty bearer, and consideration should be given as to whether there was any breach of this duty. As noted earlier, the NHS (Wales) Act 2006 is the key statute on overarching duty to provide a health service.

[927] NHS (Wales) Act 2006 s 1.

[928] NHS Wales, 'Structure' <www.wales.nhs.uk/nhswalesaboutus/structure> accessed 10 January 2022.

The GP as a contractor to the NHS[929] is responsible for delivering a range of primary care services as set out in a contract which exceeds 250 pages[930] and directs the GP as part of a range of first line services. The GP has a duty of care to P once a doctor to patient relationship has been established.[931] With such a relationship, P can expect to receive a medical service delivered to an appropriate[932] standard of care.[933] There is a duty on the Welsh Ministers which does not differentiate between mental and physical health or illness, and requires that they must provide or secure the provision of services to secure improvement in the physical and mental health of the people of Wales.[934]

In considering whether there was any breach of this duty of care it is noted that P was referred to counselling within the required timescale, and this counselling was undertaken and completed. As highlighted above, there is a requirement in Wales for patients presenting via this route to receive primary care counselling within 28 days,[935] and therefore this course of action was of a reasonable standard. Additionally, when P presented following the counselling, the GP escalated the treatment and sought specialist advice in line with s.10 MH(W)M 2010. Medication was reviewed and increased. There is no suggestion that there were any issues of concern around the nature or timing of this counselling, and as such it appears that this initial contact with

[929] NHS Wales, 'General Practice in Wales' <https://primarycareone.nhs.wales/careers/primary-care-roles-in-wales/general-practice-in-wales/general-practice/gms-contract/> accessed 10 January 2022.
[930] NHS Wales, Standard Primary Care Contract <www.wales.nhs.uk/sites3/Documents/480/Standard_Contract_2006.pdf> accessed 10 January 2022.
[931] LexisNexis, 'Duty of Care and Breach in Clinical Negligence Claims' <www.lexisnexis.com/uk/lexispsl/personalinjury/document/393875/564V-Y6M1-F18H-M2T8-00000-00?utm_source=psl_da_mkt&utm_medium=referral&utm_campaign=duty-of-care-and-breach-in-clinical-negligence-claims> accessed 31 January 2022.
[932] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 as further developed in *Bolitho v. City and Hackney Health Authority* [1997] UKHL 46; [1998] AC 232; [1997] 4 All ER 771; [1997] 3 WLR 1151 (13th November 1997).
[933] This standard will be explored further in relation to those interactions with services where it may be arguable that a breach of duty occurred.
[934] National Health Service (Wales) Act 2006 s 1.
[935] NHS Wales, 'Waiting Times' <https://111.wales.nhs.uk/Waitingtimes/> accessed 30 December 2021.

services was addressed appropriately, within policy and best practice, followed up by a review and referral for expert consultation.

The Secondary Care Interface – responsibilities of the Welsh Ministers

The first point of contention would be where there was a delay in P being seen by secondary mental health services. P needed to be seen as a matter of urgency by specialist mental health services. The services were not available for eight weeks, almost twice the expected timescale. P's health had been assessed as requiring a more specialist level of intervention, within a timescale recognised as 'routine' although Wales does not define waiting times further than 'time to treatment' at 26 weeks[936] (excluding mental health). In respect of this 'time to treatment', Wales expects that 85% of urgently referred cancer patients should commence treatment within 62 days,[937] but in England an urgent referral for the same patient would require an appointment with a specialist within two weeks.[938] Information on mental health targets for referrals is not particularly accessible and a direct question about such target times for Wales made to Stats Wales indicated that while there were general performance figures available, the specific referral information was not available.[939] There is however an expectation that routine referrals will be seen within four weeks of referral.[940]

---

[936] ibid.
[937] Bowel Cancer UK, 'State of the Nations: Patients Continue to See Increasing Delays in Diagnosis' (2021) <www.bowelcanceruk.org.uk/news-and-blogs/research-blog/state-of-the-nations-patients-continue-to-see-increasing-delays-in-diagnosis/> accessed 10 January 2022.
[938] Cancer Research UK, 'Your Urgent Referral Explained' (2015) <clinical-pathways.org.uk/sites/default/files/leaflet/2WW%20Urgent%20Referral%20%28wallet%20sized%29.pdf> accessed 11 January 2022.
[939] Email from Head of Publishing Hospital Activity & Performance Statistics 14/1/2022 (Appendix III).
[940] Hywel Dda University Health Board, Community Mental Health Team Service Specification Consultation Document <https://hduhb.nhs.wales/about-us/governance-arrangements/freedom-of-information/disclosure-log/disclosure-log-appendices/1-mental-health-care-pdf-16mb/> accessed 28 September 2024.

In order to consider whether there is a cause of action we must first determine whether there was a duty of care owed to P and by whom. As noted earlier, the NHS Wales Act 2006 s.1 places a duty on the Welsh Ministers:

> **1. Welsh Ministers' duty to promote health service**
> (1) The Welsh Ministers must continue the promotion in Wales of a comprehensive health service designed to secure improvement—
> (a)in the physical and mental health of the people of Wales, and
> (b)in the prevention, diagnosis and treatment of illness.
> (2)The Welsh Ministers must for that purpose provide or secure the provision of services in accordance with this Act.
> (3)The services so provided must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed.

This duty is discharged through the combined approach of developing and providing policy and guidance at Welsh Government level, setting up the local health boards and resourcing them appropriately, and monitoring and quality assuring the services. Such quality assurance is carried out through a number of routes including direct performance data monitored at Welsh Government level, and this is supplemented by oversight bodies such as Health Inspectorate Wales and the Citizens Voice Body for Health and Social Care.[941] As a Welsh resident, P is therefore entitled to access NHS services via her General Practitioner and local health board. The type, timing, and nature of the service that form the duty to be discharged to P are key to determining whether there has been any failure and thus any potential liability on the health providers.

As noted earlier in this chapter, it is arguable that there is a right to mental health. S.1 of the NHS (Wales) Act 2006 requires the Welsh Ministers to promote a *comprehensive health service* with specific reference to mental health. As part of this duty, the Welsh Ministers have produced legislation and policy guidance to be

[941] Welsh Government, 'Citizen Voice Body for Health and Social Care' <https://gov.wales/citizen-voice-body-health-and-social-care/what-we-do> accessed 30 January 2022.

followed by the NHS bodies which deliver on their behalf. At this point, it is important to assess who would be the duty holders, and what duty they owed P. In respect of the provision of a health system that is fit for purpose there are two potential duty holders. The first, the Welsh Ministers, are responsible for the Welsh legislation, producing regulations for both Welsh legislation and England and Wales legislation, and developing policy. The Welsh Ministers are also responsible for the allocation of funds to NHS Wales, and the Chief Executive of NHS Wales reports to the Cabinet Secretary for Health and Social Services.[942]

The Welsh Ministers also, under s.3 (1) of the NHS (Wales) Act 2006 must:

> **…provide throughout Wales, to such extent as they consider necessary to meet all reasonable requirements[943]—**
>
> (a) hospital accommodation,
>
> (b) other accommodation for the purpose of any service provided under this Act,
>
> (c) medical, dental, ophthalmic, nursing and ambulance services,
>
> (d) such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as they consider are appropriate as part of the health service,
>
> (e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as they consider are appropriate as part of the health service,
>
> (f) such other services or facilities as are required for the diagnosis and treatment of illness.

It is the determination of *reasonable requirements* that will form the scope of the duty of the Welsh Ministers to provide a *comprehensive health service.* It has been found

[942] NHS Wales, 'About Us' <www.wales.nhs.uk/nhswalesaboutus> accessed 30 January 2022.
[943] Emphasis added.

in many cases[944] that this duty does not compel Ministers to provide services regardless of funding. There is also established case law which recognises that human rights arguments do not persuade judges to overrule clinical judgment,[945] and on the sanctity of life of an individual versus the potential needs of others.[946] The Ministers may set up delivery bodies such as local health boards (LHB) and direct them as to how they fulfil their responsibilities,[947] and these bodies are the second duty holder. The scope of this duty is more substantive as they provide annual plans, budgets, performance data, and identify how the local plans will ensure that the LHB is compliant with governmental strategies.[948]

Based upon the nature of the duty discussed above, there is no requirement to provide any specific service within any specific timescale, despite there being a range of recommendations, objectives, and expectations for service availability. Even if it were that there was an identifiable duty, how likely is it that a court could be persuaded that the delay in providing assessment and then treatment did cause the deterioration which led to the detention? P's mental health was deteriorating, and there was no action that could be attributed to the further deterioration; we would be relying upon the argument that if she had received help, this help may have prevented the deterioration. The 'but for' argument has been well tested,[949] including in cases of failing to act,[950] and despite

[944] *R v Secretary of State for Social Services, Ex p Hincks (1980) 1 BMLR 93; R v Cambridge Health Authority ex parte B* [1995] 1 WLR 898*; R v North and East Devon Health Authority ex parte Coughlan* [1999] EWCA Civ 1871 (16 July 1999) [25]*; R (BA) v The Secretary of State for Health and Social Care and NHS Blood and Transplant* [2018] EWCA Civ 2696.
[945] *R (Condliff) v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910.
[946] *Re J (A Minor) (Wardship: Medical Treatment)* [1991] 1 Fam 33.
[947] NHS (Wales) Act 2006 ss 10-13.
[948] NHS Wales, 'Planning Framework 2019/22' (2018) <www.wales.nhs.uk/sitesplus/documents/862/Item%205.1.1%20NHS%20Wales%20Planning%20Framework%202019-22.pdf> accessed 30 January 2022.
[949] *Bailey v The Ministry of Defence & Anor* [2009] 1 WLR 1052.
[950] *Bolitho v City and Hackney Health Authority* [1997] UKHL 46.

the suggestion that a material contribution to the loss could be considered,[951] evidencing that the delay caused loss is almost impossible. So, both on the duty, and the causation, seeking redress via the tortious route is unlikely to provide a solution.

Detention under the Mental Health Act 1983

The key area of concern here though is the detention under s.3 MHA 1983 where appropriate treatment is unavailable for a long period, despite it being a key part of any treatment which would lead to the release of the patient. The MHA 1983 requires that 'appropriate medical treatment is available' for admission under s.3(2)(d), but as noted earlier, nursing and rehabilitation and care is considered 'medical treatment'.[952] There is again the issue of no entitlement to specific treatment,[953] but where an individual is detained to receive a treatment package and that package is unavailable, surely there is a Rights argument which may have traction? Case law[954] in respect of prisoners on Indeterminate Public Protection sentences found that the failure to provide the requisite courses for prisoners to complete to allow their parole is likely to infringe Art 5(1).[955] Is this however relatable to detention under the MHA 1983? Sadly, when we consider the decision in *Munjaz,*[956] which specifically considered the impact on Articles 3, 5, and 8[957] of seclusion under the MHA 1983, it found that seclusion in itself may constitute appropriate medical treatment. If holding an

[951] *Hotson v East Berkshire Area Health Authority* [1987] AC 750.
[952] Mental Health Act 1983 s 145(1).
[953] *R v Secretary of State for Social Services Ex p Hincks* (1980) 1 BMLR 93*; R v Cambridge Health Authority ex parte B* [1995] 1 WLR 898*; R v North and East Devon Health Authority ex parte Coughlan* [1999] EWCA Civ 1871 (16 July 1999) [25]*; R (BA) v The Secretary of State for Health and Social Care and NHS Blood and Transplant* [2018] EWCA Civ 2696.
[954] *R (on the application of Walker) v Secretary of State for Justice (formerly Secretary of State for the Home Department); R (on the application of James) v Secretary of State for Justice* [2008] 3 All ER 104.
[955] Human Rights Act 1998 Article 5(1).
[956] *Regina (Munjaz) v Mersey Care NHS Trust* [2005] 3 WLR 793 [794].
[957] Council of Europe (n16).

individual in such circumstances is considered treatment, then providing care, nursing, and 'habilitation' clearly offer less of an angle for challenge.

Consideration of a Public Law Challenge for a Breach of Statutory Duty

As noted above, establishing a cause of action in tort against the Welsh Ministers is not likely to succeed, but is a public law challenge for breach of a statutory duty likely to elicit a different outcome? A key issue here is the objective of any action. Where a decision is made by the Welsh Ministers or their relevant authorities, such as local health boards, in relation to the discharge of statutory duties, such decisions can be challenged through judicial review. The process of and challenges in seeking judicial review are discussed in more detail in Chapters Seven and Nine in relation to challenging COVID-19 regulations and also in seeking to enforce the duty under Part III of the MH(W)M 2010. It is though worth considering here whether a public law challenge in the case of P would have any greater chance of success, or indeed whether it would provide the outcome P sought within the timescale needed. The potential for such a challenge at the secondary care interface and in relation to the provision of 'appropriate treatment' whilst detained will be examined below.

Whilst there are potential arguments that the resource allocation decisions behind the failure to provide services within a reasonable timescale might be considered irrational as it could lead to higher overall costs, this is a very challenging argument to make. As seen earlier in Chapter One in the case of *Child B*,[958] and as will be explored further in Chapters Seven and Nine, the reluctance of the courts to interfere in ratioing

[958] *R (B) v Cambridge Health Authority* [1995] EWCA Civ 43 1 WLR 898.

decisions made by NHS bodies is well established. To that end I believe the irrationality argument offers little in this context.

Similarly, while it may be seen that P could have a legitimate expectation that she would receive the services required within the reasonable timescale, or indeed that the appropriate treatment would be available in hospital, would these form grounds under *Wednesbury?*[959] From Lord Woolf's judgment in *Coughlan,*[960] in order for a legitimate expectation claim to be seen as a head of *Wednesbury*[961] unreasonableness, P would need to show that her case was on all fours with *Coughlan* in that:

> First, the importance of what was promised to Miss Coughlan, (as we will explain later, this is a matter underlined by the Human Rights Act 1998); second, the fact that promise was limited to a few individuals, and the fact that the consequences to the Health Authority of requiring it to honour its promise are likely to be financial only. [962]

This is not the case, though the HRA 1998 point will be considered further below. It seems therefore that the grounds for judicial review of the exercise of the Welsh Minister's duties under the NHS (Wales) Act 2006 would need to demonstrate that:

1. The failure to fulfil the statutory duty of providing a health service as set out under the NHS Wales Act 2006 s.1 was unlawful in so far as they did not provide the secondary care service within their own identified reasonable time; or

2. The failure to fulfil the statutory duty of providing a health service as set out under the NHS Wales Act 2006 s.1 was unlawful in so far as their failure excessively interfered with P's fundamental rights by causing her to be

[959] *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* (1948) 1 KB 223.
[960] *R (Ex p Coughlan) v North and East Devon Health Authority* QBCOF 1999/0110/4 [80].
[961] *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* (1948) 1 KB 223.
[962] *R (Ex p Coughlan) v North and East Devon Health Authority* QBCOF 1999/0110/4 [60].

> detained for longer than necessary due to the failure to provide appropriate treatment. This failure would also engage the Article 5 and 8 Rights.

In considering these two grounds it is worth firstly revisiting the NHS Wales Act 2006 s.1 duty:

> 1. Welsh Ministers' duty to promote health service
> (1) The Welsh Ministers must continue the promotion in Wales of a comprehensive health service designed to secure improvement—
> (a)in the physical and mental health of the people of Wales, and
> (b)in the prevention, diagnosis and treatment of illness.
> (2) The Welsh Ministers must for that purpose provide or secure the provision of services in accordance with this Act.
> (3) The services so provided must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed.

The wording of this duty under s.1(1) is almost identical to that in the National Health Service Act 1977, and this was interpreted by Lord Woolf in *Coughlan* as:

> It will be noted that section 1(1) does not place a duty on the secretary of state to provide a comprehensive health service. His duty is "to continue to promote such a service".[963]

The responsibility of the Welsh Ministers to take active steps to provide particular mental health services in Wales has previously been challenged in respect of Article 8 Rights and the UNCRPD in *Dyer.*[964] In this case judicial review was sought of the failure to collect data, or to take a decision on providing a services, or to work with other health boards, or that the Welsh Ministers failed to intervene in the health board's decisions. All of these grounds failed, as did the reliance upon ECHR Article 8 Rights and Article 19 Rights of the UNCRPD, as it was found that there was no unlawful action by the Welsh Ministers or their administrations.

[963] *R (Ex p Coughlan) v North and East Devon Health Authority* QBCOF 1999/0110/4 [22].
[964] *R (on the application of Claire Dyer) v Welsh Ministers* [2015] EWHC 3712 (Admin).

In P's case, there might have been a time where she considered seeking judicial review of the failure to provide her with support prior to her detention. As noted above, P was not in such a place as to instruct, and indeed, judicial review proceedings should only be considered if all other routes of alternative remedy have been exhausted.[965] By the time such alternative routes such as complaints processes had been exhausted, P would already be in hospital. Similarly, as highlighted in *Munjaz,*[966] appropriate treatment as a condition of continuing detention under the MHA 1983 is a very broad concept, and seeking a mandatory order via judicial review would also face the challenges of ratioing noted above.

While there is engagement of P's Article 5, and 8 Rights in the detention (and the prolonged detention), P would need to evidence that the failure to provide treatment led directly to that harm. With a mental illness this would be very challenging to demonstrate as even had there been treatment within a reasonable timescale there is no guarantee that it would have been effective. This too would be the case with the specific treatment required as an inpatient. It is unlikely that it could be demonstrated to the standard required to prove fault that if EMDR had been provided earlier that the recovery would have been quicker.

It should be noted also that even if a judicial review action was successful in seeking damages for breaches of Article 5 and 8 Rights, compensatory awards even at the ECtHR level are very modest,[967] and are even lower for MHA 1983 cases in the

[965] UK Government Ministry of Justice 'Pre-Action Protocol for Judicial Review' (2021) para 5 <www.justice.gov.uk/courts/procedure-rules/civil/protocol/prot_jrv> accessed 31 August 2025.
[966] *Regina (Munjaz) v Mersey Care NHS Trust* [2005] 3 WLR 793.
[967] *James, Wells and Lee v. the United Kingdom* (2013) 56 EHRR 12; *HL v UK* 45508/99 ECHR 471.

domestic courts.[968] So as with the tort route above, the public law route would offer very limited prospects of success.

Further Thoughts

The issues considered in this fictional amalgam are those which prompted my research. The experiences highlighted were not all experienced by one individual but are reflective of those experiences people shared with me in my role. We hear much about delayed transfers of care, and indeed, it has been estimated that around 13% of hospital beds in England were occupied by patients medically fit for discharge.[969] This causes increasing pressure on services and risks lives.[970] Mental health inpatient bed occupancy levels are averaging 90% in Wales,[971] and research from 2019 showed that 48% of inpatients in Wales were detained under the MHA 1983.[972] It does pose the question that if inpatient services are the most expensive[973] part of the mental health system, why not do everything to avoid the use of these facilities, especially when early treatment can avoid detention?[974]

---

[968] *R (on the application of KB, MK, JR, GM, TB, and B) v MHRT* [2003] EWHC 193 (Admin).
[969] Francesea Cavallaro, Fiona Grimm, Lucinda Allen, Josh Keith, Charles Tallack, 'Why are delayed discharges from hospital increasing? Seeing the bigger picture' The Health Foundation (2003) <www.health.org.uk/publications/long-reads/why-are-delayed-discharges-from-hospital-increasing-seeing-the-bigger> accessed 28th September 2024.
[970] Chris Betteley, 'Delayed transfer of care 'putting lives at risk' 31st July 2024 *Cambrian News*, <www.cambrian-news.co.uk/news/health/delayed-transfer-of-care-putting-lives-at-risk-709625 accessed 28th September 2024>; Jon Sharman, 'Bed-blocking up by 52 per cent in three years, NHS figures show' *The Independent* Saturday 10 June 2017.
[971] StatsWales, Monthly NHS beds data by measure, site and specialty, March 2014 onwards, (12 month figures from April 2023-March 2024) <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/nhsbeds-by-organisation-specialty-month> accessed 28th September 2024.
[972] Welsh Government, Statistics for Wales, Patients in mental health hospitals and units in Wales at March 2019 3 <www.gov.wales/sites/default/files/statistics-and-research/2019-11/patients-mental-health-hospitals-units-31-march-2019-249.pdf> accessed 28th September 2024. No further updated publications available at time of submission.
[973] Midlands and Lancashire Commissioning Support Unit, Exploring Mental Health Inpatient Capacity (2019) 7 <www.strategyunitwm.nhs.uk/sites/default/files/2019-11/Exploring%20Mental%20Health%20Inpatient%20Capacity%20accross%20Sustainability%20and%20Transformation%20Partnerships%20in%20England%20-%20191030_1.pdf> accessed 28th September 2024.
[974] ibid 4.

Conclusion

As the thesis has developed, my starting point for action has moved for purely pragmatic reasons from developing a Right to treatment, to the development of a way of enforcing an existing duty to provide an assessment within a set timescale. This I feel offers an opportunity to test the appetite for reciprocity in Wales. To me it is clear that providing early access to services in the case of P would reduce both the impact on P and her family, and reduce the overall cost to the NHS, but this is not an overnight fix. This research is intended to inform debate and discussion with Welsh Government legislators and policymakers, and seeking to resolve the issues faced by P in one step is likely unachievable and thus is unlikely to even elicit a response. Addressing the inherent unfairness within our mental health services remains my ultimate goal, but I must identify a workable route to do so. As will be seen in later chapters, and ultimately in Chapter Nine 'The Welsh Paradigm', I believe that the greatest opportunity to change the current situation is to create a first, and perhaps seemingly inconsequential, reciprocal right. This would I believe offer a bridgehead for further research and campaigning. The experiences highlighted though recognise the despair faced by patients and families alike, both in the impact of detention and the inability to access services at a time where crisis has not yet been reached. When we consider the consequences of the failure of mental health services as noted in this chapter, an approach which seeks to prevent, or mitigate mental health crisis is surely not too much to expect?

Chapter Seven considers the fairness of the current system in relation to mental illness. I contrast the experiences of COVID-19 restrictions applied on the basis of a physical health condition, with those applied to people experiencing mental illness, and

examine whether there is parity for mental and physical health conditions. The Welsh legislative and policy perspective is then explored in the context of exploring opportunities for a Welsh solution.

Chapter Seven – Justice and Fairness in accessing mental health services: the need for a Welsh solution

In writing this thesis the overwhelming concern has been to seek a way in which a Welsh legislature can overcome the inherent power imbalance that exists between the State and those who are mentally ill. The State applies powers[975] to people already in crisis who often struggle to understand and thus challenge such application of powers[976] when they are unwell. However, there are no reciprocal duties on the State, further than those for example in the NHS (Wales) Act 2006 to provide a health service, to provide the level of care necessary to avoid such detention, even when it is requested. In simple language this is not fair. This chapter will consider how justice and fairness are two imperatives for the future of mental health legislation in Wales. In doing so I will examine the disparity between mental health and physical health in relation to legislation and policy and will consider how the Coronavirus Regulations[977] and mental health law demonstrate such disparity. Parity of esteem for mental health and physical health will be considered in relation also to the UNCRPD. The development of mental health legislation in Scotland and Wales is explored with a focus on how this has differed from that in England and Wales, before concluding on the introduction of the MH(W)M 2010.

I will also examine recent regulatory differences in the approach to COVID-19 between England and Wales, which will also offer an opportunity to consider how health restrictions can be different on either side of the border. The reaction to the

[975] As seen in Chapters Four, and Five many of these powers form part of legislation, which is aged, arguably non-compliant with conventions, lacks reciprocity, and gives the right to forcible treatment where an individual has capacity.
[976] Akther (n382) 3.
[977] The Health Protection (Coronavirus) Regulations 2020, SI 2020/129.

COVID-19 response, including multiple restrictions on movement and travel, will also be contrasted with the impact of mental health detention. This offers those of us who have never experienced detention under the MHA 1983 some degree of empathy, and understanding of how it feels, and what it means to us and our lives when our Liberty is restricted.

In philosophy, fairness and justice are often seen as intertwined concepts,[978] and justice is often seen as central to morality.[979] This was discussed in relation to personal autonomy in Chapter Two. Fairness is seen as a fundamental part of justice.[980] There is however significant argument that fairness is not justice, nor is justice fairness.[981] The heart of fairness however may be considered as the Golden Rule,[982] and has both biblical[983] and philosophical support for the concept that fairness includes having obligations to each other,[984] and that we should do unto others as we would have them do to us. As noted earlier in Chapters Two, Four, and Five, in a society where we do have to act against an individual's rights, we surely owe them a moral duty[985] of reciprocity.[986] If we accept that there is no justice without fairness, then a consideration

[978] Wayne P Pomerleau, 'Western Theories of Justice' Internet Encyclopaedia of Philosophy. <https://iep.utm.edu/justwest/> accessed 14 June 2022.
[979] Manuel Velasquez and others, 'Justice and Fairness' (2014) Markkula Center for Applied Ethics <www.scu.edu/ethics/ethics-resources/ethical-decision-making/justice-and-fairness/> accessed 14 June 2022.
[980] John Rawls, 'Justice as Fairness' (1958) The Philosophical Review Vol 67 No 2 (Apr 1958) 164, 164; Mill (n74) 198-201.
[981] Barry Goldman, Russell Cropanzano, '"Justice" and "fairness" are not the same thing' (2019) Journal of Organizational Behavior 36 313, 317.
[982] Jim Dator, What is Fairness? in Jim Dator, Dick Pratt, Yongseok Seo, Fairness, *Globalization, and Public Institutions: East Asia and Beyond* (University of Hawai'i Press 2006) 26.
[983] King James Bible, 'Matthew 7:1' <www.kingjamesbibleonline.org/Matthew-7-1/> accessed 14 June 2022.
[984] Rawls (n27) 96-97; John Locke, Essay Concerning the True Original, Extent and End of Civil Government, in *Social Contract* (1971 Oxford University Press) 4.
[985] Rousseau (n26) 174-175. Rousseau notes that …'to deprive [a man] of his free will is to deprive his actions of all moral sanction'.
[986] Reciprocity in this context is the moral duty of the state to ensure that where the state has powers to detain an individual based upon their mental health despite them having capacity, then the state owes

of the current position, and an exploration of whether or not this offers justice is a useful opening point.

Is the Current Situation Just?

As explored in Chapter Six, there are many challenges in accessing specialist support services for serious mental illness, and in considering the fairness of this it is useful to explore the recent drive for parity of esteem between mental and physical health. Parity of esteem was arguably[987] established as a legal requirement in England by s.4 of the Health and Social Care Act 2012; though it does appear to be a very limited and non-specific requirement, setting a duty to reduce inequalities without stipulating details.[988] While there have been calls for this approach to be enshrined in Welsh law,[989] it is not overly clear how much the English legislation differs, particularly in reading s.1 of the National Health Service (Wales) Act 2006. As outlined in Chapter Six, this section requires Welsh Ministers to promote a comprehensive health service – both physical and mental health - and all such decisions are subject of course to the Equality Act 2010, the Human Rights Act 1998, and treaty and convention requirements. Given the vague language in s.1C National Health Service Act 2006,

individuals a duty to act in a way to prevent the need for such detention. This formed a major part of the Department of Health, 'Report of the Expert Committee Review of the Mental Health Act 1983', (1999), led by Professor Genevra Richardson, but unfortunately did not end up as part of the Mental Health Act 2007.

[987] Centre for Mental Health, 'Parity of Esteem' (2021), <www.centreformentalhealth.org.uk/parity-esteem> accessed 2 May 2022; Kings Fund, 'Has the government put mental health on an equal footing with physical health?' (2015) <www.kingsfund.org.uk/projects/verdict/has-government-put-mental-health-equal-footing-physical-health> accessed 2 May 2022.

[988] Health and Social Care Act 2012 s 4. (inserting s 1C into the National Health Service Act 2006). This provision placed a duty on the Secretary of State to 'reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service'.

[989] Everybody's Business – A report on suicide prevention in Wales (2018) – report of the Welsh Assembly's Health Social Care and Sport Committee's inquiry <https://business.senedd.wales/documents/s83783/Report%20-%20Everybodys%20Business%20A%20report%20on%20suicide%20prevention%20in%20Wales.pdf > accessed 2 May 2022.

this provision looks more a matter of window dressing rather than legislation which will have any real effect. However, the principles of parity are often hailed as governmental commitment,[990] and in Wales, in the Minister's foreword to the NHS Wales Planning Framework 2022-2025, there is, on the face of it, a policy commitment which identifies mental health as somewhat of a special case: "We must invest in recovery, tackle health inequalities, improve mental health provision by giving parity between physical and mental health conditions, and focus on prevention." [991]

But while the phrase 'parity of esteem' has been used by both Westminster[992] and Welsh Government[993] Ministers, there appears to be a rudimentary gap in the use of the phrase and the real understanding of the challenge to provide such parity**.** While parity of esteem may arguably be seen as an ambition to ensure that mental health receives the same priority as physical health, the term itself lacks clarity and may be seen as misleading and rhetorical.[994] The drive towards parity of esteem sadly has not translated to parity of resources,[995] or treatment.[996] When considering parity of esteem, we should exercise caution in contrasting one type of condition directly with

[990] UK Parliament 'Mental health: Achieving parity of esteem' (2020) House of Commons Library <https://commonslibrary.parliament.uk/mental-health-achieving-parity-of-esteem/> accessed 2 May 2022; UK Parliament, 'Parity of Esteem for Mental Health' (2015) Research Briefing, <https://post.parliament.uk/research-briefings/post-pn-485/> accessed 2 May 2022.
[991] NHS Wales, 'Planning Framework 2022-2025' (2021) <https://gov.wales/sites/default/files/publications/2021-11/nhs-wales-planning-framework-2022-2025_0.pdf> accessed 2 May 2022.
[992] Achieving parity of esteem between mental and physical health. The Rt Hon Norman Lamb, Minister for Care Services 'Achieving parity of esteem between mental and physical health' Speech of 19 June 2013 <www.gov.uk/government/speeches/achieving-parity-of-esteem-between-mental-and-physical-health> accessed 29 August 2022.
[993] Welsh Government, Written Statement – World Mental Health Day 2015: 'Celebrating improvements to mental healthcare in Wales' Statement of Mark Drakeford, Minister for Health and Social Services 7 October 2015 <https://gov.wales/written-statement-world-mental-health-day-2015-celebrating-improvements-mental-healthcare-wales> accessed 29 August 2022.
[994] Janine Owens, Karina Lovell, Abigail Brown, Penny Bee, 'Parity of esteem and systems thinking: a theory informed qualitative inductive thematic analysis' (2022) BMC Psychiatry (2022) 22:650.
[995] Claire Hilton, 'Parity of esteem for mental and physical healthcare in England: a hundred years war?' (2015) J R Soc Med 2015 Nov 25; 109(4):133, 133.
[996] Centre for Mental Health (n987).

another, as in doing so we may conclude simply that if waiting lists are shorter for one specialty, then others with longer waiting lists are experiencing a disparate (lower) level of esteem. However, this is not necessarily true. Differences may relate to urgency in treatment need, and in the case of childbirth, for example, the child will not 'wait' even if the maternity unit is busy, but this does not mean the service is held in higher esteem.

A Royal College of Psychiatrists' Occasional Paper sets out a helpful characterisation of what parity of esteem between physical healthcare and mental healthcare would be:

- access to the most effective and safest care and treatment
- equal efforts to improve the quality of care
- the allocation of time, effort and resources on a basis commensurate with need
- equal status within healthcare education and practice
- equally high aspirations for service users; and
- equal status in the measurement of health outcomes.[997]

When we reflect upon these indicators, it is difficult to believe that mental healthcare and physical healthcare do have parity of esteem in England and Wales.

The Westminster government acknowledges that parity of treatment (or the 'treatment gap') is an indicator of parity,[998] and that there is some way to go in mental health to both provide services and measure their waiting times and impacts.[999] They recognise too that excess premature mortality is an indicator of disparity, and that this is not solely down to the mental illness itself but linked to the challenges that individuals

[997] Sue Bailey, Lucy Thorpe, Greg Smith, 'Whole-person care: from rhetoric to reality: Achieving parity between mental and physical health' (2013) Royal College of Psychiatrists (Occasional Paper OP88) 20 <www.ucl.ac.uk/core-study/sites/core-study/files/lester.pdf> accessed 1 August 2025.
[998] Carl Baker, Manjit Gheera, 'Achieving 'parity of esteem'' (2020) House of Commons Library 16 January 2020 <https://commonslibrary.parliament.uk/insights/mental-health-achieving-parity-of-esteem/> accessed 1 August 2020.
[999] ibid.

face when living with severe mental illness (SMI).[1000] Between 2018 and 2020, this excess premature mortality meant that people with SMI were 5 times more likely to die before age 75 than those who did not have SMI, and that these figures were increasing year on year for the previous 5 years.[1001] It should also be noted that parity of esteem is difficult to recognise where, 'mental health problems account for 28 per cent of the burden of disease but only 13 per cent of NHS spending',[1002] and where, 'individuals with mental health issues have the same life expectancy as the general population did 50 years ago'.[1003]

The Royal College of Nursing considers that parity of esteem: "describes the need to value mental health equally to physical health. People with complex mental health needs should have the same access to health care services and support as people with physical health needs".[1004] The Royal College of Psychiatrists goes further in considering a definition of parity of esteem which raises expectations from patients and practitioners, identifying it as ensuring:

> equal access to the most effective and safest care and treatment; equal efforts to improve the quality of care; the allocation of time, effort and resources on a basis commensurate with need; equal status within healthcare education and practice; equally high aspirations for service users; and equal status in the measurement of health outcomes.[1005]

[1000] Office for Health Improvement & Disparities, 'Premature mortality in adults with severe mental illness (SMI)' 2023 <www.gov.uk/government/publications/premature-mortality-in-adults-with-severe-mental-illness/premature-mortality-in-adults-with-severe-mental-illness-smi#introduction> accessed 24 August 2025.
[1001] ibid.
[1002] Matthew Taylor, 'We cannot continue to neglect mental health funding' (2022) NHS Confederation <www.nhsconfed.org/articles/we-cannot-continue-neglect-mental-health-funding> accessed 24 August 2025.
[1003] Martin McShane, 'Parity of Esteem' (2013) NHS England <www.england.nhs.uk/blog/parity-of-esteem/> accessed 24 August 2025.
[1004] Royal College of Nursing, 'Parity of Esteem' <www.rcn.org.uk/clinical-topics/Mental-Health/Parity-of-esteem> accessed 14 July 2024.
[1005] Royal College of Psychiatrists, 'Whole-person care: from rhetoric to reality. Achieving parity between mental and physical health' (2013) Occasional paper OP88, <www.drugsandalcohol.ie/19579/1/RCP_Occasional_paper_88.pdf> accessed 2 May 2022.

Unfortunately, neither of these definitions from such august bodies recognises that there is a fundamental issue here that prevents parity of esteem as long as an individual can be detained and treated against their will for a mental health condition. As will be explored further in this chapter, there is no equivalent impingement in rights for a physical health condition as that found under the MHA 1983, and until such a glaring dichotomy is corrected, then true parity cannot exist.

I agree with the perspective that mental health law itself 'presents obstacles to parity',[1006] a view also echoed by Szmukler, where he highlights the 'underlying assumptions that people with mental disorders are not fully self-determining and that they are inherently dangerous'.[1007] As long as there is a coercive component to the doctor patient relationship where the doctor can treat the patient against their will, this inequality will persist, thus leading to a fundamental difference in parity of esteem in mental health to that within physical health. This can potentially result in a different dynamic between doctor and patient, where trust, regard, and loyalty, three of the four elements that are essential in the doctor-patient relationship[1008] are unequal due to the power imbalance under the MHA 1983. Additionally, it has been recognised that it is often that the fear of discrimination from services, stigma, and the failure to provide an holistic approach to the individual experiencing mental illness that presents obstacles to mental health parity. [1009]

[1006] Baker (n998).
[1007] George Szmukler, 'How mental health legislation discriminates unfairly against people with mental illness' speech to Gresham College Mon 15 Nov 2010 <www.gresham.ac.uk/watch-now/how-mental-health-law-discriminates-unfairly-against-people-mental-illness> accessed 15 June 2025.
[1008] Fallon E Chipidza, Rachel S Wallwork, Theodore A Stern, 'Impact of the Doctor-Patient Relationship' (2015) Prim Care Companion CNS Disord 2015 Oct 22; 17(5).
[1009] Baker (n998).

My point is that no *physical* condition results in capacitant patients being deprived of their liberty to receive treatment, whereas the MHA 1983 allows for detention and treatment for a *mental* health condition even if that treatment may not be readily available.[1010] The fact that the Public Health (Control of Disease) Act 1984[1011] only permits detention for *quarantine* without treatment in a capacitant patient reinforces my view highlighted in Chapter 1 and earlier in this chapter, that the law does not provide for parity between mental health conditions and physical health conditions. In a nation where the law fails to ensure parity, healthcare services lack funding proportionate to disease burden, and substantial disparities in premature mortality rates remain between mental and physical health conditions, parity of esteem appears to be more of a pipe dream than a realistic policy objective.

If we are considering what appears to be 'parity of esteem *lite',* a perspective perhaps that mental health and physical health treatment and care can be considered out with the MHA 1983, then can we at least observe an equitable approach here? At the most basic level of assessment, there must be the ability to comparatively measure outcomes, demonstrate investment commensurate with need, and evidence equality of access. From the earlier fictional amalgam of P (Chapter Six), such a situation is far from visible in practice. In addition, recent enquiries to Stats Wales and interrogation of the data sets they provided demonstrate that there are no published waiting list targets for specialist mental health referrals,[1012] though there are "standards".[1013] These

[1010] Katherine Berry, 'Acute inpatient wards: Time to implement psychological therapies' (2021) Policy@Manchester <https://blog.policy.manchester.ac.uk/posts/2021/06/acute-inpatient-wards-time-to-implement-psychological-therapies/> accessed 24 August 2025.
[1011] Public Health (Control of Disease) Act 1984 s 37.
[1012] Welsh Government, 'Mental Health Data Sources' <https://gov.wales/mental-health-data-sources> accessed 2 May 2022.
[1013] Welsh Government (n918) 50 para 8.10.

"standards" relate to timescales for a response for an assessment, but not for treatment. This is in contrast with most physical health conditions,[1014] including cancer treatment,[1015] and it is explicitly stated by the National Assembly for Wales that this is due to the *specialist nature* of mental health services.[1016]

Considering that there is a specific 26-week target for 'referral to treatment' time for cardiac care and a maximum wait time of 39 weeks,[1017] it is difficult to argue that targets cannot be set for services of a *specialist nature.* Accordingly, this seems to suggest that mental health and physical health do not have parity of esteem or treatment in Wales on even the simplest measure of access to treatment. Furthermore, it also implies that the policy, or the implementation of policy in health and social care, may be discriminatory in not providing equitable access or parity in respect of mental health referrals. The Welsh Government's policy position may be seeking to provide greater alignment between mental health and physical health conditions, and indeed Wales has taken steps to create a legislative framework un-matched in the rest of the UK:

> There has been an increased focus on mental health within the Assembly over the past decade. Unique in the UK, the 2010 Mental Health (Wales) Measure (initiated by a backbench AM), aimed to facilitate earlier access to mental health services and improve care and treatment planning for patients.[1018]

[1014] National Assembly for Wales, 'Hospital waiting times – What do you need to know?' (2019) 1 Research Briefing <https://senedd.wales/media/ycspv5fr/hospital-waiting-times.pdf> accessed 2 May 2022.
[1015] NHS Wales, ' Suspected Cancer Pathway' <https://collaborative.nhs.wales/networks/wales-cancer-network/workstreams/single-cancer-pathway/> accessed 2 May 2022.
[1016] National Assembly for Wales (n1016) 1.
[1017] Letter from Head of Planned Care to Chief Executives of Health Boards, NHS Wales 24th April 2018 4 <https://gov.wales/sites/default/files/publications/2019-07/consolidated-rules-for-managing-cardiac-referral-to-treatment-waiting-times.pdf> accessed 2 May 2022.
[1018] Senedd Cymru, 'Devolution 20 – are we a healthier nation (2019 – updated 2021)' Senedd Research <https://research.senedd.wales/research-articles/devolution-20-are-we-a-healthier-nation/> accessed 2 May 2022.

A real challenge for Wales however is the inability to legislate fully in respect of mental health as the existing MHA 1983 has a major focus on matters reserved to the Westminster Government in areas such as policing, sentencing, and the wider criminal justice arena.

The Thomas Commission[1019] recommended that mental health related policing legislation should be determined in Wales so that it be integrated with devolved powers on health, social policy and education,[1020] but this has not yet to come to fruition. The Welsh Government has however welcomed this as a "landmark report", with the First Minister noting that:

> A fair, effective and accessible justice system is a cornerstone of freedom and of democracy. It is, or it should be, non-negotiable. We should not allow ourselves to become accustomed to, still less to accept, embedded failures to meet those standards. [1021]

He went further to note that:

> Now, the challenge they [referring to a number of social and logistical issues in Wales] pose will not be overcome without a change in the respective roles of Westminster and the devolved institutions.[1022]

The Counsel General has also set out a commitment to pursue the case for devolution of justice and policing to Wales.[1023]

[1019] The Commission on Justice in Wales (n891) 19.
[1020] I gave written and oral evidence to this Commission in support of this approach 183 @ 4.135.
[1021] National Assembly for Wales, 'Statement by the First Minister: Report of the Commission on Justice in Wales' 5th November 2019 para 130 <https://record.assembly.wales/Plenary/6039#A54186> accessed 29 August 2022.
[1022] ibid para 132.
[1023] Senedd Cymru, Written Statement: Update on the development of the justice system and the legal sector in Wales. 30th September 2021 Mick Antoniw MS Counsel General and Minister for the Constitution <https://gov.wales/written-statement-update-development-justice-system-and-legal-sector-wales> accessed 29 August 2022.

As noted in Chapters Four and Five, the legislative context for mental health in England and Wales is very much one of public protection as opposed to rights to treatment. In considering if, and how parity is practiced, the COVID-19 pandemic has provided us with some startling examples of health-based regulations impacting on human rights. While people across the world have experienced huge restrictions to their liberty and freedom of movement during the pandemic as a consequence of COVID-19, this did not, in the overwhelming majority of situations, result in detention for patients.[1024] News stories from nations where physical restrictions, alarms, or the military were used to prevent infection spread[1025] suggest a dystopian, oppressive, and inhumane approach in relation to a known antigen which has caused millions of deaths. COVID-19 quarantine restrictions in less oppressive regimes impacted on freedom of movement,[1026] expression,[1027] or attendance at birthday parties.[1028] This dichotomy in approach might best be examined by seeking to apply a mental health law approach to an example from COVID-19.

During the COVID-19 pandemic there was a major challenge in managing compliance with regulations, and in persuading the population to receive vaccinations, resulting in strong public health messaging about the rationale, safety, and necessity for

[1024] Robert L Parry, 'Shanghai lockdown: US warns citizens of arbitrary Covid detention in China' (2022) *Sunday Times* April 10 2022. There were some significant exceptions which were regarded as oppressive.
[1025] Luke Taylor, 'Covid-19: China installs fences and alarms in Shanghai in effort to curb cases' (2022) BMJ 2022:377:o 1076; Helen Cahill, 'Zero tolerance: Shanghai dystopian Covid lockdown drives investors away' (2022) *The Telegraph* 24 April 2022.
[1026] Welsh Government, 'Wales Coronavirus guidance' <https://gov.wales/coronavirus> accessed 2 May 2022.
[1027] Harry Taylor, 'Police break up Good Friday church service over apparent Covid rule breaches' (2021) *The Guardian* 3 April 2021.
[1028] Jennifer Scott, 'Boris Johnson and Rishi Sunak reject calls to resign over lockdown fines' (2022) *BBC News* 13 April <www.bbc.co.uk/news/uk-politics-61083402> accessed 2 May 2022.

immunisation.[1029] Conspiracy theories were widespread and social media was a global mechanism for the distribution of "fake news".[1030] Research is developing which seeks to understand the behaviours and understanding of those people who either denied COVID-19 existed, or determined that there was little or no risk, and early studies note the level of beliefs that COVID-19 was a conspiracy.[1031] It is argued that believing in conspiracy theories in itself is not delusional, but feeling compelled to act on the belief may cross the threshold of paranoia.[1032] It is also possible that some individuals are more susceptible to this behaviour due to underlying neurological conditions.[1033] On that basis, it is worth considering how in the UK people who rejected the public health message on COVID-19 were dealt with by use of the criminal law rather than mental health legislation, and how this demonstrates a discriminatory approach.

Consider the example of an individual (at the height of the pandemic during the most rigorous of regulations) who believes that COVID-19 is no more dangerous than a cold. They contract the condition, and refuse to isolate, instead going out into public places with the intention of sharing the virus as they believe that this will demonstrate that there is little or no risk, and indeed, the herd immunity approach should be

[1029] World Health Organisation, 'Statement for Healthcare Professionals: How COVID-19 Vaccines Are Regulated for Safety and Effectiveness' (Revised March 2022) <www.who.int/news/item/17-05-2022-statement-for-healthcare-professionals-how-covid-19-vaccines-are-regulated-for-safety-and-effectiveness> accessed 16 June 2022.
[1030] World Health Organisation, 'Social Media & COVID-19: A Global Study of Digital Crisis Interaction among Gen Z and Millennials' (2021) <www.who.int/news-room/feature-stories/detail/social-media-covid-19-a-global-study-of-digital-crisis-interaction-among-gen-z-and-millennials> accessed 16 June 2022.
[1031] Paul Thagard, 'The cognitive science of COVID-19: Acceptance, denial, and belief change' (2021), Methods 195 92, 99; Tobias Rothmund, Fahima Farkhari, Carolin-Theresa Ziemer, Flávio Azevedo, 'Psychological underpinnings of pandemic denial-patterns of disagreement with scientific experts in the German public during the COVID-19 pandemic' (2012) Public Understanding of Science Vol 31(4) 437, 438.
[1032] Ronald W Pies, Joseph M Pierre, 'Believing in Conspiracy Theories is Not Delusional' (2021) <www.medscape.com/viewarticle/945290?reg=1> accessed 13 June 2022.
[1033] Bruce L Miller, 'Science Denial and COVID Conspiracy Theories Potential Neurological Mechanisms and Possible Responses' (2020) JAMA 2020; 324(22):2255, 2256.

followed. They are approached by a police officer who challenges them on this behaviour, and the individual deliberately coughs in the face of the police officer. This behaviour would arguably be based upon irrational delusions, and could be considered as a Delusional Disorder.[1034] Delusional disorders are a mental disorder[1035] and as such, an individual could be subject to detention under the MHA 1983, initially under s.136 by the police officer. Further detention could then follow under ss.2 or 3 MHA 1983 if it were determined that they are 'suffering from a mental disorder of a nature or degree which warrants the detention of the patient in a hospital, and they ought to be so detained in the interests of their own health or safety or *with a view to the protection of other persons*.'[1036]

However, if the individual has capacity, and is acting on beliefs which are not based in fact but are held by them to be so, there are three potential approaches to how this matter could be addressed. The first, as advised by the Crown Prosecution Service[1037] is that criminal law is applied, and the irrational belief and delusional behaviour offers no defence. A recent unreported case identified that Paul Edwards held the belief that the COVID-19 vaccination programme was harmful, and that the effects of the pandemic were overstated, resulting in him smashing windows at vaccination centres.[1038] He was convicted of criminal damage, and sentenced to 21 months

[1034] Psychology Today, 'Delusional Disorder' (2022) <www.psychologytoday.com/us/conditions/delusional-disorder> accessed 13 June 2022.
[1035] Alexandre Gonzalez-Rodriguez and others, 'Delusional disorder: an overview of affective symptoms and antidepressant use' (2013) Eur J Psychiat vol 27 4 265, 266.
[1036] Mental Health Act 1983 s 2, emphasis added.
[1037] Crown Prosecution Service, '"Coronavirus Coughs" at Key Workers Will Be Charged as Assault, CPS Warns' (2020) <www.cps.gov.uk/cps/news/coronavirus-coughs-key-workers-will-be-charged-assault-cps-warns> accessed 13 June 2022. This statement followed the cases of Rafferty and Mott who were both prosecuted for the offence as set out in the article.
[1038] BBC News, 'Covid: Anti-Vax Campaigner Vandalised Vaccination Centres' (15 June 2022) <www.bbc.co.uk/news/uk-wales-61819325> accessed 16 June 2022.

custody,[1039] but not a mental health disposal. It is interesting to note the Judge's remarks "You haven't shown any insight into the harm your behaviour caused, or its potential to have caused, to vulnerable individuals".[1040] Such beliefs and actions with no insight in different circumstances could arguably result in a mental health disposal.

The second approach is that the Health Protection (Coronavirus) Regulations 2020[1041] apply and as such the individual is dealt with under the Public Health (Control of Disease) Act 1984. In this case, where previously an application would be made to a magistrate to detain the individual until they are no longer infectious, during the pandemic, police and public health officials could exercise those powers without judicial oversight.[1042] It should be noted that under s.45E of this legislation, the individual cannot be treated against their will if they are deemed to have capacity.[1043] Individuals who lack capacity may be treated under the s.4 best interests provisions of the MCA 2005.

The third option, and the one of most significant to this thesis, would be the use of the MHA 1983. In this case, the individual could potentially be detained for an initial period of up to 28 days and medicated against their will despite them having capacity.

[1039] ITV News, '"Arrogant" Anti-Vaxxer Jailed for Smashing Windows of Two Vaccine Centres' (16 June 2022) <www.itv.com/news/wales/2022-06-16/arrogant-anti-vaxxer-jailed-for-smashing-vaccine-centre-windows> accessed 16 June 2022.
[1040] ibid report of remarks of Judge Rowlands.
[1041] The Health Protection (Coronavirus) Regulations 2020, SI 2020/129.
[1042] S 51 and Sch 51 Coronavirus Act 2020.
[1043] Public Health (Control of Disease) Act 1984 s 45E Medical treatment.
(1) Regulations under section 45B or 45C may not include provision requiring a person to undergo medical treatment.
(2) "Medical treatment" includes vaccination and other prophylactic treatment.

There is no requirement for curative nor even therapeutic treatment.[1044] The Mental Health Act Code of Practice for Wales notes that:

> There may be patients whose particular circumstances mean their appropriate treatment consists solely of nursing and specialist day-to-day care under the clinical supervision of an approved clinician, for example those with very advanced dementia. Appropriate treatment does not have to involve medication or individual or group psychological therapy.[1045]

Such a detention would remain on the individual's medical records, and up until recent times[1046] this meant that an individual could be disqualified from Jury or Parliamentary Service or removed from a role as a company director.

In a report on the application of the Health Protection (Coronavirus) Regulations, the Crown Prosecution Service[1047] identified that over 1,200 people were successfully prosecuted for breaches in the first year. None of these related to the prosecution of individuals who refused to comply with lawful instructions, but the intention of the powers was to allow police or public health officials to detain and then for an appeal to a magistrate against that detention.[1048] Special arrangements were made to allow live links to the magistrates' court[1049] to provide for oversight. As detention was unlikely to exceed 14 days (the original isolation period as identified in the Health Protection (Coronavirus Restrictions) (No. 4) (Wales) Regulations 2020), an appeal

[1044] S.3(2)(d) of the MHA also notes that any treatment need only be appropriate, not necessarily therapeutic or curative.
[1045] Welsh Government (n665) para 23.9.
[1046] Mental Health (Discrimination) Act 2013.
[1047] Crown Prosecution Service, 'CPS Review Findings for First Year of Coronavirus Prosecutions' (2021) <www.cps.gov.uk/cps/news/cps-review-findings-first-year-coronavirus-prosecutions> accessed 13 June 2022. This document is now unavailable but is also referenced by: Expert Witness, 'CPS review findings for first year of coronavirus prosecutions' (2021) <www.expertwitness.co.uk/articles/news/cps-review-findings-for-first-year-of-coronavirus-prosecutions> May 14 2021 accessed 6 August 2025, and Crown Prosecution Service, '6,500 coronavirus-related prosecutions in first six months of pandemic' (2021) <www.cps.gov.uk/cps/news/6500-coronavirus-related-prosecutions-first-six-months-pandemic> accessed 6 August 2025.
[1048] Sch 26 Coronavirus Act 2020.
[1049] Magistrates' Courts Act 1980 ss 57ZA to 57ZF.

would have to be heard in this time to quash the order. This potential to appeal flies in the face of the rights offered to those detained under the MHA 1983 in that there is no right of appeal to a magistrate, and any application to review detention must be made to the Mental Health Act Tribunal. Within the rules for the Tribunal, an application to challenge detention must be made within 14 days of detention under s.2 MHA 1983 or 6 months of admission for treatment under s.3 MHA 1983. If these deadlines are missed it is likely that there will be at least a six-month delay before a further application may be made. Where an application is made, a Tribunal will normally hear the case within 7 days under s.2 or 2 months under s.3 MHA 1983.[1050] This means that an individual could be detained under the MHA 1983 for 21 days before an appeal is heard. The approach to provide for judicial oversight for a detention likely to last no more than 14 days seems far more reasonable than that provided for under the MHA 1983.

This is a key point for the consideration of parity. As noted earlier, there has been extensive comment[1051] on the use of law to manage the COVID-19 pandemic, with much of the intervention being seen as oppressive. Indeed, despite the Coronavirus Act 2020 being passed by Parliament and the broad recognition of the global crisis, there has been real discomfort at the Government having the ability to make regulations without returning to the House to seek a mandate. This in part has led to a Private Members' Bill[1052] to amend the Public Health (Control of Disease) Act 1984 in order to ensure there is Parliamentary scrutiny of such regulatory powers in the

[1050] Gov.uk, 'Apply to the Mental Health Tribunal' <www.gov.uk/mental-health-tribunal> accessed 13 June 2022.
[1051] Parry (n1026); Taylor (n1027); Cahill (n1027); Taylor (n1029).
[1052] UK Parliament 2021-2022 Session. Public Health (Control of Disease) Act 1984 (Amendment) Bill <https://bills.parliament.uk/bills/2974/publications> accessed 13 June 2022.

future. The COVID-19 pandemic resulted in travel restrictions, business interruption, self-isolation, visiting restrictions, and other restrictions on personal liberty[1053] which have been deemed as reasonable in the circumstances. These were subject to judicial review,[1054] and relaxed, and ultimately revoked as soon as possible so as not to unduly impact on the rights of citizens.

Parity Considered in the Context of the UNCRPD

What is startling from the analysis above is that despite protests and legal challenges in connection with COVID-19 restrictions, the State still has far more draconian powers to detain and hold individuals under the MHA 1983 in hospital and in the community than any of the restrictions imposed under the Coronavirus Act 2020. This is despite such powers appearing to be in direct contradiction of the United Nations Convention on the Rights of Persons with Disabilities[1055] (UNCRPD) which the UK ratified in 2009. The specific areas of note here when considering the difference in the approach to COVID-19 and mental illness are predicated on the definitions in Article 2,[1056] and the interpretation of Articles 3 (General principles), 4 (General obligations), 5 (Equality and non-discrimination), 12 (Equal recognition before the law), 14

[1053] House of Commons Library, 'Coronavirus: The Lockdown Laws' 5 (Research Briefing, 2021) <https://commonslibrary.parliament.uk/research-briefings/cbp-8875/> accessed 13 June 2022.
[1054] *R(Dolan) v Secretary of State for Health and Social Care* [2020] EWCA Civ 1605.
[1055] United Nations General Assembly (n24).
[1056] These are: "Discrimination on the basis of disability" means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.
"Reasonable accommodation" means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.

(Liberty and security of person), and 25 (Health). Each of these issues will be addressed individually below.

Specific action has been taken which ensures some UK law complies with the Convention in respect of mental health, and a clear example is that of the Mental Health (Discrimination) Act 2013 as noted above in relation to the role of company directors detained under the MHA. This legislation also addressed the UK's failure to comply with Article 29 of the Convention - Participation in political and public life, which states:

> States Parties shall guarantee to persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others, and shall undertake:
>
> (a) To ensure that persons with disabilities can effectively and fully participate in political and public life on an equal basis with others, directly or through, freely chosen representatives, including the right and opportunity for persons with disabilities to vote *and be elected*, … [emphasis added].

Before the Mental Health (Discrimination) Act 2013, which repealed s.131 of the MHA 1983, an individual who had been detained for a period of more than six months would automatically be removed from their seat as an MP.[1057] A statement from the Government at the time noted:[1058] 'This law is out of date. It sends out entirely the wrong message that if you have mental health problems your contribution is not welcome in public life. This should not be the case.'

[1057] Cabinet Office Press Release, 'Section 141 of the Mental Health Act to be abolished' (2011) <www.gov.uk/government/news/section-141-of-the-mental-health-act-to-be-abolished> accessed 14 June 2022. The commentary for this press release notes that the powers had never been used but the Lunacy (Vacating of Seats) Act 1886 had resulted in the removal of Dr Charles Leach MP after a protracted illness. The language of the Act again reminds us of the discriminatory approach to mental health.
[1058] ibid.

This approach to amending existing legislation to give effect to Conventions such as the UNCRPD is well established, and the introduction to the Human Rights Act 1998 relates this specifically to the giving further effect to the European Convention on Human Rights 1950. As noted above, the UK Government ratified the UNCRPD and therefore has agreed to make the necessary changes to ensure the rights set out in the Convention are respected in practice.[1059] As noted in Chapter Five, there was a commitment in the Queen's Speech of May 2022[1060] to draft a Bill to reform the Mental Health Act 1983. This followed the Independent Review of the Mental Health Act 1983[1061] (the 'Professor Sir Simon Wessley' review). It should be noted though that even if all recommendations within the review were included in a draft Bill, this would still fail to address the majority of the issues noted below in relation to compliance with the UNCRPD.

First, Article 3 of the UNCRPD requires signatory nations to respect 'individual autonomy including the freedom to make one's own choices'. As noted earlier, under the Coronavirus Act 2020, where the power to detain for public safety was available, there was no corresponding power to treat (or vaccinate) if the individual had capacity. This is in direct contrast with the MHA 1983 where, even when an individual has capacity, they may be treated against their will and without judicial oversight if it is determined to be clinically appropriate. In many circumstances this can include powerful medications which can impact on cognitive functions[1062] and subsequently

[1059] Equality and Human Rights Commission, The United Nations Convention on the Rights of People with Disabilities. What does it mean for you (2010) <www.equalityhumanrights.com> ISBN 978 1 84206 278 4, 6.
[1060] House of Lords, The Queen's Speech 2022 <www.gov.uk/government/speeches/queens-speech-2022> accessed 14 June 2022.
[1061] Department of Health and Social Care (n50).
[1062] Michael Rehse and others, 'Influence of Antipsychotic and Anticholinergic Loads on Cognitive Functions in Patients with Schizophrenia' (2016) Schizophrenia Research and Treatment Article ID 8213165,1.

impact their capacity. It is arguable therefore that the failure to respect the individual autonomy of mental health patients is not in line with the UNCRPD. The MCA 2005 provides for judicial oversight by the Court of Protection for treatment decisions where such decisions have significant implications for the individual. It does not however offer the same protection for decisions against a person's will under the MHA 1983.

A recent systematic review of the international literature has identified that, 'the existing body of literature suggests that, overall, the workings of mental health tribunals are not compatible with the universal right to exercise legal capacity identified in Article 12 of the CRPD'.[1063] This review notes that Mental Health Tribunals can act as rubber stamping authorities, and that while the Tribunals exist, there is a lack of knowledge on how to request a hearing.[1064] Article 12 requires that:

> States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.[1065]

When reading this, it is difficult to see that the United Kingdom Government can balance the safeguards, or indeed the current state of mental health law, with the duty to be compliant with this Article. Reflecting again on the case of COVID-19 where a restriction might be for 14 days, fast track procedures were developed for appealing against detention during that period of detention. Whereas limited safeguards under

[1063] Aisha Macgregor, Michael Brown, Jill Stavert, 'Are mental health tribunals operating in accordance with international human rights standards? A systematic review of the international literature' (1999) Health and Social Care in the Community 2019;27: e494-e513, 511.
[1064] ibid 507.
[1065] United Nations General Assembly (n24).

the MHA 1983, which might result in no Tribunal for 12 months,[1066] demonstrate significant weakness. Arguably, the current state of play suggests that neither Article 3 nor Article 12 are being given sufficient effect, and as such the protection here does not suggest a fair nor just treatment of those with a mental illness.

Considering next Article 4[1067] – the requirement to adopt, modify, amend, legislate for the implementation of the rights in the Convention. While there was no discussion at the time of the phrase 'parity of esteem', the Mental Health Act 1959 sought to align the view that mental illness was comparable to physical illness, and the MHA 1983 was the first to consider consent in relation to detained patients.[1068] Gostin[1069]was at the forefront of the challenges which led to the MHA 1983, building on civil rights challenges, cases of abuse, and a society ready to see change. During this period, he also argued that all treatment against the will of a detained patient with capacity should be reviewed by an independent body,[1070] something that, while under the purview of the Mental Health Act Tribunal and the relevant regulators today, has been found to be lacking[1071]in practice. The official position on the 2002 Draft Mental Health Bill was that it sought to amend the MHA 1983, 'to take account of: advances in our thinking about mental health; developments in mental health care policy and therapeutic practice; changes in the structure of the NHS; and changes in the role of mental health professionals'.[1072]

[1066] As noted earlier, if a patient fails to request a tribunal within set timescales it is possible that this will result in a period of detention of 12 months under s 3 before a Tribunal hears any case.
[1067] United Nations General Assembly (n24).
[1068] George Szmukler, Larry O Gostin, Mental Health Law: 'Legalism' and Medicalism' – 'Old' and 'New', in George Ikkos, Nick Bouras, (eds) *Mind, State and Society: Psychiatry and Mental Health in Britain 1960-2010* (2022 Cambridge University Press) 72-73.
[1069] ibid 75-76.
[1070] ibid 75.
[1071] Macgregor (n1065) 494.
[1072] Parliamentary Office of Science and Technology (n684) 2.

There was however a missed opportunity in this Draft Bill to address the human rights impact of mental health legislation. In fact, the Bill was widely criticised for proposing to increase the use of compulsion both in the community, and for those individuals who were considered to have Dangerous Severe Personality Disorder.[1073] This initial Draft Bill was withdrawn to be replaced by an amended version in 2004, and this fared similarly poorly with a critical response from the Mental Health Alliance's patient and professional voices.[1074] The use of compulsion in the community did find some favour, subject to that compulsion being the least restrictive option, and that the appropriate services were available to patients[1075] - an argument predicated on reciprocity.[1076]

The Scottish Government has made some steps toward a reciprocity argument, following what are now known as the "Millan Principles",[1077] and incorporated these in the Mental Health (Care and Treatment) (Scotland) Act 2003. The development of this Act followed closely the route of the failed 2002 Draft Mental Health Bill[1078] in that a specialist committee was formed to consider the issues before making recommendations as to what should be included in the new Draft Bill. In Westminster this was chaired by Professor Genevra Richardson, and in Scotland their committee

[1073] David Batty, 'Q&A: dangerous and severe personality disorder' (2002) *The Guardian online* <www.theguardian.com/society/2002/apr/17/mentalhealth.crime1> accessed 16 June 2022; Parliamentary Office of Science and Technology (684) 3; Ailbhe O'Loughlin, 'Hidden agendas: the complicated criteria behind the detainment of offenders with severe personality disorders' (2019) York.ac.uk <www.york.ac.uk/research/themes/dspd/> accessed 16 June 2022.
[1074] Zosia Kmietowicz, 'Rip up draft mental health bill and start again, says BMA' (2005) BMJ 2005 Feb 12:330(7487):326.
[1075] House of Lords and House of Commons (n688) 67 para 190.
[1076] ibid 110 para 340. This evidence was submitted by the author's organisation and the author attended the evidence sessions for this consultation to support a patient and a carer who gave evidence directly to the Committee.
[1077] These "Millan Principles" are set out as principles to which interventions under the Act and the accompanying Code of Practice should have regard. They include non-discrimination, equality, respect for diversity, reciprocity, informal care, participation, respect for carers, least restrictive alternative, benefit, and child welfare. Scottish Executive, 'New Directions. Report on the Review of the Mental Health (Scotland) Act 1984' January 2001 Scottish Executive 481-482.
[1078] Department of Health (n687) 3 para 6.

was chaired by Rt Hon Bruce Millan. Both committees took evidence from patients, professionals, and service providers, though the Scottish approach seemed more inclined to accepting recommendations in relation to reciprocity than the Westminster Government,[1079] and this was reflected in the subsequent legislation. This does not mean however that the Scottish legislation meets the requirements of Article 4, and this will be explained in relation to reciprocity below.

The Scottish legislation requires those responsible for discharging the duties of the Act to, 'have regard' to a range of very positive and well-intentioned requirements,[1080] though not specifically reciprocity, which was a key recommendation. These include patient involvement in decision making, family and carer views, and the importance of providing the maximum benefit to the patient,[1081] but rely upon, 'having regard' rather than 'must' or even 'should'. While we in Wales are rightly proud of the requirement within the Rights of Children and Young Persons (Wales) Measure 2011 that Ministers have due regard to the UNCRC,[1082] this, as with the Scottish legislation, unfortunately lacks real teeth. Due regard is a duty to consider the impact on rights of relevant decisions, but this has been seen as both an incentive and additional paperwork.[1083] A requirement to act or to provide a particular service within a timescale is far more powerful. For a breach of due regard, redress through complaints

[1079] NHS Education for Scotland, 'Learning Resource Mental Health (Care and Treatment) (Scotland) Act 2003' (2010) 11 para 4 <www.nes.scot.nhs.uk/media/ryofw5zx/mental-health-care-and-treatment-scotland-act-2003.pdf> accessed 16 June 2022.
[1080] Mental Health (Care and Treatment) (Scotland) Act 2003 s 1(2).
[1081] ibid ss 1(3)(4).
[1082] United Nations General Assembly (n156).
[1083] *A duty to have due regard incentivises routine assessment of the rights in question; and although leading to what is pejoratively termed "additional bureaucracy", the collection of relevant data can aid the analytical assessment of service delivery.* Lucy Vickers, 'An English Duty to Have 'Due Regard' – An Effective Means of Upholding Children's Rights?' (2016) (OxHRH Blog 1 November 2016) <https://ohrh.law.ox.ac.uk/an-english-duty-to-have-due-regard-an-effective-means-of-upholding-childrens-rights/> accessed 29 August 2022.

procedures or potentially judicial review for an administrative failing is likely only to lead to decisions being reconsidered: action for a failure to comply with a statutory duty to act or provide a service provides far greater opportunities for justice. There is a right to assessment included in the legislation,[1084] and much has been made of the right to have views 'taken account of',[1085] but unfortunately no corresponding right to any specific plan for treatment or timescale to receive treatment.[1086]

In 2010, Wales made a further step towards patient rights in mental health with the passing of the Mental Health (Wales) Measure 2010 (MH(W)M 2010) which set out duties and rights under four main headings. These included the duty to both provide assessments of need at primary care level and appropriate services,[1087] the appointment and coordination of care planning,[1088] reassessment of patient needs,[1089] and the duty to provide advocacy services before detention.[1090] The advocacy duty will also be considered under Articles 5 and 14,[1091] but this starts to recognise the importance of support to seek help and advice before detention which may prevent detention. The genesis of the MH(W)M 2010 has been discussed in further detail in Chapter Five and earlier in this Chapter.

[1084] Mental Health (Care and Treatment) (Scotland) Act 2003 Part 14.
[1085] Scottish Government, 'The New Mental Health Act: A guide to consent to treatment - Information for Service Users and their Carers' (2005) para 5 <www.gov.scot/publications/new-mental-health-act-guide-consent-treatment-information-service-users-carers> accessed 18 June 2022.
[1086] See earlier comparison in this chapter with requirements for a 'time to treatment' target for cardiac care.
[1087] Mental Health (Wales) Measure 2010 Part 1.
[1088] ibid Part 2.
[1089] ibid Part 3.
[1090] ibid Part 4.
[1091] United Nations General Assembly (n24).

The MH(W)M 2010 did not give a right to any particular treatment, but did provide for basic performance data on Parts One to Three, and this performance information is publicly available. In 2011, Lesley Griffiths AM, the then Minister for Health and Social Services, introduced the National Service Model for Local Primary Mental Health Support Services by aiming for a model which:

> encourages flexibility in how those services may be delivered, but not variability in what services are to be delivered. It is based on the premise that local primary mental health support services will support, not supplant, General Medical Services.[1092]

The Minister noted that there would be legal responsibilities for Local Health Boards and local authorities to 'arrange and deliver' these services, but there was no right for any person to have any particular service,[1093] though it did set a target of 28 days for assessments to be completed.[1094] It should however be noted here that this is no different from a physical health perspective, and the argument as to why timely access to mental health services should be a right will form the basis for the Welsh Paradigm in Chapter Nine.

The separation into Parts One and Two for Primary and Secondary mental health services poses a question as to why the Welsh Government have deemed it possible to set a target of 28 days for assessment and a further 28 days for commencement of therapeutic interventions for Part One but have failed to do so for Part Two. Patients falling under Part One of the Measure are those who are by very definition, primary care patients, not deemed by their general practitioner (GP) to require the intervention

[1092] Welsh Government, Mental Health (Wales) Measure 2010 National Service Model for Local Primary Mental Health Support Services (2011) 5 <www.wales.nhs.uk/sitesplus/documents/863/Mental%20Health%20Measure%20-%20Primary%20Care%20Model.pdf> accessed 16 June 2022.
[1093] ibid.
[1094] ibid 23 para 4.17(c).

of specialist services. Patients falling under Part Two of the Measure are defined as those who require the support of secondary care mental health services. Interestingly, NHS Digital use the following definitions: Primary care is usually a patient's first point of contact, and includes: general practice, community pharmacy, dentistry, optometry (eye health). Secondary care includes: planned or elective care - usually in a hospital, urgent and emergency care, including 999 and 111 services, ambulance services, hospital emergency departments, and out-of-hours GP services, *mental health care*[1095] (emphasis added). This approach follows strongly a methodology which believes that mental health services should be for the mentally ill rather than providing a 'one size fits all' for life challenges.

Indeed, the Westminster Government has made the following bold statement:

> Poor wellbeing is distinct from mental illness, and we do not want to 'medicalise' the normal worries and stresses of life, but over the long term it can have detrimental effects on our life satisfaction, productivity at school and work, and on our physical health.[1096]

This is refreshing but not new. Thomas Szasz noted in 1960 that: 'The notion of mental illness thus serves mainly to obscure the everyday fact that life for most people is a continuous struggle, not for biological survival, but for a "place in the sun," "peace of mind," or some other human value.'[1097] Life offers major challenges for many people and it is how they cope and how their coping strategies work for them that often

[1095] NHS Digital, 'The Healthcare Ecosystem' <https://digital.nhs.uk/developer/guides-and-documentation/introduction-to-healthcare-technology/the-healthcare-ecosystem#primary-care> accessed 18 June 2022.
[1096] Department of Health and Social Care, Open consultation Mental health and wellbeing plan: discussion paper (2022) ch 1 <https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper#chapter-1-how-can-we-all-promote-positive-mental-wellbeing> accessed 18 June 2022.
[1097] Thomas S Szasz, 'The myth of mental illness' (1960) American Psychologist 15 113, 118.

determines their wellbeing.[1098] While wellbeing is key to how individuals live their lives, the NHS notes that while stressful life events may trigger episodes of conditions such as schizophrenia, they are not causative.[1099] Despite schizophrenia being one of the top fifteen causes of disability,[1100] and the World Health Organisation recognising that 'a range of effective care options for people with schizophrenia exist, and at least one in three people with schizophrenia will be able to fully recover.',[1101] no equivalent targets are set for people with severe illness in the same way as Part One sets targets for primary care. As will be discussed later, it is also the potential for Part Two patients to be deprived of their liberty that is key to the argument for reciprocity.

Parts Two and Three of the Measure were to receive their own Code of Practice[1102] which set out in detail how the Measure should operate, including setting duties for care coordinators,[1103] and providing detail of how Part Three should operate.[1104] This new right under Part Three provided for a duty on services and an entitlement for a patient to a reassessment of their health and needs. The Code of Practice notes that the Entitlement to Assessment means:

> A former user of secondary mental health services is able to seek a further assessment of their mental health, with a view to determining whether secondary mental health services or community care and housing or well-being

[1098] ibid 117; Charles Stangor, Jennifer Walinga, *Introduction to Psychology – 1st Canadian Edition* (2014 Victoria BC: BC campus) ch 16, 753 <https://opentextbc.ca/introductiontopsychology/> accessed18 June 2022; Krzysztof Stanislawski, 'The Coping Circumplex Model: An Integrative Model of the Structure of Coping with Stress' (2019) Frontiers in Psychology 16 April 2019.
[1099] NHS, 'Causes – Schizophrenia' (2019) <www.nhs.uk/mental-health/conditions/schizophrenia/causes/> accessed 18 June 2022.
[1100] Theo Vos, 'Global, regional, and national incidence, prevalence, and years lived with disability for 328 diseases and injuries for 195 countries, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016' (2017, The Lancet 2017 Sep 16;390(10100):1211 Figure 1(c).
[1101] World Health Organisation, 'Schizophrenia: Key Facts' (2022) <www.who.int/news-room/fact-sheets/detail/schizophrenia> accessed 18 June 2022.
[1102] Welsh Government (n918).
[1103] ibid chapter 3.
[1104] ibid chapter 8.

> services may be required to improve *or prevent a deterioration of their mental health*.[1105] (emphasis added)

This last phrase offers somewhat of a toe dipping exercise into the area of reciprocity. This relates to patients who have previously been assessed as needing specialist mental health services,[1106] and was intended to improve accessibility for specialist support. Part Three though will be the focus of the Welsh Paradigm in Chapter Nine. Part Two was an expansion of the assessment right seen earlier in the Scottish legislation. It provides for a duty to produce a Care and Treatment Plan[1107] in a standardised format[1108] which takes a step further than assessing need to setting out in writing the plan for delivering care to meet those needs. Unfortunately, at the time that these Regulations were enacted, there was no set timescale for the preparation of the plan, simply a recommendation that it should be distributed within 8 weeks of the care coordinator being appointed.[1109] This again seems to suggest that there is no parity between primary and secondary care needs, never mind parity between physical and mental health, as the Part One timescale would require that treatment was in place by that time.

What the duty to provide a Care and Treatment Plan does offer is the opportunity to challenge authorities when the needs identified in the care plan are not met. This then provides an avenue for challenge through complaints procedures, ombudsman services, or ultimately via judicial review. To be able to do this though an individual needs knowledge, a will to do so, and the capability to make applications, raise

[1105] ibid 51 para 8.18.
[1106] Defined as "former users of secondary mental health services" Welsh Government (n918) 49 para 8.1.
[1107] Welsh Government (n918) chapter 4.
[1108] The Mental Health (Care Coordination and Care and Treatment Planning) (Wales) Regulations 2011, WSI 2011/2942 (W.318).
[1109] Welsh Government (n918) chapter 4 para 4.87.

concerns, attend meetings etc. which if one has a serious mental illness and is potentially detained poses problems. This is not therefore a route which is accessible to many people.[1110]

However, in respect of the Care Programme Approach in England (a similar approach to a Care and Treatment Plan), where there are duties to provide an after-care plan after detention, there is some case law.[1111] Under s.117 of the Mental Health Act 1983, duties are placed on the relevant health or local authorities to make provision for aftercare for those individuals previously detained under ss.3, 37, 45A , 47, 48, and that such service are free of charge even where there are charging arrangements in place. In Wales this duty is devolved to the Welsh Ministers, and under s.117(6), a key phrase for the purposes of this thesis defines "after-care services" as those: '(b) reducing the risk of a deterioration of the person's mental condition (and accordingly, *reducing the risk of the person requiring admission to a hospital again for treatment for a mental disorder*)', [emphasis added]. This reference, recognising that there is an ability for services to be planned and delivered in a way that will reduce the potential for re-admission, especially where this relates to an individual previously detained, provides a good springboard for the argument that there is a duty to provide care to prevent detention.

[1110] The timescales to seek permission for a judicial review are set out in s 54.5 of the Civil Procedure Rules 1998 SI 1998/3132 as amended in 2017 and set a deadline of no longer than 3 months from the date the grounds arose for the challenge, but if the court does not feel that this was addressed promptly, the 3 months is not guaranteed.

[1111] *R (AK) (by her mother and litigation friend GK) v The London Borough of Islington and North Central London Clinical Commissioning Group* [2021] EWHC 301 (Admin).

In *Re. (AK)*,[1112] the court considered whether there was a duty for the defendants to provide a Care Programme Approach (CPA) plan on discharge rather than an assessment and plan under the Children Act 1989,[1113] and, in finding that there was and that the plan under the Children Act did not meet the standards of the CPA plan, ordered[1114] that a new assessment be conducted. As HHJ Lickey found,[1115] "The care plan does not 'set out the practicalities of how the patient will receive the treatment, care and support from day-to-day'". When taken together with the duty under the MHA 1983 s.117 and those noted earlier in relation to the Welsh Ministers (s.117(6)), it is arguable then that through the Care and Treatment Plan,[1116] Welsh patients have a right to an agreed plan of care, and delivery of that care, *with the expectation that that will on a day-to-day basis provide such support as is needed to prevent readmission.* This suggests that this could be a special right in respect of mental health patients for services to act to prevent readmission rather than just to provide a particular care intervention. This will be considered below following a review of how the courts consider challenges on rationing of healthcare. The key area here will be the clinical decision making, how risk management and assessment is considered, and ultimately a cost argument, but seeking to reference a more specific duty in relation to the MHA 1983 s.117.

This offers some ground for debate when one considers the judgment in *Condliff*[1117] which set out that s.3 of the National Health Services Act 2006 was a 'public law duty

[1112] ibid.
[1113] Children Act 1989 s 17.
[1114] *R (AK) (by her mother and litigation friend GK) v The London Borough of Islington and North Central London Clinical Commissioning Group* [2021] EWHC 301 (Admin) [31].
[1115] ibid [30(viii)].
[1116] Mental Health (Wales) Measure 2010 Part 2.
[1117] *R (on the application of Condliff) v. North Staffordshire Primary Care Trust* [2011] EWCA Civ 910 CA [4].

not a direct duty owed to individual patients'. While it is likely that s.117 of the MHA 1983 is intended to also provide a public law duty, the references to the individual's particular circumstances (via their personalised risk assessment) is suggestive of a duty for services to act to prevent readmission of that patient. If this is the case, and there is a duty to provide those services necessary to prevent readmission, it is still likely only to be those services deemed clinically beneficial[1118] and subject to any reasonable rationing approach by the NHS body. These local policies however are open to challenge and have been in relation to the blanket type approaches to these policies, either in relation to waiting times[1119] without individual consideration, or treating all people with particular conditions[1120] as one rather than considering individual circumstances.

Conclusion

In considering the understanding of parity between the experiences of those with physical health conditions and those with a mental health condition, it is clear that there is a recognition that parity should exist. But what can this parity really mean? As noted above, while professional bodies, government, and the policy discussions give voice to the concept, we still have a situation where there is clear demarcation in law between mental and physical health. No treatment without consent in a capacitous individual is possible for a physical health condition, but yet it is legislated for a capacitous person under the MHA 1983. COVID-19 provided us all the experience of

[1118] *R v Cambridge Health Authority ex parte B* [1995] 1 WLR 898; *R (on the application of Ross) v West Sussex Primary Care Trust* [2008] EWHC 2252 (Admin).
[1119] *R (on the application of Watts) v Bedford Primary Care Trust and Secretary of State for Health* (2006) Case C-372/04 ECJ; *R (on the application of Ross) v West Sussex Primary Care Trust* [2008] EWHC 2252 (Admin).
[1120] *R (Rogers) v Swindon NHS Primary Care Trust* [2006] EWCA Civ 392.

restrictions on movement, and impingement on our personal lives; this was understood to be because of the global crisis due to the pandemic. It is significant however that even where there was such a crisis, the rules on detention for infection control purposes continued to follow the requirements for judicial involvement to protect rights.

It may be that such a dichotomy is considered necessary in the legislation, but as we have seen throughout this thesis, the argument for reciprocal rights to treatment to compensate for such an impingement on rights, does not appear unreasonable. As noted in *Condliff,*[1121]the NHS duty to provide services is a public one, not a case specific duty, and following that principle, we may need to consider how a public duty could be so imposed as to provide reciprocity. The earlier discussion in this chapter indicates that even where there has been the introduction of legislation, such as the MH(W)M 2010, which sets out duties on services, there is little to ensure such duties are fulfilled. Chapters Eight and Nine explore how the MH(W)M 2010 may be developed by Regulation, to give effect to the intention of Jonathan Morgan AM when he introduced the Measure as noted in Chapter Five.

[1121] *R (on the application of Condliff) v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910 CA [4].

Chapter Eight - A Welsh Perspective: Enshrining Rights, Citizenship and Reciprocity

Introduction

In considering how and why Wales might be able to adopt a human rights approach, it is worth revisiting the current state of mental health legislation in England and Wales (as outlined in Chapters Four and Five) which means that the State still has the ability to remove the liberty of an individual solely based on a disability.[1122] This conflicts with the UNCRPD.[1123] The MHA 1983 provides relevant authorities with the powers to detain an individual who has capacity for appropriate treatment for a mental disorder, in circumstances where the only person at risk of harm is that individual themselves.

Contrast this with the legislation relating to suicide in individuals who have other disabilities such as cancer. In England and Wales, suicide has not been a criminal act since 1961,[1124] though it remains a crime to assist another in taking their own life.[1125] In guidance from the Crown Prosecution Service it is interesting to note the public interest factors tending against prosecution. These seem to suggest that "A prosecution is less likely to be required if: the victim had reached a voluntary, clear, settled and informed decision to commit suicide".[1126] In *R (Nicklinson and anor) v MOJ*[1127], LJ Neuberger set out:

> In three subsequent decisions, the Strasbourg court has stated in clear terms that article 8.1 encompasses the right to decide how and when to die, and in

[1122] Mental Health Act 1983.
[1123] United Nations General Assembly (n24) Art 14.
[1124] Suicide Act 1961 s 1.
[1125] ibid s 2.
[1126] Crown Prosecution Service (n268) s 45.
[1127] *R (on the application of Nicklinson and another) (Appellants) v Ministry of Justice (Respondent)* [2014] UKSC 38 [29].

particular the right to avoid a distressing and undignified end to life (provided that the decision is made freely).

This suggests that the option of taking one's own life is a human right, and *particularly* so where there is a distressing potential end to life. It is however particularly challenging where an individual has a serious mental illness to determine whether they are able to make, 'a voluntary, clear, settled and informed decision to commit suicide'[1128] while they are suffering from that mental illness.

The MCA 2005 as legislation alone cannot offer a clear, unambiguous route through the challenges posed by an individual with a serious mental illness who has capacity and wishes to take their own life. There is however an approach which offers a potential human rights focus which addresses the complexity of such individual cases. Richardson[1129] explores this in relation the case of Kerie Wooltorton,[1130] and offers a perspective on a model of supported decision making in such cases. This chapter will examine a model where a similar approach is considered within the MH(W)M 2010. This is aligned with the Care and Treatment Plan in Part Two of the MH(W)M 2010 and developed to consider the potential for an incremental enforcement of rights under Part Three of the MH(W)M 2010 – the right for re-referral.

[1128] Crown Prosecution Service (n268).
[1129] Genevra Richardson, 'Mental capacity in the shadow of suicide: What can the law do?' (2013) International Journal of Law in Context 9.1 87, 87.
[1130] Kerrie Wooltorton intentionally ingested antifreeze, presented at hospital but refused treatment and was deemed to have capacity to make that decision. She had prepared an 'advance directive' stating that she did not wish to receive any treatment other than comfort measures, and though while previously she had been detained under the MHA 1983, she was not deemed to be detainable. This meant that as she was deemed to have capacity, her wishes to refuse curative treatment were complied with and she died. Piotr Szawarski, 'Classic cases revisited: The suicide of Kerrie Wooltorton' (2013) JICS Volume 14 Number 3 July 2013 211, 211.

Why is Wales a Suitable Legislature for Enshrining Rights?

If we truly believe in citizenship and collective responsibilities, then how do we enshrine rights, and accept reciprocity as the foundation of a Welsh way? There is an opportunity here for the Welsh Government to provide leadership in ensuring the rights of individuals are respected. As noted in Chapter Three, Wales has a proud history of making law relating to mental health,[1131] and since the inception of the Welsh Assembly (now Senedd Cymru), on 1st July 1999, health and social care have been devolved matters. This has led to a number of Acts, Measures, and the related regulations and codes of practice, and there is now a need to consolidate much of the Welsh specific legislation.[1132] In total, to November 2024, there have been 44 Acts of the National Assembly for Wales[1133] and 22 Measures.[1134] Of these, 7 Measures were directly relating to health, social care or housing, and 14 Acts were either directly (or indirectly in relation to the NHS Finance (Wales) Act 2016)) relating to health, social care, domestic violence and abuse, or housing.

Within this legislative programme, Wales has had to mirror the Westminster Government in respect of devolved powers in such legislation as the Social Services and Well-being (Wales) Act 2014, and the Care Act 2014. These Acts were aimed at consolidating much of the existing social care legislation[1135] but now had to respect the devolution settlement. While commentators such as Clements[1136] note disappointment with the way some legislation is drafted, and he suggests that much of

[1131] Jones (n286).
[1132] Written Statement: The future of Welsh law: classification, consolidation codification (17 October 2019) GOV.WALES <www.gov.wales/written-statement-future-welsh-law-classification-consolidation-codification> accessed 29 January 2023.
[1133] The National Archives, National Assembly for Wales Acts <www.legislation.gov.uk/anaw.
[1134] The National Archives, National Assembly for Wales Measures <www.legislation.gov.uk/mwa>.
[1135] Clements (n52).
[1136] ibid 1.

this should have been addressed through the use of regulations, others[1137] laud the approach Wales has taken in developing an alternative paradigm. The Westminster Government has strongly favoured the introduction of Care and Treatment Plans,[1138] in the Mental Health Bill 2024, with these having been mandatory in Wales for over 10 years under the MH(W)M 2010 as noted in Chapter Seven. This is an example of the benefits of devolution highlighted by Williams, where he suggests that, 'Devolution within the United Kingdom offers an opportunity to all four nations to learn from each other and must provide an irritant to complacency and national insularism'.[1139] Wales has acted as a test bed for mental health policy and practice which is now seen as an example for the updating of the MHA 1983.

Wales has also sought to embrace the ability now provided through devolution to improve the protections for and the understanding of human rights. The Rights of Children and Young Persons (Wales) Measure 2011 preamble notes this is, 'A MEASURE of the National Assembly for Wales to make provision for and in connection with giving further effect in Wales to the rights and obligations set out in the United Nations Convention on the Rights of the Child.'[1140] The Children (Abolition of Defence of Reasonable Punishment) (Wales) Act 2020, gave greater effect to those negative rights in relation to physical punishment.[1141] The positive rights under the Rights of Children and Young Persons (Wales) Measure 2011 remain

[1137] Peter K Mackie, Ian Thomas, Jennie Bibbings, 'Homeless Prevention: Reflecting on a Year of Pioneering Welsh Legislation in Practice' (2017) European Journal of Homelessness Vol 11 No 1 May 2017.
[1138] Department of Health and Social Care (n50) 25.
[1139] John Williams, 'A New Law on Adult Social Care: A Challenge for Law Reform in Wales' (2012) Statute Law Review 33(2) 304 314-315.
[1140] Rights of Children and Young Persons (Wales) Measure 2011, Introductory text.
[1141] This negative right, while very important, simply addresses an anomaly related to age and assault. A positive right based Act might perhaps have required parents to ensure that a child is provided with the skills to take advantage of their rights to freedom of expression (under Article 13 of the UNCRC) United Nations General Assembly (n156).

limited though to having *due regard*, as noted in Chapter Seven. Wales, now as a developing legislature, has the opportunity to develop a human rights approach to other legislation and to create duties on State agents and bodies, for example, to protect the positive rights of people with disabilities.

Using the Law to Improve Patient Rights

The development of supported and enhanced patient involvement in decision making and advance directives[1142] has also been considered in the recent review of the MHA 1983. It should be noted though that shared decision making and supported decision making are not the same thing, and the language around this has been used without precision. In 2008 the General Medical Council (GMC) published a guide for doctors: 'Consent: patients and doctors making decisions together',[1143] at no point does this guidance refer to shared decision making. Support in this context is in reference to information provided and an assessment as to whether the patient needs additional support to make decisions on treatment. Richardson[1144] recognised supported decision making as an obligation under Article 12(3) of the UNCRPD, and this, as noted by the UNCRPD Committee itself, throws up a challenge in understanding.[1145] The UNCRPD Committee reinforced the obligation on States to provide access to support in exercising capacity, but noted that '"[s]upport" is a broad term',[1146] and that, 'advance planning mechanisms' may also be utilised.[1147] The UNCRPD Committee

[1142] Department of Health and Social Care (n50) 17.
[1143] <www.gmc-uk.org/-/media/documents/GMC-guidance-for-doctors---Consent---English-2008---2020_pdf-48903482> accessed 28 August 2023.
[1144] Richardson (n1131) 87.
[1145] United Nations, General Comment, Committee on the Rights of Persons with Disabilities Eleventh Session (2014) Art 12 para 2 <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement> accessed 28 August 2023.
[1146] ibid Art 12 para 3.
[1147] ibid.

were however clear, '[s]upport in the exercise of legal capacity must respect the rights, will and preferences of persons with disabilities and should never amount to substitute decision-making'.[1148]

Dinerstein defines supported decision making as:

> a series of relationships, practices, arrangements, and agreements, of more or less formality and intensity, designed to assist an individual with a disability to make and communicate to others decisions about the individual's life.[1149]

This fits well with the UN's General Comment[1150] noted above and in Chapter Five, although Dinerstein wrote two years before the UN published their Comment, and there is no reference to Dinnerstein's work in the General Comment. It is not clear whether Article 12(4) of the UNCRPD prohibits any substitute decision making, as the General Comment refers to "best interpretation of will and preferences".[1151] This has been the subject of much debate.[1152]

A strongly advocated approach highlights the argument that people with a psychotic illness will suffer health detriment, loss of autonomy, and be poorly served if they cannot be compelled to receive treatment when they are unwell, as they would not have capacity to make informed choices.[1153] While there are some significant

[1148] ibid.
[1149] Robert D Dinerstein, 'Implementing Legal Capacity Under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road From Guardianship to Supported Decision-Making' Human Rights Brief 19 no 2 (2012): 8 <https://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1816&context=hrbrief> accessed 28 August 2023.
[1150] United Nations (n1147) para 2.
[1151] ibid.
[1152] Matthé Scholten, Jakov Gather, 'Adverse consequences of article 12 of the UN Convention on the Rights of Persons with Disabilities for persons with mental disabilities and an alternative way forward' (2018) Journal of Medical Ethics 2018;44:226; George Szmukler, 'The UN Convention on the Rights of Persons with Disabilities: 'Rights, will and preferences' in relation to mental health disabilities' (2017) International Journal of Law and Psychiatry Volume 54 2017 90; Paul Skowron, P, 'Giving substance to 'the best interpretation of will and preferences' (2019) International Journal of Law and Psychiatry 62 (2019) 125.
[1153] Scholten (n1154) 229; Freeman (n842).

challenges here, we should reflect on the discussion in Chapter Two where autonomy and capacity were discussed. It was noted that there are many views of autonomous decisions, including the Kantian argument that a decision is only autonomous if it is moral.[1154] People make bad decisions about their health and wellbeing on a daily basis. It is clear that tobacco use is the main cause of lung cancer,[1155] but there is no suggestion that as this is a perverse personal choice in relation to health, nor that it is part of a health condition - an addiction to nicotine – that forceable treatment is required to substitute the correct behaviour.

The key issue of differentiation between mental health and other health services, in relation to the arguments propagated in this thesis, is fundamentally connected to the loss of liberty of a person with capacity in order to receive health or social care treatment from the State to protect their wellbeing. It is noted that the MHA 1983 also provides a route for the protection of others, and this in itself remains contentious as an individual may not have committed any offence but is detained without trial. However, for the purposes of this study, the detention to avoid harm to self is sufficient in making the argument. In the discussion below which references the development of the MHA 1983, it should be noted that I was a member of the Advisory Panel[1156] to the Independent Review of the Mental Health Act 1983. Within the final Committee report 'Modernising the Mental Health Act' of the Independent Review of the Mental Health Act,[1157] it has become clear that while there was a recognition of the call for a

[1154] Michael Gass, 'Kant's Causal Conception of Autonomy' (1994) History of Philosophy Quarterly, 11(1) 53, 53.
[1155] NHS, 'Causes-Lung cancer' <www.nhs.uk/conditions/lung-cancer/causes/> accessed 28 August 2023.
[1156] Department of Health and Social Care, 'Independent Review of the Mental Health Act 1983: Advisory Panel' <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779055/MH_review_advisory_panel_independent_review.pdf> accessed 29 January 2023.
[1157] Department of Health and Social Care (n50).

rights-based approach, there was an admission that this review stopped short of calling for that within the legislation:

> In our Interim Report we already signalled that we were minded to retain a Mental Health Act, with compulsive powers, whilst being totally committed to shift towards a more rights-based approach, improving respect and dignity, and ensuring greater attention is paid to a person's freely expressed wishes and preferences. Furthermore, we intended that all reasonable support will be available to enable patients to take their own decisions where that can be done. None of those positions have changed.[1158]

The Chair of the Review, Professor Sir Simon Wessely, an eminent psychiatrist,[1159] having recognised that the Review had not recommended fully implementing the UNCRPD,[1160] noted that

> [D]uring the course of the Review I have learned from many wise people that legislation is a rather more blunt instrument that I had naively believed, is rarely effective on its own, and works best alongside practical Measures – in this case to reduce both the place for and the need for coercion, the central concern of the CRPD committee in this context.[1161]

This is an argument that I have heard from civil servants and individuals within professional social care bodies, but it does not explain how and why public health interventions have deliberately used legislation where messaging, advice, and informal guidance has failed. Supporting examples would include the use of legislation to enforce the wearing of seatbelts,[1162] the banning of hand-held mobile phones while driving,[1163] and the wearing of helmets while riding a motorcycle.[1164]

[1158] ibid 17.
[1159] King's People, 'Professor Sir Simon Wessely' <www.kcl.ac.uk/people/professor-sir-simon-wessely> accessed 29 January 2023.
[1160] Department of Health and Social Care (n50) 12.
[1161] ibid 13.
[1162] The Motor Vehicles (Wearing of Seat Belts) Regulations 1993, SI 1993/176.
[1163] The Road Vehicles (Construction and Use) (Amendment) (No. 4) Regulations 2003, SI 2003/2695.
[1164] The Motor Cycles (Wearing of Helmets) Regulations 1973, SI 1973/180.

Interestingly, the latter was heavily debated in Parliament as it was deemed a significant infringement on public Liberty.[1165] A noteworthy argument relating to the impact on Liberty was further debated in relation to the risks an individual takes upon themselves should they choose not to wear a helmet, and that they would cause a cost to the community.[1166] Such an issue was seen as essentially one where for an individual taking the risk of causing harm to themselves, this was their own business, and the law should not intervene.[1167] The wearing of helmets has without doubt saved lives,[1168] and choosing not to wear one is thus irrational and possibly based on delusional ideas of the ability of an individual to ride a motorcycle safely.

As noted earlier, such paternalistic principles to prevent harm, when applied to an individual deemed to experience a mental health condition, are likely to result in detention under the MHA 1983, even if the individual wishes to risk the potential harm. It seems therefore that legislation aimed at maximising Liberty, or at least justifying the infringement upon an individual's Liberty, is more likely to find favour than legislation which does not, when considering State obligations under a ratified United Nations treaty such as the UNCRPD. This suggests then that an approach to develop a Welsh law to prevent or reduce detention in itself might be unlikely to gain traction, challenge existing thinking, and, as this is not a devolved matter despite relating to health, fall outside Welsh Government competence. So how do we change

[1165] Hansard HC Deb 5 April 1973, vol 854 cols 745-75 at 745.
[1166] ibid at 749.
[1167] Hansard HC Deb 31 May 1956, vol 553 cols 489-506 at 499.
[1168] Centres for Disease Control and Prevention, 'Motorcycle Safety' (2022) <www.cdc.gov/transportationsafety/mc/index.html> accessed 29 January 2023. In the United States, helmets saved an estimated 1,872 lives in 2017. 749 more lives could have been saved if all motorcyclists had worn helmets in 2017.

things in Wales without having specific legislation forbidding the use of detention on health grounds?

The key here it to identify a duty, make it more difficult to fail in that duty, or to penalise poor performance, whilst retaining the expectation that even once redress is provided, there is still a requirement for delivery of service, thus making it easier / more favourable to deliver the duty. Perhaps an example from another area to consider would be the duty to properly pay tax on time. If one fails to do so, the tax is still payable but there is a penalty attached. Indeed, the tax owed and the penalty continue to 'penalise' until the duty is fulfilled.[1169] Indeed, in the Parliamentary Scrutiny of the Mental Health (Wales) Measure (2010) it is noted:

> While witnesses commented that the National Service Framework had set a "fantastic framework for mental services", Hafal[1170] and the College of Occupational Therapists agreed that it lacked "teeth". Jonathan Morgan AM commented:
>
> Although they are there to guide the NHS to provide better services, there is no public duty that exists. There is no legal duty on those bodies to provide either the assessment, the level of treatment and care that that person may require or ensure that that person gets access to the level of advocacy that they may need [...]
>
> > *It is very clear that the national service frameworks in themselves, although providing a strategic direction, do not have the legislative oomph in the way that placing duties through Assembly Measures on the back of this* LCO [Legislative Competence Order] *could. I think that is quite fundamental.*[1171]

[1169] HMRC, Penalties for Late Payment and Interest Harmonisation (2002) <www.gov.uk/government/publications/penalties-for-late-payment-and-interest-harmonisation/penalties-for-late-payment-and-interest-harmonisation> accessed 29 January 2023.

[1170] It should be noted that as the Deputy Chief Executive of Hafal at this time I had a considerable input into both policy, and publicity on Hafal's behalf. I also gave evidence to both the Welsh Government and the Westminster Government in relation to the Mental Health (Wales) Measure 2010.

[1171] House of Commons, Welsh Affairs Committee. Proposed National Assembly for Wales (Legislative Competence) (Health and Health Services and Social Welfare) Order 2009 (HC 778, 2009) The Stationery Office para 35, emphasis added.

As discussed in Chapters Two and Three, there is of course a route under the common law for individuals to sue for damages under the tort of trespass against the person, and of false imprisonment.[1172] Even without a specific contract there would be an expectation that health and local authority[1173] services to an individual with a mental illness would be delivered with reasonable care and skill.[1174] In practice, seeking damages via the tortious route is, however, often beyond many people who are mentally ill (as noted in Chapter Seven).[1175] The very significant difficulties faced in making such a case along with the requirement to do so within three years for medical negligence claims[1176] can mean that by the time an individual may be fit enough to make a case that the potential for redress may have passed.

In this next section I will review the existing approach in Wales to supported decision making within Care and Treatment Planning.[1177] This will also consider how the existing duties within the MH(W)M 2010 offer an opportunity to identify a cohort of individuals who might be affected by a failure to act appropriately, and to attach a 'penalty' should such individuals end up detained.

[1172] *In Re. S-C* [1995] EWCA Civ 60.
[1173] *Cassidy v Ministry of Health* [1951] 2 KB 343, Denning LJ 859-860.
[1174] *R v Bateman* (1925) 94 LJKB 791 (CCA).
[1175] Omar Salem, 'A Question of Justice: Exploring How the Civil Justice System Responds to Mental Health and Learning Disabilities' (2021) <www.centreformentalhealth.org.uk/blogs/question-justice-exploring-how-civil-justice-system-responds-mental-health-and-learning-disabilities> accessed 21 August 2023 ; Ministry of Justice, 'Court experience of adults with mental health conditions, learning disabilities and limited mental capacity Report 3: At court' (2010).
[1176] Limitation Act 1980 s 11(4).
[1177] A requirement of part 2 of the MH(W)M 2010 and a recommendation in the Review of the Mental Health Act for the Westminster Government to include in any amendments to the MHA 1983.

The Mental Health Wales Measure 2010

This landmark legislation[1178] was developed following Jonathan Morgan AM, Shadow Minister for Health and Social Services in the Third Assembly winning the periodic ballot under Standing Order 22.50.[1179] This allowed for an Assembly Member (other than a member of the Government), to bring forward a proposed Order on a subject of their choice, and Jonathan had been engaging with a number of interested parties in relation to mental health legislation.[1180]

A key part of this consultation was a meeting between Jonathan Morgan and a member of Hafal, one of the precursor organisations now part of Adferiad Recovery, of which the author is the Chief Executive. Significant parts of this chapter are based on events where the author was engaged in the consultations and evidence sessions both at the Senedd and to the Welsh Affairs Select Committee in Westminster. In response to an initial question from Dr Hywel Francis MP, about what the Legislative Competence Order (LCO) would allow the Welsh Assembly Government to do that they could not do within existing powers, I noted this about getting quality treatment:

> What we actually see with this is that the LCO will provide a duty to provide, in effect, a right to assessment, treatment and advocacy rather than simply hoping that those sorts of things are going to happen….
>
> It should not be based on somebody being lucky to get the right professional, it should be based on having that right through the duty to provide that assessment, treatment and advocacy so that people do not end up in higher levels of care; do not end up losing employment, simply because there is no duty on the mental health services to do what policy has already set. The Assembly Government has excellent policy as far as the National Service Framework [NSF] and strategy, but there are no teeth to it. You cannot use the NSF to say, "You are not doing this". The NSF is that whole process of setting objectives, of having aspirations and saying, "This is what we would like to

[1178] Welsh Government (n918) 2.
[1179] Welsh Assembly Government, Mental Health (Wales) Measure 2010 Explanatory Memorandum (2010) 21 <https://senedd.wales/media/rnpp2r2k/ms-ld8002-em-e-english.pdf> accessed 3 September 2023.
[1180] ibid.

> see. This is what we intend to have", but this LCO is about having teeth to say, "You are not delivering it, you are now going to be in trouble for that".[1181]

In developing this thesis, this theme remains strongly in focus; I still believe that without appropriate consequences for failure to provide services, there is limited benefit to patients even when the law is well intended and seeks to safeguard Rights.

The MH(W)M 2010 came about through the powers granted to the National Assembly of Wales by the Government of Wales Act 2006 (GoWA 2006).[1182] The GoWA 2006 meant that the National Assembly could now pass primary legislation without needing to hold a referendum.[1183] This was however a complicated,[1184] time consuming,[1185] and overly bureaucratic[1186] process, where the UK Government failed to provide the breadth of competence set out in Schedule 7 of the GoWA 2006.[1187] The need to follow this complex route to enact Welsh primary legislation was later revoked following the National Assembly for Wales Referendum 2011, though any legislation must still be within the competence set out in Schedule 7 (as amended) of the GoWA 2006.[1188]

The MH(W)M 2010 started initially as noted above as an opposition member's proposal, but this proposal received early support from the then Health Minister

---

[1181] House of Commons, Welsh Affairs Committee (n1173).
[1182] Government of Wales Act 2006 Part 3.
[1183] David Moon, Tomos Evans, 'Welsh devolution and the problem of legislative competence' (2017) British Politics Vol 12 3 335, 341.
[1184] Silk Commission, 'Empowerment and Responsibility: Legislative Powers to Strengthen Wales' (2014) Cardiff: Commission on Devolution in Wales 14.
[1185] House of Commons, Welsh Affairs Committee, Fifth Report Review of the LCO Process (2010) part 4 para 74-76.
[1186] Sue Griffiths, Paul Evans, 'Constitution by Committee? Legislative Competence Orders under the Government of Wales Act (2007–2011)' (2013), Parliamentary Affairs 66(3): 480, 482.
[1187] National Assembly for Wales, Constitutional and Legislative Affairs Committee, 'Professor Thomas Glyn Watkin, Evidence to the Inquiry: A stronger voice for Wales: engaging with Westminster and the devolved institutions' (2017) IGP011, 2 <https://business.senedd.wales/documents/s63570/IGP011%20Professor%20Thomas%20Glyn%20Watkin.pdf> accessed 3 September 2023.
[1188] Bowers (n809) 6-7.

Edwina Hart AM, and officials at the Welsh Assembly Government.[1189] In the Explanatory Memorandum provided to the Welsh Affairs Committee and endorsed by the Welsh Government, six key needs were identified that the proposed LCO would address. These were:

1. The existing framework does not provide for a comprehensive duty vis-à-vis the provision of the assessment of mental health and the treatment of mental disorder outside of compulsion;
2. The need for an improved focus on early intervention and treatment through statutory duties as regards the provision of assessment and treatment which is the preferred option of many service users and their families;
3. The extant duties on local authorities to provide certain assessments do not translate into duties to provide services arising out of the assessments;
4. The duties for assessment by local authorities are applicable only in respect of those who are mentally disordered, and not those who appear to be exhibiting symptoms or manifestations of such disorder. This can result in individuals having to reach a certain level of ill health before becoming eligible for assessment;
5. There is a patchwork of duties in respect of specialist mental health assessment and treatment within secondary services. In Wales such services are increasingly provided on a multidisciplinary basis, which involves a range of professionals and services. Those working within such services are keen to ensure, in line with the Welsh Assembly Government's strategies and service frameworks for mental health, that multidisciplinary working in this way should be strengthening. This would allow for a more seamless approach to service provision for the individual recipient, and for those services to be focused on the needs of the individual in line with effective care planning;
6. The existing legislative framework does not provide for a wide ranging and comprehensive advocacy service—the role of the IMHA is limited to specific functions in respect of qualifying patients in limited circumstances. There is a need to ensure advocacy is available for people at a time when their mental health and usual support mechanisms may be breaking down, leaving them vulnerable when key decisions about treatments and support may need to be made.[1190]

The Welsh paradigm discussed in Chapter Nine seeks to address points one to four specifically by seeking to introduce financial penalties where failure to comply with

[1189] UK Parliament, 'Welsh Affairs Committee (n808) para 8.
[1190] UK Parliament, 'Welsh Affairs Committee (n808) para 23.

Part Three of the Measure can reasonably be attributed to an individual being detained under the MHA 1983.

The Key Opportunities within the Mental Health (Wales) Measure 2010

As noted in Chapter Seven, there are two main provisions within the MH(W)M 2010 for the purposes of this thesis which will be considered in the development of the Welsh paradigm. The first is Part Two of the Measure – a duty to provide a Care and Treatment Plan. As discussed, this is an extension of the rights in Scotland to assessment, but still falls short of Jonathan Morgan's third aim – a desire for a duty to provide services arising from an assessment. Within the MH(W)M 2010 Code of Practice, there are six Guiding Principles:

1. Relevant patients[1191] and their carers should be involved in the planning, development and delivery of care and treatment to the fullest extent possible;
2. Equality, dignity and diversity;
3. Clear communication in terms of language and culture is essential to ensure relevant patients and carers are truly involved and receive the best possible care and treatment. In Wales, this also means all possible steps should be taken to ensure that bilingual (Welsh and English) services are available;
4. Care and treatment should be comprehensive, holistic and person focussed;
5. Care and treatment planning should be proportionate to need and risk;
6. Care and treatment should be integrated and coordinated.

When we consider the earlier discussion on supported decision making, this approach fits well with an inclusive, informative, and person-centred model. Advanced decisions[1192] are part of this process, along with crisis planning,[1193] and the Measure requires the care coordinator[1194] to collaborate, engage, agree the outcomes that the treatment is designed to achieve, and should aim to use language which the patient

[1191] The phrase "relevant patient" is defined at s 12 of the MH(W)M 2010 as "an individual is a relevant patient if a mental health service provider is responsible for providing a secondary mental health service for the individual".
[1192] Welsh Government (n918) para 4.83.
[1193] ibid 35.
[1194] A role and function set out in The Mental Health (Care Coordination and Care and Treatment Planning) (Wales) Regulations 2011, WSI 2011/2942 (W.318), s 4 and Schedule 1.

would use themselves.[1195] A key passage in the Code of Practice relates to where patients do not agree with the plan, or where there is disengagement from the process. This still seeks to follow a supported decision-making route by seeking to make decisions that family and carers contribute to, rather than substituting professional perspectives.[1196] Capacity is also addressed and acknowledgement of the importance of being at the centre of the care planning process,[1197] as is the requirement to note whether the plan was agreed or not by the patient, and if not, why.[1198]

Despite these very positive intentions, the Code of Practice is too heavily loaded with "should", and too lightly uses "must",[1199] this means that it can be very challenging to argue a breach of duty where there is latitude in the language. While the intentions of Jonathan Morgan and the original legislators are reflected in some of the intention within the Measure and accompanying code, there remains the challenge identified earlier by Jonathan Morgan:

> It is very clear that the national service frameworks in themselves, although providing a strategic direction, do not have the legislative oomph in the way that placing duties through Assembly Measures on the back of this LCO could. I think that is quite fundamental.[1200]

This follows the theme noted earlier in my response to the Welsh Affairs Select Committee that the lack of consequences for failing to deliver were a particular concern,[1201] and I believe suggests that a change to provide reciprocity is necessary.

[1195] Welsh Government (n918) 22-24.
[1196] ibid para 4.11.
[1197] ibid para 4.13.
[1198] ibid para 4.16.
[1199] A review of the Code records 'should' used 229 times, 'must' used 42 times. Even taking into account syntax in dialogue, this remains very advisory and minimally prescriptive.
[1200] House of Commons, Welsh Affairs Committee (n1173) para 35.
[1201] House of Commons, Welsh Affairs Committee (n1173).

Does Part Two of the Measure Offer a Potential Route to Reciprocity?

Part Two of the Measure sets out the responsibilities connected with the patient assessment, development of a Care and Treatment Plan, and the subsequent coordination of the provision of services. Unfortunately, this is where the Measure missed the opportunity to develop a Welsh approach of reciprocity despite the intentions of its creators. Chapter Five of the Code of Practice is titled "Coordination of the Provision of Services" and identifies the "Duty to provide services",[1202] but then generally misses the point about duties as it states the service provision requirement is only a duty, "where practicable".[1203]

As discussed earlier in Chapter Seven, NHS rationing and resource allocation has been the subject of a number of human rights challenges but, with some rare exceptions,[1204] courts generally remain of the view expressed by Sir Thomas Bingham MR in *R v Cambridge Health Authority ex parte B,* that:

> Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make. In my judgment, it is not something that a health authority such as this authority can be fairly criticised for not advancing before the court.[1205]

So, for the purposes of this thesis, it appears that Part Two of the Measure lacks the clear and unambiguous duties which may offer an opportunity to argue sufficiently for a breach of duty in relation to patients then subject to detention due to a failure to provide service.

[1202] Welsh Government (n918) 38-41.
[1203] ibid para. 5.4.
[1204] Amy Ford, 'The Concept of Exceptionality: A Legal Farce' (2012) Medical Law Review 2012 Sep; (20(3): 304, 336.
[1205] *Regina v Cambridge Health Authority ex parte B* [1995] 1 WLR 898 [906].

Part Three of the Measure: developing an existing duty

Part Three of the Measure seems perhaps a fairly innocuous route for a fundamental change mechanism; it is a right for reassessment for patients discharged from services under Part Two,[1206] and thus impacts on a very specific group of people. In 2014, the Welsh Government published the "Duty to Review Interim Report",[1207] and my organisation, Hafal (as was at that time), played a significant role in seeking feedback for the review team. This report identified that in a nine-month period in 2013, there were 8,570 patients discharged from or transferred out of secondary mental health services across Wales. These patients would be eligible for reassessment under Part Three, and in the same period, there were 909 people who sought reassessment (around 100 per month), 630 of which were undertaken, and 394 people accepted back into services.[1208]

This means that the potential patient group where an enhanced right might be feasible would be around 100 a month across Wales; arguably a very small group, and unlikely to impact substantially on health funding. Therefore, this would provide an opportunity for the Welsh Government to demonstrate a reciprocal and enforced duty, which would not have significant financial burdens even if penalties were imposed. Taking aside the improvement for patients, by avoiding compulsory admission, the cost savings could be motivational. In so far as changing practice, the embarrassment factor and the scrutiny for those who failed to provide appropriate monitoring and service provision would be transformative.

[1206] Mental Health (Wales) Measure 2010, Parts 2 and 3.
[1207] Welsh Government (n817) 18.
[1208] ibid 19.

Conclusion

In this chapter, the genesis of the MH(W)M 2010 and the intention of those who legislated for the changes has been explored to consider how this legislation may be utilised to address the current unfairness in mental health services in Wales. The intention and commitment to shared decision making within the MH(W)M 2010, and the approach of successive Welsh Governments to seek a Rights-based approach in Welsh legislation, suggests an opportunity for further development. Wales has already developed mental health legislation that other parts of the UK are seeking to emulate, especially in the Mental Health Bill 2024.

Two key opportunities for introducing a duty with redress within the MH(W)M 2010 were considered, and, while Part Two appears to have more of a direct link to the delivery of individual care packages, it may not offer as much as Part Three. An important factor in the development of any such duty is that it is workable, not punitive, and of benefit to both patients and service providers. As noted, the small numbers for such an initial duty, and the high cost of inpatient care offer incentives both from a Rights-based focus, and on a financial and resource basis.

In Chapter Nine, the existing duty under the MH(W)M 2010 will be discussed, current statistics reviewed to consider performance to the standards within services, and the potential for improved rights for patients identified. A mechanism for redress and the consequential reciprocity available should a change be made under Part Three will be further developed and a draft amendment regulation offered as a point for discussion.

Chapter Nine - The Welsh Paradigm

As outlined in Chapter Six, the focus of this thesis has evolved over many years, morphing from an original concept of the development of a Rights approach to individuals seeking first time help with their mental health into a more pragmatic stalking horse for the introduction of reciprocity in Welsh mental health law. Through my work with mental health campaigning organisations, I have been closely engaged in both Westminster Government and Welsh Government consultations. These included the draft Mental Health Bill 2002,[1209] Mental Health Act 2007, Mental Health (Wales) Measure 2010, and a range of other health and social care policy and legislative developments. In considering each of these, the principle of a least restrictive approach[1210] has been given much lip service, but the Westminster legislation is still predominantly a law which sets out the legal framework for detention for a health condition.

The Welsh Code of Practice for the Mental Health Act 1983 set out an expectation of a least restrictive approach,[1211] not limited to the use of detention. As noted in Chapters Four and Five, the Richardson Review of the MHA 1983 went a step further. It sought a shift in the way that detained mental health patients are treated, by suggesting a reciprocal duty be imposed on the NHS to provide the services required to treat the condition at a level of quality.[1212] The Review stated:

> …it is hard to justify the introduction of a legal right to a specific level of mental health care where no equivalent right exists in relation to physical health care. However, notwithstanding the desire for informality, the provision of mental health care, unlike virtually all other forms of health care, may have to be delivered by the use of compulsory powers. In these circumstances we

[1209] Parliamentary Office of Science and Technology (n684).
[1210] Welsh Government (n665) 8 Guiding Principles para 1.1.
[1211] ibid.
[1212] Department of Health (n50) 1.12, 14.

> are persuaded that the principle of reciprocity imposes special obligations: when society compels an individual to accept mental health care services those services must be available and of an appropriate quality. We have therefore felt justified in recommending special rights for those who are made subject to compulsion, but at the same time, we have been anxious not to allow that principle to be used to filter resources away from those in need who are not under compulsion.[1213]

For me however this leaves the following questions unanswered. What about patients who seek help? What duty is there to provide them with the services required at an appropriate level of quality?

This falls generally under the National Health Service Acts of 2006,[1214] which in the National Health Service (Wales) Act 2006 states:

> **1. Welsh Ministers' duty to promote health service**
>
> (1) The Welsh Ministers must continue the promotion in Wales of a comprehensive health service designed to secure improvement—
>
> (a) in the physical and mental health of the people of Wales, and
>
> (b) in the prevention, diagnosis and treatment of illness.
>
> (2) The Welsh Ministers must for that purpose provide or secure the provision of services in accordance with this Act.
>
> (3) The services so provided must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed.[1215]

Whilst mental health is specifically referenced, it is the particular challenges that people with mental illness face from the legislation that sets them apart. The Right to life applies to all patients.[1216] What about the Right to respect for a private and family life[1217] and the Right to liberty and security applying to all patients?[1218] As explored in Chapters Four and Five, patients with a mental illness are subject to special

[1213] ibid.
[1214] National Health Service Act 2006; National Health Service (Wales) Act 2006.
[1215] National Health Service (Wales) Act 2006 s 1.
[1216] Human Rights Act 2005 Article 2.
[1217] ibid Article 8.
[1218] ibid Article 5.

arrangements through the MHA 1983 which mean that they can be detained and treated against their will despite having capacity. Such detention impacts massively upon the individual's ability to exercise these Rights and others, and as such, I believe this places those patients in a different category to patients where such detention is not a potential consequence of lack of treatment or poor-quality services. This chapter sets out an initial route to provide both a focus for service improvement, and reassurance to patients that their health needs will be considered appropriately, by seeking to impose a duty on the NHS in Wales, whose failure would then be subject to the Putting Things Right process.[1219]

Part Three of the Mental Health (Wales) Measure 2010 – Why does this provide an opportunity to develop reciprocity?

In seeking an opportunity to either develop a duty, or to identify an existing one which offers a route to a simple redress process for patients, it is worth noting the challenges faced by mental health patients in accessing the legal system while being detained and treated for their condition. Whilst there are appeal routes against detention, as highlighted in the example of P in Chapter Six, via the Mental Health Tribunal and Hospital Managers' Hearings, these are limited, and do not address the damage caused by the detention. Challenging the *fact* of the detention is not a subject I discuss in detail in this thesis as, so long as the processes prescribed in the MHA 1983 are followed, detention is likely to be legal.[1220] My concern is about the duty of the NHS

[1219] Putting Things Right is the process for the NHS in Wales to resolve concerns and complaints as governed by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, WSI 2011/704 (W.108).
[1220] *In re S.-C. (MENTAL PATIENT: HABEAS CORPUS)* [1996] QB 599 P603 B-H.

in particular to act in a manner which avoids the need for detention, or at the least minimises the risk of detention.

In respect of any claim for failure to provide appropriate treatment which then led to detention, this would normally need to be taken up within three years of the alleged negligence,[1221] or one year if it were to be a claim under the Human Rights Act 1998 (hereafter HRA 1998). As noted in Chapter Seven, the major difficulty in making a claim against the NHS for failure to prevent detention, is that the case law supports the argument that the NHS cannot be compelled to provide any particular service,[1222] and the patient would need to evidence causation in a negligence claim. This means that a patient would have to evidence how the failure to provide a particular intervention led directly to their detention, and it is likely that even if they were able to do so, the courts would not support placing a duty on the NHS to provide specific services other than in exceptional circumstances.[1223]

There have been a number of high-profile cases brought under Article 2 of the ECHR as incorporated by the HRA 1998 for failures in care which have resulted in the loss of life,[1224] though these have not often been successful. Many claims under Article 5 of the HRA 1998 have been in relation to deprivation of liberty and the Mental Capacity Act 2005 (MCA 2005) and generally consider matters where an individual

[1221] Limitation Act 1980 s 11.
[1222] Department of Health, Reference Guide to Consent for Examination or Treatment (2009) 8 para 11 <https://assets.publishing.service.gov.uk/media/5a7abdcee5274a34770e6cdb/dh_103653__1_.pdf> accessed 7 May 2024.
[1223] Keith Syrett, 'Healthcare resource allocation in the English courts: a systems theory perspective' (2019) Northern Ireland Legal Quarterly 70(1) spring 2019, 115.
[1224] *DD v Dudley and Walsall NHS Trust* [2014] MHLO 145 (PI); *Francis v UK* 3346/02 [2003] ECHR 707; *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2.

lacks capacity and their situation is a *de facto* detention. Even where detention under the MHA 1983 has been seen to interfere with Article 5 Rights, an acknowledgement of that breach can be sufficient to avoid paying compensation,[1225] and cases such as this can take many years to be resolved. A reported challenge to an unlawful detention by a *private hospital* group did however result in a Part 36[1226] payment of £11,500 as compensation for unlawful detention for 17 days[1227] due to failure to follow the requisite requirements.

Similarly, when a failure to appoint a psychiatric supervisor delayed discharge of a patient whose detention was no longer justified, the UK Government settled the case for £5,500 plus costs, despite this relating to a six-month extended detention.[1228] As highlighted in Chapters Five, Six, and Seven, detention, even when justified and potentially lifesaving, impacts on much more than the Article 5 Rights of an individual,[1229] and has lasting effects including reducing the engagement with family and friends. The routes through the judicial process though are complex, time consuming, and unlikely to offer justice for individuals already marginalised by stigma, and often disempowered through financial and other cognitive challenges

[1225] *IH v the United Kingdom* - 17111/04 [2005] ECHR 934 para 2.
[1226] The Civil Procedure Rules 1998 SI 1998/3132, Part 36.
[1227] *PB v Priory Group Ltd* [2018] MHLO 74.
[1228] *PHILLIPS v the United Kingdom* - 64509/01 [2000] ECHR 702.
[1229] Multiple searches of Lexis Library and Westlaw using a combination of the terms: 'HRA, Article 5, Detention, MHA, Mental Health, Prevention, Negligence', have not identified any case law relating to actions for unnecessary detention as a result of failure to provide mental health services. Cases such as *Clunis v. UK* [1998] ECHR 45049/98 and *Traylor v Kent and Medway NHS Social Care Partnership Trust* [2022] QBD 4 WLR 35 have been brought to seek damages for loss as a result of argued negligence by the NHS which led to homicide or very serious harm to self and / or others including Article 2 breaches. While both claims identified here were rejected, the *Clunis* case followed the established principle of *ex turpi causa non oritur action,* as Clunis had been found guilty by diminished responsibility. However, in Traylor, as he had been found not guilty by reason of insanity, if causation had been made out, Johnson, J. noted that this argument could not apply as it required a finding of guilt (at 107-108).

relating to their illness. This is where existing Welsh law, I believe, can be modified either by policy, or regulation to offer redress.

Part Three of the MH(W)M 2010 is titled, 'Assessments of Former Users of Secondary Mental Health Services'. The intention behind Part Three of the MH(W)M 2010 was set out by the then Minister for Health and Social Services, Lesley Griffiths, as:

> Part 3 of the Measure introduces a safeguard for people who have formerly used specialist services and have been discharged. It achieves this by placing a duty on Local Health Boards and local authorities to assess whether former users of specialist care services once again need such services. It therefore removes the requirement for referral via the G.P. and allows people to refer themselves to specialist care if they believe that their mental health is deteriorating. This safeguard will remove delays in accessing specialist care and ensure a more timely response to relapse.[1230]

This part of the MH(W)M 2010 relates specifically to patients already known to, and having received treatment from, specialist mental health services (secondary mental health services).[1231] As such their condition, situation, assessment and co-produced holistic care plan have already been identified and actioned[1232] under Part Two of the MH(W)M 2010. This means that the numbers of patients subject to this part of the legislation are quantified (as those discharged from secondary mental health services over a rolling three-year period), and this offers a focussed group of people for whom a new reciprocal right can be tested.

At the end of December 2023, the total numbers of patients receiving services under Part Two of the MH(W)M 2010 was 19,246,[1233] but based on local health board

[1230] Welsh Government (n918) 2.
[1231] Mental Health (Wales) Measure 2010 Part 3.
[1232] ibid Part 2.
[1233] Welsh Government, Statistics. Mental Health (Wales) Measure 2010: October to December 2023, Part 2: Care and Treatment Plans (2024) <www.gov.wales/mental-health-wales-measure-2010-october-december-2023> accessed 7 May 2024.

figures, less than 15 people per month discharged from such services sought a reassessment.[1234] The Welsh Government monitors how many people eligible for reassessment under Part Three receive an assessment within a maximum of 28 days though this data is not considered robust.[1235] In data from 2023,[1236] there were approximately 67 who received the reassessment within the set timescale and 29 who did not.[1237] Initially I intended to identify how many of these individuals were detained under any section of the MHA 1983 before their reassessment was completed. In discussions with HIRU,[1238] it became clear that the search parameters required to track this request were not something that was routinely identified or recorded in medical notes. In light of the very small number of individuals who did not receive their reassessment within the timescale, seeking to quantify those individuals offered little in making an argument for a wider approach, particularly when the failure rate of compliance with Part Three was available. If the Welsh paradigm is adapted, robust data collection would be a requirement of the local mental health partners and as such, trends could be observed and the effectiveness of this approach evaluated.

How do Parts Two and Three of the Mental Health (Wales) Measure 2010 Operate?

As discussed earlier, Part Three of the MH(W)M 2010 is only applicable to individuals who have been subject to Part Two of the MH(W)M. In summary, Part Two in this context refers to those individuals who have been under the care of secondary mental health services, and who will have been supported and treated by specialist services

[1234] Appendix III.
[1235] Appendix III notes.
[1236] Appendix III.
[1237] Figures obtained by multiplying the average monthly figures across 6 health boards by the 9 months the figures related to and rounding to whole numbers.
[1238] HIRU – Health Informatics Research Unit at Swansea University.

for a significant mental illness. That in itself identifies those individuals (referred to as *Relevant Patients)*[1239] who have required:

> (a) a service in the form of treatment for an individual's mental disorder which is provided under Part 1 of the National Health Service (Wales) Act 2006;
>
> (b) a service provided under section 117 of the Mental Health Act 1983;
>
> (c) a community care service the main purpose of which is to meet a need related to an adult's mental health;[1240]

and, this service is not one provided by a General Medical Services contract,[1241] i.e., not one provided by a GP.[1242] This, in itself, I suggest identifies a specific group of individuals who have, or have had, significant mental health needs, and specialist services are aware of these, and of how the individual responds to treatment. This means that this is not a general population issue. It is not an issue where this is arguable that the GP should be the first port of call, indeed, if it were, why does Part Three exist?

Part Two also requires a Care and Treatment Plan (CTP) to be produced for all relevant patients,[1243] and this must involve the patient and carers,[1244] and should consider eight specific areas within the patient's life.[1245] Such CTPs must also include a section to record what might be indications of a relapse, and how to address a crisis,[1246] and the statutory code to the MH(W)M 2010 notes that these plans should identify factors that are important in maintaining independence, and agreeing contingencies.[1247] The CTP should also be monitored for any change of circumstances, as it is noted[1248] that such

[1239] Welsh Government (n918) 10, para 2.2.
[1240] ibid para 2.3.
[1241] Mental Health (Wales) Measure 2010 s 49(2).
[1242] National Health Service (Wales) Act 2006 s 42.
[1243] Welsh Government (n918) 22 para 4.1.
[1244] ibid 25 para 4.18.
[1245] ibid chapter 4.
[1246] ibid 35 para 4.81-4.82.
[1247] ibid 35 para 4.85.
[1248] ibid 42 para 6.5.

monitoring may identify relapse indicators and allow for intervention. This CTP formed a key part of the intention of the MH(W)M 2010 in so far as the development of the legislation was based upon the experiences of patients.

As noted earlier in Chapters Five, Seven, and Eight, Jonathan Morgan AM, who brought forward the Legislative Competence Order which led to the MH(W)M 2010,[1249] was so influenced by the experiences of Lee McCabe[1250] that he used his ballot to seek to introduce mental health legislation. The experience for Lee in having a quality plan for his care, changed the course of his life, and this was what Jonathan stated was the "most compelling evidence for why reform is so long overdue".[1251] It is therefore highly significant that the recommendation for ensuring the use of a care and treatment plan in the Wessley review of the MHA 1983 was accepted by the UK Government in their response to the review.[1252] For me, whilst this demonstrates that Welsh policy was clearly some way ahead of that in England in 2010 when the MH(W)M 2010 was first enacted, it also says that in order to retain that citizenship and patient coproduction approach in Wales, we now need to take a step further. That step is set out below in Developing the Welsh Paradigm.

[1249] Senedd Wales (n788).
[1250] Lee McCabe at this time was a client within a Hafal service and had been very seriously ill. He met with Jonathan Morgan AM who used Lee's experience as a driver for the MH(W)M 2010. Lee gave evidence to the Welsh Affairs Committee setting out his attempts at suicide and how he was helped by having a quality care plan based on his wishes for his recovery. UK Parliament, Welsh Affairs Committee (n808) Q 26.
[1251] MentalHealthWales, '"Finishing line in sight" for Jonathan Morgan's mental health LCO' (2009) <https://mentalhealthwales.net/2009/12/finishing-line-in-sight-for-jonathan-morgans-mental-health-lco/> accessed 7 April 2024.
[1252] Department of Health and Social Care, Consultation outcome. Reforming the Mental Health Act, Executive Summary (2021) <www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#executive-summary> accessed 7 April 2024.

Developing the Welsh Paradigm

While this proposed regulatory or policy change relates to a very small number of individuals, it does offer the potential for the first directly consequential redress for failing to provide a mental health intervention before an individual needs to be detained to receive that mental health intervention. Reference earlier to a stalking horse is in relation to developing a simple, low impact, generally manageable duty on the NHS to provide a particular response to a specific request, and that such a development may be considered the starting point towards greater enhancement of rights.

When an individual is discharged from Part Two of the MH(W)M 2010, this means that the relevant patient is no longer deemed to require those specialist services from secondary mental health services.[1253] This does not mean that an individual is "cured" or that they have no need for less specialist mental health support services. A discharged patient must be provided with written information in relation to the reason for their discharge, a plan should be made in relation to the ongoing support necessary,[1254] and the patient formally advised of their rights under Part Three of the MH(W)M 2010.[1255]

Secondary mental health services are specifically defined at s.49 of the MH(W)M 2010,[1256] but a more practical explanation of the functions in practice is provided in Welsh Government Policy Implementation Guidance:

[1253] Welsh Government (n918) 46 para 7.2.
[1254] ibid 47 para 7.9.
[1255] Mental Health (Wales) Measure 2010 s 24.
[1256] ibid s 49.

> A secondary mental health service is one which is delivered by specialist mental health practitioners in community and hospital settings to patients who, following specialist assessment for these services, have been formally accepted as requiring ongoing specialist care and treatment.
>
> Typically, secondary mental health services provide care and treatment for individuals suffering with more severe and/or enduring mental disorders where the level of need, risk and complexity requires the provision of specialist care. The services provided at secondary level will include services for individuals subject to the provisions of the Mental Health Act 1983, inpatient hospital care, community mental health teams for adults and older adults, and specialist child and adolescent mental health services at Tiers 3 & 4. The Welsh Government suggests that other specialist community functions such as crisis resolution and home treatment, assertive outreach, early intervention in psychosis, community eating disorder and specialist perinatal support services may also most appropriately be delivered as secondary mental health services, due to the levels of need experienced by the patients to whom they provide care and support. [1257]

Those rights are consequential to the duties placed upon the Local Health Board[1258] (or the local mental health partners within a local authority) for a three-year period from the date of discharge to carry out an assessment on discharged relevant patients, if so requested.[1259] These are separate duties from those stipulated under s.117 of the MHA 1983, which are likely to have ceased on discharge from secondary mental health services, otherwise discharge would not be appropriate.

In considering how Part Three of the MH(W)M 2010 might be developed to improve the rights of people with a mental illness, it is worth identifying the key issue at hand. Part Three is a route designed to reduce bureaucracy and delay for those known to have had, or to have, a mental illness previously deemed serious enough to require specialist treatment and support. This is not something that is a judgment, this is *fact*

[1257] Welsh Government, Welsh Government Policy Implementation Guidance on Local Primary Mental Health Support Services and Secondary Mental Health Services for the purposes of the Mental Health (Wales) Measure 2010 and related subordinate legislation (2019) 8-9 <www.gov.wales/sites/default/files/publications/2019-06/welsh-government-policy-implementation-guidance-on-local-primary-mental-health-support-services-and-secondary-mental-health-services.pdf> accessed 2 May 2024.
[1258] Mental Health (Wales) Measure 2010 s 19-21.
[1259] Welsh Government (n918) 48 para 7.14.

otherwise they would not be eligible for a Part Three discharge plan. On that basis, these individuals are those where there is a known likelihood of them needing reassessment should their condition deteriorate, and it is also known that, where there is a deterioration, it is likely to be serious otherwise they would not previously have needed specialist services. This is therefore a very specific group of people who the NHS and local government know as patients, have a plan for their ongoing care for at least three years, and for whom they have a duty under Welsh legislation.[1260] The Part Three Right for reassessment also applies to referral by the patient's GP for the reassessment to be undertaken: it does not rely upon the patient to approach mental health services directly.

That duty is to provide patients, on request and, "as soon as is reasonably practicable",[1261] with an "assessment report"[1262] within 10 working days of the assessment being completed.[1263] This report is:

> …a single report in writing which records whether a mental health assessment has identified any services which might improve or prevent a deterioration in the mental health of an adult in accordance with section 25 (purpose of assessment) of the Measure;

based upon a "mental health assessment", defined as "an analysis of an adult's mental health for the purposes provided in section 25 of the Measure" .[1264]

[1260] Mental Health (Wales) Measure 2010 Part 3; The Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) Regulations 2011, WSI 2011/2500 (W.272).
[1261] Mental Health (Wales) Measure 2010 s 26 (1); It is worth noting that in both the Welsh Government, Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010 (2012) WG14643 50, and a Welsh Government report on the Mental Health (Wales) Measure 2010 from Delivery and Performance Division, "as soon as is reasonably practicable", has been reworded as "timely". Welsh Government Data, Freedom of Information Request 15305, 6 <www.gov.wales/sites/default/files/publications/2021-08/atisn15305doc6.pdf> accessed 30 April 2024.
[1262] The Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) Regulations 2011, WSI 2011/2500 (W.272), s 2.
[1263] ibid s 4(1).
[1264] ibid s 2.

In itself, this appears clear, though there is no regulation setting out what is a "reasonably practicable" or "timely manner" for completing the assessments. In the Code of Practice, there is a suggestion that:

> Local mental health partners may include standards for response times for assessment within their written arrangements. Where such response times are included it is expected that these should, at a minimum, match the usual standards for community mental health teams – namely that emergency referrals are to be seen within 4 hours of request, urgent referrals within 48 hours of request, and all other referrals within 28 days of request.[1265]

It is arguable therefore that even without a stipulated timescale, requests for assessment under Part Three should be initially considered to determine priority, and if as an emergency seen within 4 hours, but in any case, all carried out within 28 days.

The Welsh Government does gather data on waiting times for assessment under the three categories of emergency, urgent, and routine, but suggests that as they cannot guarantee the quality of data gathering, they do not publish this information.[1266] This information was requested directly from the NHS Wales performance team on 30th April 2024,[1267] and received within 24 hours, and is included at Appendix IV. It is clear from the analysis of the data (Appendix III), that this is not a matter given much attention in a number of health boards, as the data is not being routinely collected in the same way by all health boards. Additionally, the data for Swansea Bay and Cwm Tâf Health Boards suggests that despite a very significant population in each of these areas, they receive fewer requests between them under Part Three than Powys. This does mean that the data is highly unreliable, but it is not the details of the referrals that offers us an insight here, but the very fact that this data is not considered important enough to ensure it is reliable. The management of Part Three assessments is a

[1265] Welsh Government (n918) 50.
[1266] Welsh Government Data (n1263) 9.
[1267] Appendix III.

statutory requirement, and it is remarkable that there appears to be no robust oversight in place. It adds to the argument that there should be consequences for failure to adhere to the duty, and also suggests that there needs to be a real penalty for those health boards who do not comply.

It is interesting to note though that Hywel Dda University Health Board has reported some details of their performance in their Mental Health Scrutiny Group report which is available online. They note that in April to June 2022, 100% of individuals received their reassessment in a "timely manner", and received their written report withing the 10 working days.[1268] The same report however does note that the average wait times in days was 39 days for April 2022, 46 days for May 2022, and 35 days for June 2022 – all of which are significantly higher than the average one might expect if the maximum expected time is 28 days. They also reported that in a four-month period, only 24 individuals self-referred, but did not provide the data for GP referrals. Just over a year later, the report identified 26 individuals self-referring over a three-month period, with average wait times of 20, 29, and 33 days for the three months of October, November, and December 2023.[1269]

In considering the data analysis at Appendix III[1270] it appears that there is a compliance rate of around 40% for reports to be provided within the required 10-day timescale,

[1268] Hywel Dda University Health Board, Mental Health Scrutiny Group Report (2022) 5-6 <https://hduhb.nhs.wales/about-us/governance-arrangements/board-committees/mental-health-legislation-committee-mhlc/mhlc-3-october-2022/item-7-the-mental-health-wales-measure-2010-report/> accessed 30 April 2024.
[1269] Hywel Dda University Health Board, Mental Health Legislation Committee Report (2024) 4 <https://hduhb.nhs.wales/about-us/governance-arrangements/board-committees/mental-health-legislation-committee-mhlc/mhlc-26-march-2024/item-6-scrutiny-group-update-and-mental-health-wales-measure/> accessed 30 April 2024.
[1270] The table at Appendix III is developed from the raw data provided by the NHS at Appendix IV.

and a likelihood that there are an average of 3 people per month not receiving that assessment within 28 days.[1271] It is likely therefore from the information available, that mental health assessments are not being carried out within the same timescales as would be expected of referrals directly to community mental health teams,[1272] and individuals are waiting longer than is reasonably practicable or timely. Of all of those who have received their assessment, there is a disappointing rate of 40% of those who would receive their statutory outcome report within the timescale. This thesis is seeking to offer a route to set the timescales, and to identify a mechanism where financial redress can be made if a known harm could be avoided, but it occurs due to failing to meet deadlines.

The Welsh Government clearly had it in their contemplation in developing the Code of Practice, that waiting times for reassessment should be no longer than that waiting time for people referred without the benefit of Part Three of the MH(W)M 2010.[1273] They set out clearly in the regulations the nature of the assessment,[1274] and the Minister also highlighted that this was a specific safeguard for a particular group of patients.[1275] To that end, should it not be clearer on what the Part Three Right means to an individual, and what are the consequences for failure to deliver? The Part Three Right and the performance targets are already within Welsh Government legislation,[1276]

[1271] Appendix III - Average number of those assessed following a referral for a routine assessment waiting over 28 calendar days from receipt of referral to assessment.
[1272] Welsh Government (n918) 50.
[1273] ibid 50.
[1274] The Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) Regulations 2011, WSI 2011/2500 (W.272), s 2.
[1275] Welsh Government (n918) 2.
[1276] Mental Health (Wales) Measure 2010.

regulation,[1277] and policy,[1278] and yet the statistical monitoring is deemed to be of low quality, but where this is available, the NHS is failing to meet the requirements.

The next question relates to the harms caused and is there a way of identifying a harm which is directly consequential, or using a civil burden of proof, demonstrable on the balance of probabilities? As can be seen from the figures in Appendix III, the numbers of people seeking reassessment remains low: approximately 130 recorded per year.[1279] These individuals are seeking support with a known mental health condition, and as they have been under secondary mental health services, there is an obvious potential for them to become subject[1280] to the MHA 1983.

For me this suggests that the measure of harm here, at least initially, would be the harm of detention under the MHA 1983 to receive an assessment of an individual's mental health. The argument for redress I suggest would flow from a duty of care to complete a Part Three assessment within the same timescales as those set out for community mental health team referrals,[1281] and to provide a report in a specified format within 10 working days. If this assessment was requested under Part Three and the local mental health partner fails to meet the set timescales, there is an arguable breach of this duty. Considering the three-step test in *Caparo*,[1282] the duty is one placed upon the health boards by the MH(W)M 2010 and associated Regulations, and the duty owed

[1277] The Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) Regulations 2011, WSI 2011/2500 (W.272).
[1278] Welsh Government (n918).
[1279] Appendix III monthly average multiplied by 12.
[1280] Sian Oram and others, 'Patterns of use of the Mental Health Act 1983, from 2007-2008 to 2016-2017 in two major London secondary mental healthcare providers' (2019) British Journal of Psychiatry 2019 Nov; 5(6): 3102, 2. It is noted that this data was specific to two London boroughs.
[1281] Welsh Government (n918) 50.
[1282] *Caparo Industries Plc v Dickman* [1990] UKHL 2 (08 February 1990).

is to the patient who requests an assessment under Part Three. As noted earlier, as these are patients who have already been under the care of secondary mental health services, proximity is even more obvious, as are the potential consequences understood by patient and health board should there be a failure of duty.

The most ludicrous part of this issue is that if a patient's condition deteriorates to the point where their condition leads them to pose a risk to their safety or the safety of others, the response is to carry out an assessment of their condition under s.2 MHA 1983.[1283] This is a more complex assessment, as it is not simply an assessment of need and how the condition may be mitigated or treated, but includes legal protections and requirements as it is an assessment carried out while the patient is detained. Even the initial decision to detain to carry out the assessment is more time consuming and litigious than completing a Part Three assessment as this potentially takes place in a public place[1284] or with a magistrate's order in the patient's own home,[1285] both requiring police intervention.

An assessment under Part Three as identified earlier[1286] is designed specifically to avoid such situations, and this Ministerial statement[1287] I believe offers a purposive view of the intention of the Welsh Government in developing the MH(W)M 2010 and suggests that health boards must improve performance on Part Three. I believe the way to incentivise the NHS in Wales to respect the rights of those with serious mental

[1283] Mental Health Act 1983 s 2.
[1284] ibid s 136.
[1285] ibid s 135.
[1286] Welsh Government (n918) 2.
[1287] ibid.

illnesses, is to create a financial disincentive for them to fail in their Part Three duties and thus create the first reciprocal approach in the use of the MHA 1983.

There are significant psychological challenges[1288] for people who are experiencing serious mental illness to seek legal redress for any delays in care, treatment decisions, or failures in care as there are practical ones. The very nature of a serious mental illness often leads to an inability to pursue litigation where thought processes are impacted. Medication often has a wide range of debilitating side effects, and, more pragmatically, the lack of knowledge of how to challenge a system which should provide you with care and support but detains you when it fails, offers little comfort in the State for fairness or equity. While advocacy is provided under the MHA 1983,[1289] the role of the Independent Mental Health Advocate is explained as:

> Independent advocacy is regarded as an important safeguard for those individuals who are receiving care and treatment for mental health problems. At one level, independent advocates provide the kind of support that individuals might ordinarily receive from partners, friends or family members, with whom dilemmas might be discussed and whom individuals might ask to accompany them to difficult meetings or consultations.[1290]

This in itself does not suggest a role which supports individuals to identify system failures which have resulted in their detention, but more ensures that the detention and treatment thereafter is compliant with legislation.

So, an individual who is eligible for an assessment under Part Three but does not receive it in a timely manner, may subsequently be detained under the MHA 1983 to

[1288] Larry H Strasburger, 'The litigant-patient: mental health consequences of civil litigation' (1999) J Am Acad Psychiatry Law 1999;27(2):203, 203.
[1289] Mental Health Act 1983 s 130.
[1290] Welsh Government, Delivering the Independent Mental Health Advocacy Service in Wales: Guidance for Independent Mental Health Advocacy Providers and Local Health Board Advocacy Service Planners (2011) WG14369 para 86.

receive an assessment of their mental health and any necessary treatment and support required. They do not receive advice or guidance on how to seek redress for this failure which has resulted in their detention, nor do they receive any automatic compensation for their loss of Liberty.

This loss of Liberty may or may not have been necessary dependent on the progression of their mental illness, but in the absence of a Part Three assessment, it is moot that such detention for assessment would have been unnecessary should timescales had been met. For an individual whose condition is deteriorating and is awaiting a Part Three assessment, they would need to wait 28 days before it could be argued that the local health board had breached their duty. At this point, the patient's condition is unlikely to have been improved without intervention, and this would have a significant impact on their ability to make a complaint or to engage with a community advocate. As such, time would be progressing, and the potential for further deterioration increasing. This statement is based solely on the presumption that if an individual needs mental health services and does not receive them, then they are unlikely to be able to progress treatment and support themselves. That said, there is some evidence that mental health services are sometimes not intensive enough to make a major difference,[1291] but this thesis is arguing for earlier, and more targeted support for patients already known to the service. At this point, entering the complaints procedure of the local health board via the Putting Things Right[1292] process means that they may expect a response within 30 working days (actually 40 days including weekends). To

[1291] M Ten Have, J Nuyen, A Beekman, R de Graaf, 'Common mental disorder severity and its association with treatment contact and treatment intensity for mental health problems' (2013) Psychol Med 2013 Oct;43(10):2203-13. doi: 10.1017/S0033291713000135. Epub 2013 Feb 7 2210-2211.
[1292] Welsh Government, NHS Wales Complaints and Concerns: Putting Things Right (2023) <www.gov.wales/nhs-wales-complaints-and-concerns-putting-things-right> accessed 3 May 2024.

date the patient has been waiting 68 days, and recourse from this point is via the Public Services Ombudsman for Wales who take 25 days to assess the case, then up to 12 months to complete their investigation.[1293]

As can be seen from the data in Appendix III, less than 50% of patients received these assessments within the month, and there is little reliable data to offer comfort that extended waiting times are not common. By this time, having gone through the appropriate complaints route, it is likely that options to force the local health board to complete the assessment via judicial review would be extinguished as the assessment is likely to have been completed by then. In any event, judicial review proceedings would be costly and complex for someone fit and well, and this individual is dealing with the symptoms of a serious mental illness. This situation is though too broad for what I believe is a mechanism which offers a route to reciprocity in Wales. Whilst not diminishing the incredibly difficult situations faced by patients where their Part Three assessment has not been completed and they remain in the community, my focus is Liberty.

Considering now the situation of an individual, seriously mentally ill and detained in hospital, following a failure to provide them with a Part Three assessment. They may be in a position once their condition stabilises to complain to the local health board or to seek compensation for personal injury, but they would need to do so within three years.[1294] The potential for action for the tort of trespass on the person has a six-year

[1293] Ombudsman Wales, 'What We Do When We Get Your Complaint About a Public Service Provider in Wales' <www.ombudsman.wales/fact-sheets/complaints-against-public-bodies-our-procedure/> accessed 3 May 2024.
[1294] Limitation Act 1980 s 11(4).

limitation,[1295] but as the individual would by this time have met the criteria for detention under the MHA 1983, the "trespass" would have been legally justified.[1296] Additionally, legal aid is generally unavailable unless in exceptional circumstances to take action for negligence against an NHS body.[1297] Should they wish to consider action in respect of their treatment under the Human Rights Act 1998, they generally would have one year to make such a claim,[1298] or three months should they wish to seek judicial review of their treatment.[1299] As Williams notes,

> Judicial review is a cumbersome and expensive way of challenging the decisions of public authorities. It is not an appeal against the merits of a decision by a public body, but a review of the decision-making process.[1300]

The reforms to legal aid have also led the Joint Committee on Human Rights to note that, 'for many people enforcement of their human rights is now, "simply unaffordable"'.[1301] In general then, an individual with a severe mental illness would have limited time, resources, or available advice on how to challenge such a detention which resulted from a failure of the local health board to meet their statutory duty.

The Welsh Paradigm is an opportunity to develop a mechanism to provide automatic redress for an individual who falls into this category. It cannot, at least at this point, be a panacea for all mental health rights impingements in a system that currently does not even seem to be able to record properly how many people are waiting, and how

[1295] ibid s 2.
[1296] Mental Health Act 1983 s 2.
[1297] Legal Aid, Sentencing and Punishment of Offenders Act 2012 s 10 and Part 2, ss 2,3, and 8.
[1298] Human Rights Act 1998 s 7(5)(a).
[1299] Civil Procedure Rules Part 54 Rule 54.5.
[1300] John Williams, '1998 Human Rights Act: Social Work's New Benchmark' (2001) British Journal of Social Work (2001) 31**,** 831, 833. Williams references here Laws J in *R v Somerset County Council, ex parte Fewings* [1995] 1 All ER 513 [515g]. Laws J notes 'The only question for the judge is whether the decision taken by the body under review was one which it was legally permitted to take in the way that it did', in respect of how the Court operates in judicial review.
[1301] UK Parliament, 'Enforcing human rights' (2018), Tenth Report of Session 2017-19 of the Joint Committee on Human Rights 3.

many have been seen under their statutory duty. It can however focus on one part of the system, create an initial set of automatic consequences, thus placing a financial incentive on the local health board to adhere to their duty. The next section will reflect upon and distinguish my approach from previous financial penalty systems imposed in England, before describing a potential Welsh approach. I will then identify the rationale, the proposed mechanism, and the link to the NHS Redress (Wales) Measure 2008, which will offer an initial route to Welsh law improving the human rights of the seriously mentally ill.

The Delayed Discharge Experiment in England

The proposal made here may be usefully compared to – and distinguished from - the failed introduction of financial penalties in England under the Community Care (Delayed Discharges) Act 2003. This statute mandated financial penalties to be charged to local authorities by the NHS for delayed discharges from hospitals where it was deemed that the delay in discharge was through a failure (or failures) by a local authority to fulfil set duties.[1302] These duties included patient needs assessments, carer's assessments, and the provision of support to fulfil those identified needs.[1303] Where these duties were not met, a mechanism existed whereby the relevant NHS body (the hospital where the patient remained undischarged) charged the local authority for the cost of this extended stay.[1304]

[1302] Care Act 2014 Sch 3 s 4.
[1303] ibid.
[1304] ibid.

David Behan (later Sir David Behan), the Chief Inspector of the Commission for Social Care Inspection stated in 2005:

> Fines have indeed helped to accelerate a downward trend in the number of delayed discharges, as the Government intended. In parts of the country where health and social services already had a sound working partnership and a good range of community support, the outcome has been wholly positive. The new system seems to have brought health and social care together rather than pulled them apart, as feared.[1305]

It has, however, been suggested that this approach may have incentivised a diversion in some community care budgets to address older adult services, resulting in funds moving from older adult psychiatry services to avoid payments to general hospitals.[1306] If such an approach was taken, this would likely cause other challenges in the system with support for the adult psychiatry patients, but the penalties only applied to acute care beds[1307] so the local authority could avoid fines without improving discharge support. It has also been noted that some data demonstrated around a 15% reduction in delayed transfers over two years, but an increase in readmission rates of almost 24%,[1308] whether or not this can be interpreted as a failure of the policy, it offers food for thought.

This charging approach was modified by Schedule 3 of the Care Act 2014, which permitted but did not mandate the NHS to charge local authorities for delayed discharge.[1309] Although it was reported that by 2017 that the charging powers under

[1305] David Behan, 'Delayed Transfers of Care – An Early Review of Progress' (2005) Journal of Integrated Care Vol 13 Iss 1 February 2005 43, 47.
[1306] Ajit Shah, 'The impact of the Community Care (Delayed Discharge) Act 2003 on the length of stay and bed occupancy in Old Age Psychiatry Units in England' (2007), Int J Geriatr Psychiatry 2007; 22: 1164, 1165.
[1307] Tees, Est and Wear Valleys NHS Foundation Trust, 'Delayed Transfers of Care in the Non-Acute and Mental Health Sectors Protocol' (2020) 3-4 <www.tewv.nhs.uk/wp-content/uploads/2021/11/Delayed-Transfers-of-Care-in-the-Non-Acute-and-Mental-Health-Sectors-Protocol.pdf> accessed 17 August 2025.
[1308] Karen Bryan, 'Policies for reducing delayed discharge from hospital' (2010) British Medical Bulletin 2010; 95:33 38-40.
[1309] Care Act 2014 Sch 3 s 4.

the were rarely used, it appears that this was not a universal approach, with 16 councils having been charged between £2,280 and £280,540 in the previous year.[1310] While fines were levied in 2016, by 2017 it was noted that the situation was changing nationally, with most hospitals no longer applying these 'fines' as there was recognition that delayed discharges were the responsibility of both the NHS and local authorities together.[1311]

The challenge with this approach - of one emanation of the State fining another State body - is that this risks money simply recirculating within the same system: but with increased bureaucracy, potential unintended consequences for patients (increased readmission rates), and little structural change. Health providers might, through their own system faults, have longer waiting lists for services than they should. Waiting times are often considered measures of performance in the NHS.[1312] Should the NHS choose to blame the local authority for delays in discharge for the NHS inability to perform to targets, then politically it relieves pressure on the NHS provider, whether or not the NHS provider could have done better itself. The NHS may then hold the local authority responsible for the delayed discharges and fine them, resulting in local authorities, who often lack resources to provide the social care to enable prompt discharge, being further impoverished through the penalties imposed. The NHS hospitals may receive funds from the local authority for the delayed discharges, but if

[1310] Mithran Samuel, 'NHS Trusts have fined councils up to £280,000 for delayed discharges' (2017), Community Care <www.communitycare.co.uk/2017/10/13/nhs-fined-councils-280000-delayed-discharges/> accessed 7 August 2025.
[1311] Local Government Association, 'Managing Transfers of Care – Frequently asked questions' (2017) 4 <www.local.gov.uk/sites/default/files/documents/2017-11-27%20Delayed%20transfer%20of%20care%20data%20and%20what%20it%20all%20means%20%28Final%29.pdf> accessed 7 August 2025.
[1312] The King's Fund, 'NHS waiting times: how are different service waiting times linked?' (2024) <www.kingsfund.org.uk/insight-and-analysis/data-and-charts/patient-waiting-times> accessed 17 August 2025.

they are not then delivering against their waiting list targets, they may not receive all of their activity-based payments,[1313] and thus will be worse off. The funds which might have been available to the NHS hospital are not then paid and potentially retained by Government, the local authority pays over additional funds and has less to invest in social care, and the patient continues to lose out by remaining in hospital.

It can be argued that this model appears to help no one, and as noted above, the Care Act 2014 took a more pragmatic approach by permitting the NHS body to charge,[1314] rather than mandating it under s.6 of the Community Care (Delayed Discharges etc.) Act 2003. Schedule 3 of the Care Act 2014 was ultimately revoked by the Health and Care Act 2022 with a greater emphasis on collaborative working between NHS and local authorities to address discharge needs. It can be seen from the initial commentary above, that the imposition of fines did trigger a response, but this response was not one which appeared to provide a sustainable change in provision or approach, and indeed, may have resulted in increased readmission rates.

To be clear, my proposal for the Welsh Paradigm can be distinguished from the approach in England under the Community Care (Delayed Discharges) Act 2003. As shown above, and in Chapters Seven and Eight, the timely assessment of the patient under Part III of the MH(W)M 2010 as a statutory duty, is to determine whether the individual needs to receive specialist mental health services and support. Such an assessment, carried out in the community before the patient deteriorates, is key to

[1313] Fiona Boyle, 'Briefing / Introduction to the NHS payment scheme' (2024) Healthcare Financial Management Association <www.hfma.org.uk/publications/introduction-nhs-payment-scheme> accessed 7 August 2025.
[1314] Care Act 2014 Sch 3 s 4(2).

potentially preventing a crisis situation and keeping the patient at home. Once such a crisis arrives though, this may ultimately result in an assessment of needs under the MHA 1983 resulting perhaps in detention which may have been preventable. More timely responses will not increase the costs to the NHS or local authority as it will allow for earlier treatment and potentially prevent such admissions, which as noted in Chapter Six are far more expensive than community support. My approach is not to fine for failure, but to compensate the individual where the failure has led to harm – the consequential embarrassment to the NHS of having to pay a patient for such failure, will focus the mind and improve performance. The level of compensation proposed in this chapter is far more limited than that potentially due for delayed discharges above, and ultimately, this is not a 'merry-go-round of funds', but a compensatory payment to a patient who has been wronged.

How would the Welsh Paradigm Work?

In setting this out, I believe that they key area of concern would the period an individual may be detained for to receive an assessment under the MHA 1983,[1315] as this would provide both recognition for the fact of detention, but also of the length of detention that resulted. The failure to provide the assessment in a timely fashion is the breach of duty,[1316] so I propose that a reasonable approach would be to associate a

[1315] Mental Health Act 1983 s 2.
[1316] Mental Health (Wales) Measure 2010 Part 3.

value to each day an individual is detained for assessment, when that assessment should have been carried out earlier.

An individual known to services under Part Two of the MH(W)M 2010[1317] would have had a Care and Treatment Plan which included a crisis plan for application should the individual exhibit signs of relapse,[1318] be at risk of relapse, and as such this information would be readily accessible to services. This would offer a swift and informed approach to reassessment, along with the previous Care and Treatment Plan itself. In failing to provide that reassessment under Part Three, I propose that should the patient then need to be detained for a mental health assessment, *before the Part Three assessment is completed,* then the redress approach is triggered. For the purposes of this approach, the failure to assess relates purely to the assessment within the 4-hour, 48 hour, or 28 days timescales set out in the Code.[1319]

Part Three assessment requests can be via a GP who may well identify that the nature of the patient's presentation means that such a reassessment should be an emergency or urgent. Such emergency assessments may result in admission, though as can be seen from the figures in Appendix III, less than 6% of patients were accepted back into secondary care, so it is not likely that many individuals receiving Part Three assessments are admitted under secondary services. From this it could also be argued that the potential numbers of people who do not receive their Part Three assessment and are subsequently detained to receive a mental health assessment under s.2 of the

[1317] ibid Part 2.
[1318] Welsh Government (n918) paras 4.81-4.82.
[1319] ibid 50.

MHA 1983[1320] is very small. This is why the Welsh Paradigm offers a workable first step to a more rights focussed approach: the exposure to the NHS in Wales for redress is very limited and these are patients who would cost more to admit, especially when the NHS has to use private mental health beds.[1321] This means that it would benefit the NHS to have a strong focus on preventing emergency admissions, and patients known to the service would offer a 'low hanging fruit' approach to show progress on such matters.

Taking costs aside, the power the State holds to detain individuals for a health condition must be used proportionately, and as a last resort: the current approach appears to be one of detention by default if the local health board fail to meet their statutory duty. In failing in such duties, this results in delays to, or perhaps even lack of treatment for a serious or severe mental illness. People with severe and enduring mental illness are at greater risk of poor physical health and reduced life expectancy compared to the general population,[1322] and thus such failures have a profound impact. This can never be acceptable, as it is clearly more than the loss of Liberty that impacts on the individual and their family,[1323] and it should be the aim of the Welsh Government to demonstrate their commitment to the least restrictive approach in mental health services.[1324] As any detention under s.2 MHA 1983 is for up to 28 days,

[1320] Mental Health Act 1983 s 2.
[1321] Gwyn Loader, 'Betsi Cadwaladr spends £1m a month on mental health treatment' (2024) *BBC Wales News online* <www.bbc.co.uk/news/uk-wales-68934000> accessed 6 May 2024 ; Future Care Capital, 'Outsourcing mental health services is proving costly for the NHS' (2024) <https://futurecarecapital.org.uk/latest/outsourcing-nhs-mental-health-services-proving-costly/#:~:text=Beds%20often%20bought%20at%20short%20notice%2C%20increasing%20cost&text=The%20average%20cost%20of%20a,%C2%A314mn%20in%202022%2D23> accessed 7 May 2024.
[1322] Public Health England, 'Health matters: reducing health inequalities in mental illness' (2018) <www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness> accessed 3 May 2024.
[1323] See Chapters Two and Five for discussion on broader impacts of loss of liberty.
[1324] Welsh Government (n665) 8 Guiding Principles para 1.1.

the redress would be limited to a maximum of 28 days, at least in a first phase: the purpose of this thesis is to start the debate on how redress might be applicable across both Welsh mental health law, and any new Mental Health Act.

Implementation of this Approach in Practice

How would this be workable? Whilst the data reporting to Welsh Government on Part Three has been demonstrated to be less than reliable, admissions under the MHA 1983 are subject to somewhat greater scrutiny. There is a requirement for formal records of the detention,[1325] and the use of the MHA 1983 is monitored by Health Inspectorate Wales.[1326] Additionally, all s.2 detentions may be challenged at the Mental Health Tribunal.[1327] This provides reassurance that detentions are recorded and monitored, and provides the background to a framework where each individual's situation may be determined and assessed with respect to the Welsh Paradigm.

All detained patients are considered as qualifying compulsory patients and are thus eligible for Independent Mental Health Advocacy Services[1328] (hereafter IMHA). Paragraph 6.4 of the Mental Health Act 1983 Code of Practice for Wales sets out the role as, 'the IMHA provides support to qualifying patients to ensure they understand the Act and their own rights and safeguards.'[1329] I would argue that should a Welsh Paradigm approach be adopted, the duty of the IMHA would be to ensure that the patient was supported in raising a complaint, or indeed the IMHA could raise that

[1325] The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008, WSI 2008/2439 (W.212) part 2.
[1326] Welsh Government (n665) 5 Inspectorates' role.
[1327] Mental Health Act 1983 Part V.
[1328] Welsh Government (n665) 31-32.
[1329] ibid.

complaint on the patient's behalf if the patient was awaiting a Part Three[1330] reassessment. I would in fact go further with this and suggest that as there is a requirement that the patient is informed about and offered the support of an IMHA[1331] in Wales, the information about the reasons that the patient may wish to access the advocate must include redress for failure of Part Three. How this could be implemented through legislation will be discussed in further detail below, but as IMHAs may access patient's medical records (with their permission),[1332] such access should identify referrals and self-referrals under Part Three.[1333] It is also far more likely that should there be an associated penalty for failure to comply with the Part Three Duty, the record keeping would improve so such matters could be determined with greater certainty.

Once it is established that the breach of Part Three of the MH(W)M 2010 has occurred, and the detention has been authorised, a simple route to redress should be available, as, 'the regulations make such provision as the Welsh Ministers think fit about redress'.[1334] A suggested route would be a standard form setting out the patient's personal details, the date of request for a Part Three MH(W)M 2010 reassessment, the date of admission under s.2 MHA 1983, and the length of the s.2 detention. This form would then be submitted to the relevant local health board via the Putting Things Right[1335] process who will address matters as set out in Regulation.[1336]

[1330] Mental Health (Wales) Measure 2010 Part 3.
[1331] Welsh Government (n665) 34-35.
[1332] Mental Health Act 1983 s 130B(3)(c)(d).
[1333] Mental Health (Wales) Measure 2010 Part 3.
[1334] NHS Redress (Wales) Measure 2008 s 2(1).
[1335] Welsh Government (n1294).
[1336] The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, WSI 2011/704 (W.108) Regulations 22-29.

I have deliberately not considered detention under sections 135 and 136 of the MHA 1983 for this purpose, and I will rely upon the use of section 2 as this would add too much complexity to a new development. Sections 135 and 136 are those used by police to remove an individual from a public place (s.136) or, with a court order, from a private place such as a patient's home (s.135). This removal is for the purposes of transporting the patient to a place of safety for an assessment to be carried out and the powers last for 24 hours under s.136 or 36 hours under s.135. These assessments are preliminary to any determination as to whether the patient would need to be detained for assessment under section 2 MHA 1983, and future development of the Welsh Paradigm may offer an expansion of the scope.

When I initially commenced my research, I was of the view that new legislation may be necessary as I had originally considered a much wider scope for redress – that relating to failure to provide the necessary services under Part Two of the MH(W)M 2010.[1337] Indeed, during the course of this research a new Mental Health Standards of Care (Wales) Bill has been proposed following a Members' ballot in the Senedd,[1338] though as of the 27th November this was withdrawn as a consequence of the Mental Health Bill 2024.[1339] There were however a number of routes available via Regulation, where the Welsh Ministers may set a timescale for Part Three MH(W)M 2010.[1340] Section 52(1) of the MH(W)M 2010[1341] provides that the Welsh Ministers may make orders or regulations by statutory instrument. There are exclusions in s.52(5) relating

[1337] See further footnote 20, p.14.
[1338] Senedd Commission, 'Development of the Mental Health Standards of Care (Wales) Bill' (2023) <https://senedd.wales/senedd-business/legislation/proposed-member-bills/development-of-the-mental-health-standards-of-care-wales-bill/> accessed 28 January 2024.
[1339] Senedd Wales, The Record of Proceedings (27 November 2024) paras 157-1661 <https://record.senedd.wales/Plenary/14184?lang=en-GB#A92440> accessed 28 November 2024,.
[1340] The Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) Regulations 2011, WSI 2011/2500 (W.272) s 2.
[1341] Mental Health (Wales) Measure 2010 s 52(1).

to the definition of secondary mental health services, the length of applicability for a Part Three assessment, and primary care assessments, but notes:

> Any power of the Welsh Ministers to make an order or regulations under this Measure includes power–
>
> (a) to make different provision for different cases or classes of case, different areas or different purposes;
>
> (b) to make provision generally or subject to specified exemptions or exceptions or only in relation to specific cases or classes of case;
>
> (c) to make such incidental, supplemental, consequential, transitory, transitional or saving provision as the Welsh Ministers think fit.[1342]

In carrying out the research it became clear that the rationing arguments as set out in Chapter Seven set an almost impossible challenge to imposing a specific duty relating to a particular type of service or care package. In the case of a Part Three Right, I would suggest that a statutory instrument (SI) stipulating a maximum timescale for the performance of s.26 of the MH(W)M 2010, which currently sets an 'as soon as is reasonably practicable' timescale, be addressed via an amending Regulation, attached as Appendix V. This I believe offers an opportunity for Wales to be at the forefront of developing reciprocity in mental health services.

There is an acknowledgement of the State's power to act to deprive an individual of their Liberty under the MHA 1983. Such detention, I believe, is in conflict with the commitment to Article 14 of the UNCRPD,[1343] as the criteria for detention is that the individual, "is suffering from mental disorder of a nature or degree which warrants the detention of the patient".[1344] The UK government identifies a number of mental health conditions which can lead to classification as a disability in law, and these include

[1342] ibid s 52(2).
[1343] United Nations General Assembly (n24).
[1344] Mental Health Act 1983 s 2(2)(a).

depression, bipolar disorder, and schizophrenia. It is interesting to note that the NHS in Scotland considers that, "It is only possible for someone to be compulsorily detained at a hospital if they have a severe mental disorder, such as schizophrenia, and if detention is necessary".[1345] Such a condition therefore is highly likely to be considered a disability, and Harvey et al[1346] suggest that between 60 and 75% of people with schizophrenia were considered disabled in the United States. In recognising that there is a significant inconsistency in the powers in the MHA 1983 and the rights from the UNCRPD, the State must consider how it mitigates such harms, and provides systems to both avoid unnecessary detention, and compensates for failures.

Wales has limited powers in relation to the MHA 1983 as this is not devolved legislation: the Welsh Government however has the ability to set standards for care and provide redress when such standards are not met, particularly where they result in loss of liberty. In the conclusion to this thesis, I will explain further how this approach offers the stalking horse for future developments in improving the rights of the mentally ill in Wales through Welsh law.

[1345] NHS Inform, 'Schizophrenia, Treatment' (2023) <www.nhsinform.scot/illnesses-and-conditions/mental-health/schizophrenia#treatment> accessed 7 May 2024.
[1346] Philip D Harvey and others, 'Functional impairment in people with schizophrenia: focus on employability and eligibility for disability compensation' (2012) Schizophr Res 2012 Sep;140(1-3):1, 7 <www.ncbi.nlm.nih.gov/pmc/articles/PMC3399960/pdf/nihms367156.pdf> accessed 7 May 2024.

Conclusion

Wherever a man is against his will, that to him is a prison.[1347]

When we consider life in a society, we understand that there are societal rules and norms which we follow otherwise there are consequences. Such consequences may be minor, and it is within our control to avoid these. What about the consequences of having a serious illness which means that you may lose your liberty despite not having done anything wrong, and despite asking for help to avoid the deterioration of your condition? In this research I have considered how that impacts on the negative Freedoms of the person, and the consequential impact on the positive Freedoms. The ability to steer a course through one's life, while always dependent upon society, and those around us, remains fundamental in being ourselves. When we are prevented from making life choices due to issues that are beyond the control of anyone, we may understand and adjust. When such restrictions may be preventable, but those who have the power to have intervened only intervene *after* restrictions have become necessary, this unfairness, particularly in relation to a disability is far from what might be expected by a citizen of a society.

The power imbalance that exists under the Mental Health Act 1983 is remarkable; it is deemed as incompatible with international conventions, and yet remains extant despite being reviewed several times with the aim of addressing Rights issues. Having considered the development of the law and the need to both ensure the safety of the patient and the public, it remains inconceivable that patients are best served by finding way to lock them up rather than treat them appropriately. The proposed Regulations

[1347] Epictetus, in Laurance (n614) iii.

that have been developed from this thesis are intended as a potential first step in Wales towards the right to receive treatment at a time where it may avoid deterioration to the point where detention becomes necessary. While such matters are likely impossible to predict with any great accuracy, this initial approach focussed upon timescales for assessment I believe offers a route to holding services to account and demonstrating the value of early engagement.

As noted earlier in Chapters Seven, Eight, and Nine, the monitoring of performance against the MH(W)M 2010 is patchy at best. Providing some teeth to ensure correct application of the MH(W)M 2010 I believe begins a journey of accountability, and it is only through accountability that we will see improvement in services. Williams asks, 'Does law assist practitioners to promote rights, or is it confined to ensuring accountability and regulating practice?'[1348] While he expresses significant concerns about the impact substandard law can have on the ability of a practitioner to promote rights, and indeed suggests that this can cause greater infringement of Rights,[1349] I agree with him that it can also have an indirect positive impact.[1350] So long as the law supports a Rights focussed approach, does not require greater impingement on Rights, and holds the practitioner (and their employer) to account for failure to apply that approach, I believe good law can assist practitioners in protecting the Rights of clients. It is not though through a law that we will see change, it is the potential financial impact and subsequent scrutiny that I believe offers more than simply additional legislation.

[1348] John Williams, 'Social Work, Liberty and Law' (2004) British Journal of Social Work (2004) 34 37, 37.
[1349] ibid 49.
[1350] ibid 50.

If a Right to assessment under Part Three of the MH(W)M 2010 is supported by a financial penalty for a defined failure as proposed, this provides an opportunity to demonstrate performance improvements post imposition of the approach. Such improvements would almost certainly follow, as this would result in the proper monitoring of such assessments in case of claims. This in itself would mean that such assessments are more likely to take place within the timescale set out in the MH(W)M 2010. If such improvements can be demonstrated, I would suggest that there are many other opportunities to drive a reciprocity focussed agenda in mental health services. This I believe could be considered in relation to my initial ambition for the thesis, the creation of an actionable Right to be seen by specialist mental health services within a set time scale.

If it can be demonstrated that by having a consequential automatic financial penalty where services fail to meet their own set timescales under Part Three of the MH(W)M 2010, why could this not perhaps be something for consideration for GP referrals? If a GP makes an urgent referral for mental health assessment, and there is an agreed timescale, surely failure to see the patient within that timescale before the patient ends up detained to receive that same assessment should have similar consequences to that proposed under Part Three? There are also likely longer-term consequential opportunities to argue for imposing automatic redress and continuing this journey towards holding services to account where they fail to provide treatment where this has been explicitly identified as necessary to prevent detention. This could be related to the Care and Treatment Plan (CTP) under Part Two of the MH(W)M 2010, and indeed, in finalising this thesis, the Westminster Government has introduced the Mental Health Bill 2024 which proposes making a CTP a requirement for detained

patients.[1351] It is for others to consider whether this offers opportunities to further develop the research into the realm of guaranteeing the treatment that would be received post detention ahead of detention, but I believe this is worthy of consideration.

I have used the term 'stalking horse' throughout this thesis, and it is of course used in its figurative sense here. It is intended to explain how I believe a small, and seemingly insignificant policy or legal change may offer major outcomes for citizens of Wales in the longer term. As noted earlier in this chapter, the potential cost of implementing the Welsh paradigm would be minimal as it is unlikely that health boards or local authorities would wish to be seen as paying out compensation for their failure to carry out an assessment within a reasonable time, and this in itself would likely ensure compliance. By having a system where such compensation payments are made, a record of such payments would be required, and, in effect, a 'league table' of performance by health boards could be seen, something again which would likely drive improvement in performance. The workload would not be significantly altered – these assessments must be carried out, and indeed are in many cases; rather, it is simply a matter of changing priorities to ensure these assessments are completed within a reasonable timescale, and keeping accurate records.[1352] So, putting aside the patient experience drivers here, it is clearly not in the interests of the health board or local authority to take an approach which would expose them to criticism or financial

[1351] Mental Health HL Bill (2024) 47 (59/1) s 20.
[1352] As noted in Appendix III there is a lack of consistent data for compliance with Part III of the MH(W)M 2010. Should a liability attach to assessments not completed within a set timescale, I believe this in itself would provide the motivation for health boards to improve their record keeping. Failure to have accurate records would likely lead to greater compensation payments as the ability to defend such claims would be impacted by lack of data.

penalty. This means that the patient is likely to experience an improvement in service without too great an additional burden on the services.

Therefore, if there is little risk to the service providers, there is an opportunity for Welsh Government to develop regulations which increases Rights, improves services, and has negligible attendant costs; this appears to be a win-win situation. Further, in the longer term, the proposed Welsh paradigm models a movement towards a Rights-based approach where there are measurable and enforceable rights for patients to receive services. If this could be developed for Part III of the MH(W)M 2010, could this also be developed in relation to access times for *other* parts of the mental health services covered by the MH(W)M 2010, such as advocacy (Part IV), or a Care and Treatment Plan (Part II)? Could there be opportunities to identify a Welsh approach to addressing delays in providing treatment to patients under the MHA 1983, where the therapy they may need in order to be discharged from their section is not available within a reasonable timescale?

Although going beyond the focus of this thesis, it is possible for this approach (suitably amended) to be rolled out to other health and social care contexts, for example patients awaiting continuing care assessments for health care in nursing homes. These are not areas I have considered in this thesis, but I believe that if the Welsh Government takes a courageous approach to implementing such a regulation as that proposed here, it sets a moral precedent to consider its applicability more widely. I would argue that mental health is an excellent place to start in order to demonstrate the intention to deliver true parity of esteem, but then such parity would surely suggest that the development of enforceable Rights for physical health conditions must follow. I am not naïve enough

to think that this would be a straightforward process, and the machinery of Government can often mean change takes significant time and energy, but Wales can offer an alternative approach to addressing fairness and justice in service provision.

Returning to the particular focus of this thesis, mental health, the new Mental Health Bill 2024 brings further opportunities for mental health legislation to be discussed, and as noted in Chapter Five, this can result in clear lines of demarcation between Government and patients and professional groups.[1353] This has not though been the case as I have seen it in the development of Welsh mental health law, with the Welsh Government appearing more willing than those in Westminster to take note of patients and those who have to apply the law. There does of course remain a challenge with any such legislation, where the body responsible for the application of the law, is also the body responsible for the provision of services. This can potentially result in situations where resource allocation decisions by the Government may prevent them from ensuring services are in place to avoid the use of detention, and thus the Government may be responsible for preventable detention.

We in Wales have a Senedd election ahead in May 2026 and likely a differently constituted Government. I proposed to share my draft Regulations and rationale with the relevant Minister and officials to try and improve the Rights of the seriously mentally ill in Wales. Whether such discussions will have any traction I cannot know, but when we are looking to the development of a new Mental Health Act, the Welsh Government has a significant role in demonstrating the human rights credentials it

[1353] Daw (n685) 131-148.

aspires to. The new Mental Health Bill 2024 recognises the innovation in Welsh legislation,[1354] particularly in relation to CTPs and broadening the Right to advocacy. If the Welsh Government wishes to retain the position of pathfinders in Rights for the seriously mentally ill, then reciprocity must be a key component of any new Welsh legislation.

[1354] Mental Health HL Bill (2024) 47 (59/1) ss 20, 38.

Appendix I

Article 25 - Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

(b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

(c) Provide these health services as close as possible to people's own communities, including in rural areas;

(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

(e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;

(f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Article 26 - Habilitation and rehabilitation

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

(a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;

(b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

APPENDIX II

W E L S H S T A T U T O R Y I N S T R U M E N T S

2024 No. XXXX (W.XXX) (C.XXX)

MENTAL HEALTH, ENGLAND AND WALES

The Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) (Amendment) Regulations 2024

Made

The Welsh Ministers make the following Regulations in exercise of the powers conferred by sections 52(2) and 55(3) of the Mental Health (Wales) Measure 2010(**1**).

Title, coming into force and interpretation

1.— (1) The title of these Regulations is the Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) (Amendment) Regulations 2024.

(2) These regulations come into force on 1 April 2025.

(3) In these Regulations—

(a) "the Measure" ("*y Mesur*") means the Mental Health (Wales) Measure 2010;

(b) "qualifying patient" ("*claf cymwys*") has the same meaning as in section 130C of the Mental Health Act 1983(**2**);

(c) "Welsh qualifying informal patients" ("*cleifion anffurfiol cymwys Cymru*") has the same meaning as in section 130J of the Mental Health Act 1983(**3**).

(d) "local mental health partners" ("*partneriaid iechyd meddwl lleol")* has the same meaning as in section 1 of the Mental Health (Wales) Measure 2010.

(e) "healthcare professional" ("*gweithiwr gofal iechyd proffesiynol"*) has the same meaning as in section 40 of the National Health Service (Wales) Act 2006(**4**).

Amendments to the Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) Regulations 2011

2. The Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) Regulations are amended in accordance with regulations 3 to 5.

Introduction of Timescales for Reassessment under Part III of the Measure

3.— (1) A new Regulation 2(A) is inserted into the Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) Regulations 2011 which sets timescales for the assessment to be carried out, and clarifies "reasonably practicable" as set out in section 26 (1) of the Measure.

(2) These timescales are subject to eligibility under section 22 of the Measure.

(3) The timescales will be reviewed annually by Ministers to improve the response time to eligible patients, but initially they will be set in line with the accepted current standard for assessment by community mental health teams, that is:

(a) Any Emergency requests for assessment (which will always be from a health professional) must be carried out within four (4) hours of receipt of that request.

(b) Any Urgent requests for assessment (which will always be from a health professional) must be carried out within forty-eight (48) hours of receipt of that request.

(c) Any Routine requests for assessment (which may be via a health professional or directly from the patient or their authorised representative must be carried out within twenty-eight (28) days of receipt of that request.

(4) These timescales are absolute, save where there is vexatious action by the patient to cause a delay which is not related to their mental health condition.

Arrangements for monitoring and recording referrals for and assessments of former users of secondary mental health services

4.— (1) The local mental health partners for a local authority area must take all reasonable steps to agree arrangements for–

(a) the identification and recording of all referrals for assessment in accordance with sections 22, 25, and 26 of the Measure, and maintain a register of these referrals by date and category, (Emergency, Urgent, Routine).

(b) the provision of a mechanism for a qualifying patient or the Independent Mental Health Advocate (acting with the authorisation of the qualifying patient) to seek redress under Regulation 5 should the patient be detained under section (2) of the Mental Health Act 1983 having not received an assessment within the timescales set out in Regulation 3.

(2) If arrangements have been agreed, the partners must ensure that the arrangements are recorded in writing.

(3) If the partners cannot agree arrangements under Regulation 4 –

(a) for so long as there is no agreement, the Local Health Board must record the referrals and assessments and maintain a register as referred to in Regulation 4(1)(a)(1)(a).

(b) the Local Health Board must inform the Welsh Ministers that agreement cannot be reached;

(c) the Welsh Ministers may determine arrangements and, if they do, must record them in writing.

(4) The local health board must provide a monthly report to the Welsh Ministers of compliance with Regulation 4.

Redress for Patients where timescales under Regulation 3(a)(b)(c) have been breached

5.- (1). Redress under the NHS Redress (Wales) Measure 2008 will be available to patients in the following qualifying group:

(a) Patients eligible for assessment under Part III of the Measure, and,

(b) Patients who have not received their assessments within the timescales set in Regulation 3, and,

(c) Patients who have subsequently been detained under section 2 of the Mental Health Act 1983 for assessment.

(2). Application for redress under the NHS Redress (Wales) Measure 2008 will be subject to the provisions in The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 but with a presumption that liability is determined by the qualification in Regulation 5 (1) of The Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) (Amendment) Regulations 2024.

(3). The required evidence to be considered in any application for redress will comprise of:

(a) confirmation that the patient was eligible under Regulation 5(1),

(b) the record of dates of referral,

(c) the record of the assessment due date,

(d) the date of detention under the Mental Health Act 1983,

(e) the length of detention under section 2 of the Mental Health Act 1983

(4). In considering the eligibility for redress, the responsible body will consider the application of Regulation 3(4).

(5). The Welsh Ministers will set a standard tariff for each day of detention, such days to be a twenty-four (24) hour period or part thereof. This tariff for the year 2025 will be £250 per day (the daily tariff) and will be reviewed annually, but in any event will be not exceed the daily equivalent limits set out in s.133A(5) of the Criminal Justice Act 1988 for detention not exceeding five years.

(6). The maximum redress under these Regulations will be 28 multiples of the daily tariff.

Cabinet Secretary for Health and Social Services, one of the Welsh Ministers
XXXXXXXX

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations are made under sections 52(2) and 55(3) of the Mental Health (Wales) Measure 2010 ("the Measure").

These Regulations are produced to give meaning to the intention of the Welsh Ministers under Part III at the time the Measure was enacted to, "remove delays in accessing specialist care and ensure a more timely response to relapse"[1355].

These Regulations place specific duties on local health boards and local mental health partners to maintain accurate records of the request for, and the completion of, Part III reassessments under the Measure. They also provide a more expedient route for redress in respect of the failure to adhere to the regulations where a patient then becomes subject to detention to receive an assessment.

(1)

2010 nawm 7.

(2)

1983 c. 20. Section 130C was inserted by section 30 of the Mental Health Act 2007 (c. 12).

(3)

Section 130J was inserted by section 36 of the Measure.

(4)

2006 c.42

[1355] Lesley Griffiths, Minister for Health and Social Services, Welsh Government (n918) 2.

Appendix III - Data table of Part Three reassessment

Adult Mental Health Services Only	ABUHB	BCUHB	C&VUHB	CTMUHB	HDUHB	PtHB*	SBUHB	Average of HB Exc BCUHB on referrals timescales
Average number of people requesting an assessment by month under Part 3 of the Measure for the 9-month period April 2023 - December 2023 inclusive by Health Board	15.00	16	32.22	0.11	8.78	2.00	0.44	10.65
Average number of those assessed following a referral for an emergency assessment waiting up to and including 4 hours from receipt of referral to an emergency assessment	0.00	no data	0.22	0.00	0.00	0.00	0.00	0.03
Average number of those assessed following a referral for an emergency assessment waiting over 4 hours and up to and including 48 hours from receipt of referral to an emergency assessment	0.00	no data	0.44	0.00	0.00	0.00	0.00	0.06
Average number of those assessed following a referral for an emergency assessment waiting over 48 hours and up to and including 28 calendar days from receipt of referral to an emergency assessment	0.00	no data	0.00	0.00	0.00	0.00	0.00	0.00
Average number of those assessed following a referral for an emergency assessment waiting over 28 calendar days from receipt of referral to an emergency assessment	0.00	no data	0.00	0.00	0.00	0.00	0.00	0.00
Average number of those assessed following a referral for an urgent assessment waiting up to and including 4 hours from receipt of referral to an urgent assessment	2.00	no data	0.11	0.00	0.11	0.13	0.00	0.34
Average number of those assessed following a referral for an urgent assessment waiting over 4 hours and up to and including 48 hours from receipt of referral to an urgent assessment	0.00	no data	0.89	0.00	0.11	0.00	0.00	0.14
Average number of those assessed following a referral for an urgent assessment waiting over 48 hours and up to and including 28 calendar days from receipt of referral to an urgent assessment	0.00	no data	0.22	0.00	0.22	0.00	0.00	0.06
Average number of those assessed following a referral for an urgent assessment waiting over 28 calendar days from receipt of referral to an urgent assessment	0.00	no data	0.00	0.00	0.00	0.00	0.00	0.00
Average number of those assessed following a referral for a routine assessment waiting up to and including 4 hours from receipt of referral to assessment	13.00	no data	1.44	0.00	0.33	0.13	0.11	2.14
Average number of those assessed following a referral for a routine assessment waiting over 4 hours and up to and including 48 hours from receipt of referral to assessment	0.00	no data	2.33	0.11	0.11	0.88	0.00	0.49
Average number of those assessed following a referral for a routine assessment waiting over 48 hours and up to and including 28 calendar days from receipt of referral to assessment	0.00	no data	5.56	0.00	4.67	1.00	0.11	1.62
Average number of those assessed following a referral for a routine assessment waiting over 28 calendar days from receipt of referral to assessment	0.00	no data	20.67	0.00	0.78	1.00	0.00	3.21
Of those patients assessed under Part 3 of the Measure how many outcome assessment reports were sent within the month								
Average percentage up to and including 10 working days after the assessment had taken place for the 9 months April 2023-December 2023	26.67%	81.25%	28.97%	100.00%	60.76%	12.50%	50.00%	40%
Average percentage after 10 working days after the assessment had taken place for the 9 months April 2023-December 2023	0.00%	4.17%	12.41%	0.00%	2.53%	12.50%	0.00%	4%
Average percentage of outcome assessment reports sent within the month for the 9 months April 2023-December 2023	26.67%	85.42%	41.38%	100.00%	63.29%	25.00%	50.00%	44%
Average percentage of people accepted onto the caseload under Part 3 of the Measure within the month for the 9 months April 2023-December 2023	6.67%	25.00%	12.76%	0.00%	11.39%	12.50%	0.25%	6%

ABUHB - Aneurin Bevan University Health Board. This health board has failed to provide data since July 2022, so data was rolled over within reporting format. This has been included only for completeness of reflecting health boards in Wales

BCUHB - Betsi Cadwaladr University Health Board. This health board does not report any data relating to referral times.

C&VUHB - Cardiff and Vale University Health Board

CTMUHB - Cwm Taf Morgannwg University Health Board

PtHB - Powys Teaching Health Board - full data only available for 8 months from April 2023-November 2023 so figures averaged on 8 months

SBUHB - Swansea Bay University Health Board - Figures to 2 decimal points

Cover email to the raw data

Hi Alun,

Please see attached Health Board returns including data from Apr-23 to Dec-23. Please note, data on the form which does not appear on our publication is unvalidated.

Aneurin Bevan University Health Board has been unable to submit data since July 2022, therefore data has been rolled over.

Regards,

From: Alun Thomas [redacted]

Sent: Tuesday, April 30, 2024 11:55 AM

To: HSS - Performance Data <HSS.Performance@gov.wales>

Subject: Mental Health (Wales) Measure Part 3 - Assessment of Former Users of Secondary Mental Health Services

Good Morning,

I've been looking for the full data submissions by health boards for the Part 3 compliance, and can only find the Outcome assessment report compliance: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-

Health/Mental-Health-Measure/Part-3/outcomeassessmentreportcompliance-by-lhb-month.

I know that the information submitted also provides the details on compliance against the emergency, urgent and routine timescales for assessment, but I cannot find any record of this.

I am writing my doctoral thesis and need to reference compliance rates with these timescales so would appreciate it if you were able to point me in the right direction. The template form is attached but I understand that this data may be collected in a slightly different format since 2020.

I hope you can assist,

Kind regards,

Alun

APPENDIX IV - Data sources provided by Welsh Government

Mental Health Measure (Part 3) - Monthly Submission Proforma

Summary for Health Board Population	Aneurin Bevan UHB

Please complete one sheet for each service area	Adult Mental Health
	Older Persons Mental Health
	CAMHS
	Learning Disabilities

Indicator			Data relating to the month of:											
			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
1	**The number of people resident in your LHB requesting an assessment under Part 3 of the Measure within the month** [monthly count]		15	15	15	15	15	15	15	15	15	0	0	0
2a	Of those people resident in your LHB who were assessed following a referral for an emergency assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
2b	Of those people resident in your LHB who were assessed following a referral for an urgent assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to an urgent assessment	2	2	2	2	2	2	2	2	2	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for an urgent assessment	2	2	2	2	2	2	2	2	2	0	0	0
2c	Of those people resident in your LHB who were assessed following a referral for a routine assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to a routine assessment	13	13	13	13	13	13	13	13	13	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to a routine assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to a routine assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to a routine assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for a routine assessment	13	13	13	13	13	13	13	13	13	0	0	0
2	Of those people resident in your LHB who were assessed following a referral, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to assessment	15	15	15	15	15	15	15	15	15	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral	15	15	15	15	15	15	15	15	15	0	0	0
3	Of those patients resident in your HB assessed under Part 3 of the Measure, how many outcome assessment reports were sent within the month: [monthly count]	**Up to and including 10 working days** after the assessment had taken place	4	4	4	4	4	4	4	4	4	0	0	0
		After 10 working days after the assessment had taken place	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of outcome of assessment reports sent within the month	4	4	4	4	4	4	4	4	4	0	0	0
4	**The number of people resident in your LHB accepted onto the caseload under Part 3 of the Measure within the month** [monthly count]		1	1	1	1	1	1	1	1	1	0	0	0

Mental Health Measure (Part 3) - Monthly Submission Proforma

Summary for Health Board Population	Betsi Cadwaladr UHB

Please complete one sheet for each service area	Adult Mental Health
	Older Persons Mental Health
	CAMHS
	Learning Disabilities

Indicator			Data relating to the month of:											
			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
1	**The number of people resident in your LHB requesting an assessment under Part 3 of the Measure within the month** [monthly count]		22	20	12	25	16	21	24	22	11	0	0	0
2a	Of those people resident in your LHB who were assessed following a referral for an emergency assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for an emergency assessment	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2b	Of those people resident in your LHB who were assessed following a referral for an urgent assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for an urgent assessment	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2c	Of those people resident in your LHB who were assessed following a referral for a routine assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to a routine assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to a routine assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to a routine assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to a routine assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for a routine assessment	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2	Of those people resident in your LHB who were assessed following a referral, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
3	Of those patients resident in your HB assessed under Part 3 of the Measure, how many outcome assessment reports were sent within the month: [monthly count]	**Up to and including 10 working days** after the assessment had taken place	19	13	10	12	15	13	17	16	12	0	0	0
		After 10 working days after the assessment had taken place	2	1	0	0	1	0	1	1	0	0	0	0
		The total number of outcome of assessment reports sent within the month	**21**	**14**	**10**	**12**	**16**	**13**	**18**	**17**	**12**	**0**	**0**	**0**
4	**The number of people resident in your LHB accepted onto the caseload under Part 3 of the Measure within the month** [monthly count]		7	6	4	5	3	7	5	4	2	0	0	0

Mental Health Measure (Part 3) - Monthly Submission Proforma

Summary for Health Board Population	Cwm Taf Morgannwg UHB

Please complete one sheet for each service area	Adult Mental Health
	Older Persons Mental Health
	CAMHS
	Learning Disabilities

Indicator			Data relating to the month of:											
			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
1	**The number of people resident in your LHB requesting an assessment under Part 3 of the Measure within the month** [monthly count]		**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2a	**Of those people resident in your LHB who were assessed following a referral for an emergency assessment, how many patients had waited:** [monthly count]	**Up to and including 4 hours** from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for an emergency assessment	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2b	**Of those people resident in your LHB who were assessed following a referral for an urgent assessment, how many patients had waited:** [monthly count]	**Up to and including 4 hours** from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for an urgent assessment	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2c	**Of those people resident in your LHB who were assessed following a referral for a routine assessment, how many patients had waited:** [monthly count]	**Up to and including 4 hours** from receipt of referral to a routine assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to a routine assessment	0	0	0	1	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to a routine assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to a routine assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for a routine assessment	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2	**Of those people resident in your LHB who were assessed following a referral, how many patients had waited:** [monthly count]	**Up to and including 4 hours** from receipt of referral to assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to assessment	0	0	0	1	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
3	**Of those patients resident in your HB assessed under Part 3 of the Measure, how many outcome assessment reports were sent within the month:** [monthly count]	**Up to and including 10 working days** after the assessment had taken place	0	0	0	1	0	0	0	0	0	0	0	0
		After 10 working days after the assessment had taken place	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of outcome of assessment reports sent within the month	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
4	**The number of people resident in your LHB accepted onto the caseload under Part 3 of the Measure within the month** [monthly count]		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Mental Health Measure (Part 3) - Monthly Submission Proforma

Summary for Health Board Population	Cardiff & Vale UHB

Please complete one sheet for each service area	Adult Mental Health
	Older Persons Mental Health
	CAMHS
	Learning Disabilities

Indicator			Data relating to the month of:										
			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
1	**The number of people resident in your LHB requesting an assessment under Part 3 of the Measure within the month** [monthly count]		25	24	44	41	40	33	44	37	21	0	0	0
2a	Of those people resident in your LHB who were assessed following a referral for an emergency assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to an emergency assessment	1	0	1	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to an emergency assessment	0	0	2	0	1	0	0	1	1	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for an emergency assessment	**1**	**0**	**3**	**0**	**1**	**0**	**0**	**1**	**1**	**0**	**0**	**0**
2b	Of those people resident in your LHB who were assessed following a referral for an urgent assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	1	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to an urgent assessment	0	1	2	1	2	1	2	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to an urgent assessment	0	0	2	1	0	0	0	0	1	0	0	0
		Over 28 calendar days from receipt of referral to an urgent assessment	0	0	0	0	1	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for an urgent assessment	**0**	**1**	**4**	**2**	**3**	**1**	**2**	**0**	**2**	**0**	**0**	**0**
2c	Of those people resident in your LHB who were assessed following a referral for a routine assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to a routine assessment	2	1	1	0	0	2	2	2	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to a routine assessment	0	0	4	1	3	0	2	0	1	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to a routine assessment	5	3	7	4	5	4	8	11	8	0	0	0
		Over 28 calendar days from receipt of referral to a routine assessment	26	19	20	20	25	26	15	18	23	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for a routine assessment	**33**	**23**	**32**	**25**	**33**	**32**	**27**	**31**	**32**	**0**	**0**	**0**
2	Of those people resident in your LHB who were assessed following a referral, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to assessment	3	1	2	0	0	2	2	2	1	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to assessment	0	1	8	2	6	1	4	1	2	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to assessment	5	3	9	5	5	4	8	11	9	0	0	0
		Over 28 calendar days from receipt of referral to assessment	26	19	20	20	26	26	15	18	23	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral	**34**	**24**	**39**	**27**	**37**	**33**	**29**	**32**	**35**	**0**	**0**	**0**
3	Of those patients resident in your HB assessed under Part 3 of the Measure, how many outcome assessment reports were sent within the month: [monthly count]	**Up to and including 10 working days** after the assessment had taken place	9	8	13	7	8	9	9	13	10	0	0	0
		After 10 working days after the assessment had taken place	3	1	3	7	7	5	1	3	6	0	0	0
		The total number of outcome of assessment reports sent within the month	**12**	**9**	**16**	**14**	**15**	**14**	**10**	**16**	**16**	**0**	**0**	**0**
4	**The number of people resident in your LHB accepted onto the caseload under Part 3 of the Measure within the month** [monthly count]		4	6	3	4	0	1	5	11	3	0	0	0

Mental Health Measure (Part 3) - Monthly Submission Proforma

Summary for Health Board Population	Hywel Dda UHB

Please complete one sheet for each service area
Adult Mental Health
Older Persons Mental Health
CAMHS
Learning Disabilities

Indicator			Data relating to the month of:											
			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
1	**The number of people resident in your LHB requesting an assessment under Part 3 of the Measure within the month** [monthly count]		12	19	16	16	13	24	15	19	13	0	0	0
2a	Of those people resident in your LHB who were assessed following a referral for an emergency assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	1	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for an emergency assessment	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**
2b	Of those people resident in your LHB who were assessed following a referral for an urgent assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to an urgent assessment	0	0	0	0	0	1	2	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to an urgent assessment	0	2	0	0	1	0	1	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to an urgent assessment	0	0	1	0	1	4	0	1	0	0	0	0
		Over 28 calendar days from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for an urgent assessment	**0**	**2**	**1**	**0**	**2**	**5**	**3**	**1**	**0**	**0**	**0**	**0**
2c	Of those people resident in your LHB who were assessed following a referral for a routine assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to a routine assessment	1	0	0	0	2	1	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to a routine assessment	0	0	0	1	1	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to a routine assessment	5	7	9	7	5	6	5	8	7	0	0	0
		Over 28 calendar days from receipt of referral to a routine assessment	2	2	0	0	0	0	0	6	1	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for a routine assessment	**8**	**9**	**9**	**8**	**8**	**7**	**5**	**14**	**8**	**0**	**0**	**0**
2	Of those people resident in your LHB who were assessed following a referral, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to assessment	1	0	0	0	2	2	2	0	1	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to assessment	0	2	0	1	2	0	1	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to assessment	5	7	10	7	8	10	5	9	7	0	0	0
		Over 28 calendar days from receipt of referral to assessment	2	2	0	0	0	0	0	6	1	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral	**8**	**11**	**10**	**8**	**10**	**12**	**8**	**15**	**9**	**0**	**0**	**0**
3	**Of those patients resident in your HB assessed under Part 3 of the Measure, how many outcome assessment reports were sent within the month:** [monthly count]	**Up to and including 10 working days** after the assessment had taken place	4	6	8	6	4	5	3	10	4	0	0	0
		After 10 working days after the assessment had taken place	0	0	0	0	0	1	1	0	1	0	0	0
		The total number of outcome of assessment reports sent within the month	**4**	**6**	**8**	**6**	**4**	**6**	**4**	**10**	**5**	**0**	**0**	**0**
4	**The number of people resident in your LHB accepted onto the caseload under Part 3 of the Measure within the month** [monthly count]		**0**	**1**	**3**	**0**	**0**	**2**	**1**	**3**	**2**	**0**	**0**	**0**

Mental Health Measure (Part 3) - Monthly Submission Proforma

Summary for Health Board Population	Powys Teaching HB

Please complete one sheet for each service area
Adult Mental Health
Older Persons Mental Health
CAMHS
Learning Disabilities

Indicator			Data relating to the month of:											
			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
1	**The number of people resident in your LHB requesting an assessment under Part 3 of the Measure within the month** [monthly count]		4	8	3	1	3	0	1	1	2	0	0	0
2a	Of those people resident in your LHB who were assessed following a referral for an emergency assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for an emergency assessment	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2b	Of those people resident in your LHB who were assessed following a referral for an urgent assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to an urgent assessment	1	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for an urgent assessment	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2c	Of those people resident in your LHB who were assessed following a referral for a routine assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to a routine assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to a routine assessment	1	1	2	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to a routine assessment	1	2	1	1	1	0	1	1	2	0	0	0
		Over 28 calendar days from receipt of referral to a routine assessment	0	0	3	3	1	0	1	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for a routine assessment	**2**	**3**	**6**	**4**	**2**	**0**	**2**	**1**	**2**	**0**	**0**	**0**
2	Of those people resident in your LHB who were assessed following a referral, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to assessment	1	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to assessment	1	1	2	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to assessment	1	2	1	1	1	0	1	1	2	0	0	0
		Over 28 calendar days from receipt of referral to assessment	0	0	3	3	1	0	1	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral	**3**	**3**	**6**	**4**	**2**	**0**	**2**	**1**	**2**	**0**	**0**	**0**
3	Of those patients resident in your HB assessed under Part 3 of the Measure, how many outcome assessment reports were sent within the month: [monthly count]	**Up to and including 10 working days** after the assessment had taken place	2	1	0	0	0	0	0	0	1	0	0	0
		After 10 working days after the assessment had taken place	0	0	0	1	0	1	0	0	0	0	0	0
		The total number of outcome of assessment reports sent within the month	**2**	**1**	**0**	**1**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**
4	**The number of people resident in your LHB accepted onto the caseload under Part 3 of the Measure within the month** [monthly count]		0	1	3	0	0	0	0	1	2	0	0	0

Mental Health Measure (Part 3) - Monthly Submission Proforma

Summary for Health Board Population	Swansea Bay UHB

Please complete one sheet for each service area	Adult Mental Health
	Older Persons Mental Health
	CAMHS
	Learning Disabilities

Indicator			Data relating to the month of:										
			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
1	The number of people resident in your LHB requesting an assessment under Part 3 of the Measure within the month [monthly count]		0	2	0	2	0	0	0	0	0	0	0	0
2a	Of those people resident in your LHB who were assessed following a referral for an emergency assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to an emergency assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for an emergency assessment	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2b	Of those people resident in your LHB who were assessed following a referral for an urgent assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to an urgent assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for an urgent assessment	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2c	Of those people resident in your LHB who were assessed following a referral for a routine assessment, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to a routine assessment	0	1	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to a routine assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to a routine assessment	0	0	0	1	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to a routine assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral for a routine assessment	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2	Of those people resident in your LHB who were assessed following a referral, how many patients had waited: [monthly count]	**Up to and including 4 hours** from receipt of referral to assessment	0	1	0	0	0	0	0	0	0	0	0	0
		Over 4 hours and up to and including 48 hours from receipt of referral to assessment	0	0	0	0	0	0	0	0	0	0	0	0
		Over 48 hours and up to and including 28 calendar days from receipt of referral to assessment	0	0	0	1	0	0	0	0	0	0	0	0
		Over 28 calendar days from receipt of referral to assessment	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of people resident in your LHB assessed under Part 3 of the Measure within the month following a referral	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
3	Of those patients resident in your HB assessed under Part 3 of the Measure, how many outcome assessment reports were sent within the month: [monthly count]	**Up to and including 10 working days** after the assessment had taken place	0	1	0	1	0	0	0	0	0	0	0	0
		After 10 working days after the assessment had taken place	0	0	0	0	0	0	0	0	0	0	0	0
		The total number of outcome of assessment reports sent within the month	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
4	The number of people resident in your LHB accepted onto the caseload under Part 3 of the Measure within the month [monthly count]		0	0	0	1	0	0	0	0	0	0	0	0

Appendix V

Supplementary memorandum from Hafal (DMH 413)[1356]

At this late stage in your scrutiny of the Draft Mental Health Bill we hope you will consider one further piece of evidence. As service users in Wales we have grave concerns about the scope and conditions for compulsion which the Draft Bill proposes. These matters have been addressed in Hafal's original submission. However, here we want to focus on one specific issue: reciprocal rights. The following evidence has the full support of Hafal but is also expressly the view of the undersigned.

The Need for Reciprocal Rights

1. In their review of the Mental Health Act 1983 the Richardson Committee was clear about the importance of introducing reciprocal rights. We agree with their diagnosis. Reciprocity within mental health legislation is the key to creating a humane and effective framework to support people with a mental illness. Reciprocal rights would give us back our dignity because the law would be based on agreement between government and patients: both would be required to act in a particular way at a particular stage of an illness; responsibility and obligation would be shared; and it would reduce the stigma of mental illness because the legislation would be seen by all as a genuine result of negotiation between government and patients.

2. Reciprocal rights would ensure access to early treatment. From our own experience we are convinced that this would prevent much suffering, improve safety for all, and significantly reduce the need for compulsion which the Bill so emphatically focuses upon. We believe that a new Mental Health Act should incorporate:

— A core statement of principles on the face of the Act which opens with a new principle of law: compulsion which compromises a patient's rights must be balanced fairly with legal rights to treatment and care.

— A stipulation that Codes of Practice are based on that balance between compulsion and patients' rights.

— A right to assessment on request within a set time.

— A further right to defined treatment and care including access to a psychiatrist when a basic threshold (for example the occurrence of delusional behaviour) is reached—a threshold well short of that required for compulsion to be applied.

— Improved rights to aftercare following discharge.

— Mechanisms for legal rights to be increased over time by the Secretary of State in England or the National Assembly in Wales—for example, statutory timescales for the assessment of patients could be reducible and specific new rights to care and treatment made legally enforceable.

3. It is crucial to stress the importance of reciprocal rights in Wales where we have a sound and empowering strategy agreed between patients and the Welsh Assembly Government but where progress has yet to be made on developing services to match. Already we have seen the potential impact of the new Bill on services: the key focus

[1356] House of Lords and House of Commons (n858) 256-257.

of mental health workforce planning in the Assembly was previously to improve community services; now workforce planners within the Assembly Government have been forced to redefine those priorities to accommodate the requirements for compulsion which the Bill may introduce. Legal rights to treatment would rebalance those planning priorities, ensuring services are put in place where they are needed—in the early treatment of a mental illness.

4. The Draft Mental Health Bill is a lost opportunity to improve treatment and care, improve safety for all, and give people with a mental illness the rights they deserve. By creating law with reciprocal rights at its core, the opportunity for positive change could instead be seized.

Matthew Butcher—former service user and Hafal Trustee
Linda Biaggi—service user and Hafal Trustee
Richard Lawson—service user and Hafal volunteer
Richard Mayes—service user and Hafal volunteer
Rod Morgan—service user and Hafal staff member
Christine Mead—service user and Hafal volunteer
Emma Norton—service user
Jo Roberts—service user and Hafal staff member
Keith Rogers—service user
Darryl Stevens—service user
Richard Timms—service user and Hafal volunteer
November 2004

Table of Cases

UK Cases

PB v Priory Group Ltd [2018] MHLO 74

Rabone v Pennine Care NHS Foundation Trust [2012] UKSC 2

Sayers v Harlow Urban District Council [1958] 2 All ER 342

Secretary of State for Home Affairs v O'Brien [1923] 2 KB 361

Serdar Mohammed v Ministry of Defence [2015] EWCA Civ 843

Somerset v Stewart (1772) 12 Geo 3 KB

The King v Secretary of State for Home Affairs Ex parte Lees [1941] 1 KB 72

R (AK) (by her mother and litigation friend GK) v The London Borough of Islington and North Central London Clinical Commissioning Group [2021] EWHC 301 (Admin)

Regina v Ashworth Hospital Authority (now Mersey Care National Health Service Trust) (Appellants) ex parte Munjaz (FC) (Respondent) [2005] UKHL 58

R v Cambridge Health Authority ex p B [1995] 2 All ER 129R (BA) v The Secretary of State for Health and Social Care and NHS Blood and Transplant [2018] EWCA Civ 2696

Re C (Adult: Refusal of Medical Treatment) [1994] 1 All ER 819

Rex v Coate (Keeper of a madhouse) 1772 Lofft 73

Re J (A Minor) (Wardship: Medical Treatment) [1991] 1 Fam 33

R v Bateman (1925) 94 LJKB 791 (CCA)

R (on the application of Condliff) v North Staffordshire Primary Care Trust [2011] EWCA Civ 910

R (Dolan) v Secretary of State for Health and Social Care [2020] EWCA Civ 1605

R (on the application of Claire Dyer) v Welsh Ministers [2015] EWHC 3712 (Admin)

R v Secretary of State for Social Services, Ex p Hincks (1980) 1 BMLR 93

R (Epsom and St Helier NHS Trust) v Mental Health Review Tribunal [2001] EWHC Admin 101

R (on the application of James) v Secretary of State for Justice [2008] 3 All ER 104

R (on the application of KB, MK, JR, GM, TB, and B) v MHRT [2003] EWHC 193 (Admin)

R (L) v Bournewood Community and Mental Health NHS Trust [1998] UKHL 24, 3 All ER 289

R v Martin [2001] All ER (D) 435 (Oct)

Regina (Munjaz) v Mersey Care NHS Trust [2005] 3 WLR 793

R (on the application of Nicklinson and another) v Ministry of Justice [2014] UKSC 38

R v North and East Devon Health Authority ex parte Coughlan [1999] EWCA Civ 1871

In re S.-C. (Mental Patient: Habeas Corpus) [1996] QB 599

R (Razgar) v Secretary of State for the Home Department [2004] 2 AC 368

R (Rogers) v Swindon NHS Primary Care Trust [2006] EWCA Civ 392

R (on the application of Ross) v West Sussex Primary Care Trust [2008] EWHC 2252 (Admin)

R v Somerset County Council, ex parte Fewings [1995] 1 All ER 513

R (on the application of Walker) v Secretary of State for Justice (formerly Secretary of State for the Home Department) [2008] 1 WLR 1977

Rex v Turlington 1761 97 ER 741

Traylor v Kent and Medway NHS Social Care Partnership Trust [2022] QBD 4 WLR 35

WH v Llanarth Court Hospital (Partnerships in Care) [2015] UKUT 695 (AAC)

EU Cases

B and L v The United Kingdom 36536/02, Judgment 13 September 2005

Clunis v The United Kingdom 45049/98 [1998] ECHR 116

Francis v The United Kingdom 3346/02 [2003] ECHR 707

HL v The United Kingdom 45508/99 [2004] ECHR 720 (Bournewood)

IH v The United Kingdom 17111/04 [2005] ECHR 934

James, Wells and Lee v the United Kingdom (2013) 56 EHRR 12; HL v UK 45508/99 ECHR 471

Munjaz v UK 2913/06 [2012] ECHR 1704

PHILLIPS v the United Kingdom - 64509/01 [2000] ECHR 702

Stubbings v The United Kingdom 22083/93, 22095/93 [1996] ECHR 44

R (on the application of Watts) v Bedford Primary Care Trust and Secretary of State for Health (2006) Case C-372/04 (ECJ)

The Republic of Ireland v The United Kingdom 5310/71 (1979-80) 2 EHRR 25

Wilkinson v UK (No. 1) 14659/02 [2006] ECHR 1171

Winterwerp v The Netherlands 6301/73 [1979] 2 ECHR 4

X v The United Kingdom 7215/75 [1982] 4 EHRR 188

YF v Turkey 24209/94 [2004] EHRR 715

Other Jurisdiction Cases

BVerfG Order of the Second Senate of 23 March 2011 - 2 BvR 882/09 - paras 1-82

Table of Legislation

UK Primary Legislation:

Aliens Registration Act

Care Act 2014

Children Act 1989

Community Care (Delayed Discharges) Act 2003

Coronavirus Act 2020

County Asylums Act 1808

Criminal Justice Act 1948

Criminal Justice Act 2003

Criminal Justice and Immigration Act 2008

Criminal Law Act 1967

Criminal Lunatics Act 1800

Equality Act 2010

Government of Wales Act 2006

Habeas Corpus Act 1679

Health and Care Act 2022

Health and Social Care Act 2012

Homicide Act 1957

Idiots Act 1886

Infanticide Act 1922

Limitation Act 1980

Legal Aid, Sentencing and Punishment of Offenders Act 2012

Lunacy (Vacating of Seats) Act 1886

Lunacy Act 1908

Lunacy Act 1890

Lunacy Act 1845 (also referred to as the Lunatics Act 1845)

Lunacy Act 1890

Lunacy Act 1908

Lunacy Act 1922

Lunatics Act 1842

Lunacy Act 1853

Madhouses Act 1774

Magistrates' Courts Act 1980

Marriage Act 1949

Mental Capacity Act 2005

Mental Deficiency Act 1927

Mental Deficiency Act 1938

Mental Deficiency (Amendment) Act 1935

Mental Health Act 1959

Mental Health Act 1983

Mental Health Act 2007

Mental Health (Amendment) Act 1975

Mental Health (Amendment) Act 1982

Mental Health (Discrimination) Act 2013

Mental Health (Patients in the Community) Act 1995

Mental Treatment Act 1930

National Health Service Act 1946

National Health Service Act 1977

National Health Service Act 2006

National Health Service and Community Care Act 1990

National Health Service (Wales) Act 2006

Nursing Homes Registration Act 1927

Nurses' Registration Act 1919

Offences Against the Person Act 1861

Police and Crime Act 2017

Prerogativa Regis. Of the King's Prerogative (1322)

Public Health Act 1936

Public Health (Control of Disease) Act 1984

Representation of the People Act 1918

Sexual Offences Act 1967

Sexual Offences Act 2003

Slave Trade Act 1807

Suicide Act 1961

Terrorism Act 2000

Vagrancy Act 1609

Vagrancy Act 1714

Vagrancy Act 1744

Wales Act 2017

Welsh Primary Legislation:

Children (Abolition of Defence of Reasonable Punishment) (Wales) Act 2020

Mental Health (Wales) Measure 2010

NHS Redress (Wales) Measure 2008

Rights of Children and Young Persons (Wales) Measure 2011

UK Secondary Legislation

The Health Protection (Coronavirus) Regulations 2020, SI 2020/129

National Assembly for Wales (Transfer of Functions) Order 1999, SI 1999/672

The Civil Procedure Rules 1998, SI 1998/3132

The Civil Procedure (Amendment) Rules 2017, SI 2017/95

The Mental Health Review Tribunal for Wales Rules 2008, SI 2008/2705

The Motor Cycles (Wearing of Helmets) Regulations 1973, SI 1973/180

The Motor Vehicles (Wearing of Seat Belts) Regulations 1993, SI 1993/176

The Northern Ireland Act 1998 (Devolution of Policing and Justice Functions) Order 2010

The Road Vehicles (Construction and Use) (Amendment) (No. 4) Regulations 2003, SI 2003/2695

Welsh Secondary Legislation

The Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) Regulations 2011, WSI 2011/2500 (W.272)

The Mental Health (Care Coordination and Care and Treatment Planning) (Wales) Regulations 2011, WSI 2011/2942 (W.318)

The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008, WSI 2008/2439 (W.212)

The Health Protection (Coronavirus Restrictions) (No.3) (Wales) Regulations 2020, WSI 2020/1149 (W.261)

The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009, WSI, 2009/778 (W.66)

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, WSI 2011/704 (W.108)

Bills

Ministry Of Health (Miscellaneous Provisions) Bill (1920) [Bill 215]

Mental Health HL Bill (2006-7) 76 (54/2)

Mental Health HL Bill (2024) 47 (59/1)

UK Parliament 2021-2022 Session Public Health (Control of Disease) Act 1984 (Amendment) Bill <https://bills.parliament.uk/bills/2974/publications> accessed 13 June 2022

International Instruments

Charter of the United Nations (adopted 26 June 1945, entry into force 24 October 1945) 1 UNTS XVI (UN Charter)

United Nations General Assembly, Convention on the Rights of Persons with Disabilities (adopted 13 December 2006 entered into force 3 May 2008) 2515 UNTS 3

United Nations Convention on the Rights of the Child 1989, adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 entered into force on 2 September 1990 in accordance with article 49

Council of Europe, Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (ETS No. 005) entry in force 03/09/1953

World Health Organisation, 'Preamble to the Constitution of WHO' (adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States) Official Records of WHO, no 2, p 100, entered into force on 7 April 1948

United States Declaration of Independence (1776)

United Nations General Assembly, Convention on the Rights of the Child (adopted 20 November 1989 entered into force 2 September 1990) 1577 UNTS 3

United Nations General Assembly, Universal Declaration of Human Rights (adopted 10 December 1948) 217 A(III) (UNGA)

United Nations International Covenant on Economic, Social and Cultural Rights 1966, adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 3 January 1976 in accordance with Article 27

United Nations International Health Conference, Constitution of the World Health Organization, (adopted 22 July 1946 entered into force 7 April 1948) Wld Hlth Org 2 100

Other Jurisdictions

Adults with Incapacity (Scotland) Act 2000

Basic Law for the Federal Republic of Germany in the revised version published in the Federal Law Gazette Part III, classification number 100-1 as last amended by the Act of 19 December 2022 (Federal Law Gazette I p 2478)

Mental Capacity (Northern Ireland) Act 2016

Mental Health (Care and Treatment) (Scotland) Act 2003

The Mental Health (Northern Ireland) Order 1986 No. 595 (N.I.4)

The Mental Capacity (Deprivation of Liberty) (No.2) Regulations (Northern Ireland) 2019

Official Publications / Parliamentary Papers

Bridgend County Borough Council, 'Response of Bridgend County Borough Council to Professor Michal Williams' Report 'A Well-being and Mental Health Service Fit for Wales''
<https://democratic.bridgend.gov.uk/Data/Cabinet/200808121430/Agenda/$051866.doc.pdf> accessed 26 August 2024

Cabinet Office Press Release, 'Section 141 of the Mental Health Act to be abolished' (2011) <www.gov.uk/government/news/section-141-of-the-mental-health-act-to-be-abolished> accessed 14 June 2022

Crown Prosecution Service, 'Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide' (October 2014) <www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide> accessed 22 January 2023

Cwm Taf University Health Board, Bridgend Boundary Change – Joint Transition Board, (23 April 2019) <https://ctmuhb.nhs.wales/about-us/our-board/committees/bridgend-boundary-change-joint-transition-board-jtb/#:~:text=On%20the%2014%20June%202018,Board%20(ABMUHB)%20to%20Cwm%20Taf> accessed 26 October 2024

Department of Constitutional Affairs, Mental Capacity Act: Code of Practice (HMSO 2007)

Department of Health, Caring for People: Community Care in the Next Decade and Beyond (HMSO 1989) Cm. 849

Department of Health, Draft Mental Health Bill & Mental Health Bill: consultation document, (June 2002) Cm 5538

Department of Health, Draft Mental Health Bill (2004) Cm 6305-1

Department of Health, Government Response to the Report of the Joint Committee on the Draft Mental Health Bill 2004 (2005) Cm 6624

Department of Health, Mental Health Act 1983: Code of Practice (2015) The Stationery Office

Department of Health, Reference Guide to Consent for Examination or Treatment (2009) <https://assets.publishing.service.gov.uk/media/5a7abdcee5274a34770e6cdb/dh_103653__1_.pdf> accessed 7 May 2024

Department of Health, Working for Patients (HMSO 1989)

Department of Health and Social Care, Draft Mental Health Bill (2022) CP 699

Department of Health, Modernising Mental Health Services: Safe, Sound and Supportive (Department of Health 1998) <https://webarchive.nationalarchives.gov.uk/ukgwa/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4046660.pdf> accessed 6 August 2024

Department of Health and Social Care, Modernising the Mental Health Act: Final Report of the Independent Review of the Mental Health Act 1983 (2018) <https://assets.publishing.service.gov.uk/media/5c6596a7ed915d045f37798c/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf >accessed 5 August 2024

Department of Health and Social Care, Open consultation Mental health and wellbeing plan: discussion paper. (2022) <www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper#chapter-1-how-can-we-all-promote-positive-mental-wellbeing> accessed 18 June 2022

Department of Health and Social Care, Consultation outcome. Reforming the Mental Health Act, Executive Summary (2021) <www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#executive-summary> accessed 7 April 2024

Department of Health and Social Security, 'Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff' (March 1969) Cmnd 3975

Department of Health and Social Services, Better Services for the Mentally Ill (London, HMSO 1975) Cmnd 6233

Department of Health Northern Ireland, 'Mental Capacity Act Background' <www.health-ni.gov.uk/articles/mental-capacity-act-background> accessed 5 August 2025

Department of Health for the Northern Ireland Executive, 'Bamford Review of Mental Health and Learning Disability (Northern Ireland), A Comprehensive Legislative Framework' (2007) <www.health-ni.gov.uk/sites/default/files/publications/dhssps/legal-issue-comprehensive-framework.pdf> accessed 13 July 2025

European Parliament, 'Factsheet: Free Movement of Persons' (2019) <www.europarl.europa.eu/factsheets/en/sheet/147/free-movement-of-persons> accessed 28 July 2019

Everybody's Business – A report on suicide prevention in Wales (2018) – report of the Welsh Assembly's Health Social Care and Sport Committee's inquiry <https://business.senedd.wales/documents/s83783/Report%20-%20Everybodys%20Business%20A%20report%20on%20suicide%20prevention%20in%20Wales.pdf> accessed 2 May 2022

Health and Social Care Public Health Agency Northern Ireland, 'Implementing Bamford: Knowledge from Research' (2011) <https://research.hscni.net/sites/default/files/Bamford_Summary_Report.pdf> accessed 13 July 2025

HMRC, Penalties for Late Payment and Interest Harmonisation (2002) <www.gov.uk/government/publications/penalties-for-late-payment-and-interest-harmonisation/penalties-for-late-payment-and-interest-harmonisation> accessed 29 January 2023

Home Office, 'Definition of Policing by Consent' <www.gov.uk/government/publications/policing-by-consent/definition-of-policing-by-consent> accessed 26 May 2024

Home Office, Report of the Committee of Mentally Abnormal Offenders (HMSO 1975) Cmnd 6244

House of Commons, Welsh Affairs Committee, Fifth Report, Review of the LCO Process (2010)

House of Commons, Welsh Affairs Committee. Proposed National Assembly for Wales (Legislative Competence) (Health and Health Services and Social Welfare) Order 2009 (HC 778, 2009) The Stationery Office

House of Lords, The King's Speech 2024 <www.gov.uk/government/speeches/the-kings-speech-2024> accessed 1 September 2024

House of Lords, The Queen's Speech 2022 <www.gov.uk/government/speeches/queens-speech-2022> accessed 14 June 2022

House of Lords, House of Commons, 'Joint Committee on Human Rights – Fourth Report' (2007) 2.16 <https://publications.parliament.uk/pa/jt200607/jtselect/jtrights/40/4002.htm> accessed 6 August 2025

House of Lords and House of Commons, Joint Committee on the Draft Mental Health Bill HL Paper 79-I HC 95-I (2005) The Stationery Office

House of Lords and House of Commons, Joint Committee on the Draft Mental Health Bill, HL Paper 79-II HC 95-II (2005) The Stationery Office

House of Lords and House of Commons, Joint Committee on the Draft Mental Health Bill, 'Further Memorandum from Hafal' (2004-2005) DMH 413 <https://publications.parliament.uk/pa/jt200405/jtselect/jtment/95/95mwe09.htm> accessed 27 January 2024

House of Lords and House of Commons, Joint Committee on the Draft Mental Health Bill 2022, HL Paper 128 HC 696 (January 2023)

House of Lords, House of Commons, 'Joint Committee on the Draft Mental Health Bill, Oral evidence' (26 October 2022) HC 696

Hywel Dda University Health Board, Community Mental Health Team Service Specification Consultation Document <https://hduhb.nhs.wales/about-us/governance-arrangements/freedom-of-information/disclosure-log/disclosure-log-appendices/1-mental-health-care-pdf-16mb/> accessed 28 September 2024

Law Wales, 'Timeline of Welsh Law' <http://law.gov.wales/constitution-government/how-welsh-laws-made/timeline-welsh-law/?lang=en#/constitution-

government/how-welsh-laws-made/timeline-welsh-law/?tab=overview&lang=en> accessed 7 October 2018

Letter from Head of Planned Care to Chief Executives of Health Boards, NHS Wales 24th April 2018. <https://gov.wales/sites/default/files/publications/2019-07/consolidated-rules-for-managing-cardiac-referral-to-treatment-waiting-times.pdf> accessed 2 May 2022

Midlands and Lancashire Commissioning Support Unit, Exploring Mental Health Inpatient Capacity, (2019), <www.strategyunitwm.nhs.uk/sites/default/files/2019-11/Exploring%20Mental%20Health%20Inpatient%20Capacity%20accross%20Sustainability%20and%20Transformation%20Partnerships%20in%20England%20-%20191030_1.pdf> accessed 28 September 2024

National Assembly for Wales, Constitutional and Legislative Affairs Committee, 'Professor Thomas Glyn Watkin, Evidence to the Inquiry: A stronger voice for Wales: engaging with Westminster and the devolved institutions' (2017) IGP011. <https://business.senedd.wales/documents/s63570/IGP011%20Professor%20Thomas%20Glyn%20Watkin.pdf> accessed 3 September 2023

National Assembly for Wales, Health Wellbeing and Local Government Committee Proposed Inquiry into Mental Health Services in the Community (2009) Committee Ref: HWLG(3)-03-09 <https://business.senedd.wales/Data/Health,%20Wellbeing%20and%20Local%20Government%20Committee%20-%20Third%20Assembly/20090212/Agenda/HWLG(3)-04-09%20Paper%201%20Committee%20Inquiry%20into%20Community%20Mental%20Health%20Services%20-%20Scoping%20paper%20(Pdf,%2071kb).pdf> accessed 28 August 2024

National Assembly for Wales, The Health, Wellbeing and Local Government Committee, Committee Inquiry into Community Mental Health Services (2009) <https://business.senedd.wales/Data/Health,%20Wellbeing%20and%20Local%20Government%20Committee%20-%20Third%20Assembly/20090226/Agenda/HWLG(3)-05-09%20Transcript%20(PDF,%20117kb).pdf> accessed 28 August 2024

National Assembly for Wales, The Health, Wellbeing and Local Government Committee, Committee Inquiry into Community Mental Health Services (2009) Evidence from Hafal, Committee Ref: HWLG(3)-05-09 paper 1 <https://business.senedd.wales/Data/Health,%20Wellbeing%20and%20Local%20Government%20Committee%20-%20Third%20Assembly/20090226/Agenda/HWLG(3)-05-09%20-%20Paper%201%20-%20Committee%20Inquiry%20into%20Community%20Mental%20Health%20Services%20-%20Evidence%20from%20Hafal%20(26-02-2009).pdf> accessed 28 August 2024

National Assembly for Wales, 'The Minister for Health and Social Services, Evidence to the Health Wellbeing and Local Government Committee' (2009) HWLG(3)-12-09 paper 2 <https://business.senedd.wales/Data/Health,%20Wellbeing%20and%20Local%20Government%20Committee%20-%20Third%20Assembly/20090514/Agenda/HWLG(3)-12-09%20-%20Paper%202%20-%20Committee%20Inquiry%20into%20Community%20Mental%20Health%20Services%20-%20Evidence%20from%20the%20Minister%20for%20Healt%20(14-05-2009).pdf> accessed 28 August 2024

National Assembly for Wales, The Record of Proceedings (3 October 2007) <https://senedd.wales/archive/votes-and-proceedings/03-10-2007-votes-and-proceedings/> accessed 12 October 2024

National Assembly for Wales, The Record of Proceedings Wednesday 9 December 2009 <https://senedd.wales/archive/votes-and-proceedings/09-12-2009-votes-and-proceedings/> accessed 12 October 2024

National Assembly for Wales, 'Hospital waiting times – What do you need to know?' (2019) Research Briefing <https://senedd.wales/media/ycspv5fr/hospital-waiting-times.pdf> accessed 2 May 2022

National Assembly for Wales, 'Statement by the First Minister: Report of the Commission on Justice in Wales' 5 November 2019 <https://record.assembly.wales/Plenary/6039#A54186> accessed 29 August 2022

NHS, 'Do I Have the Right to Refuse Treatment?' (2017) <www.nhs.uk/common-health-questions/nhs-services-and-treatments/do-i-have-the-right-to-refuse-treatment/> accessed 25 August 2019

NHS Wales, 'Planning Framework 2019/22' (2018) <www.wales.nhs.uk/sitesplus/documents/862/Item%205.1.1%20NHS%20Wales%20Planning%20Framework%202019-22.pdf> accessed 30 January 2022

NHS Wales, 'Planning Framework 2022-2025' (2021) <https://gov.wales/sites/default/files/publications/2021-11/nhs-wales-planning-framework-2022-2025_0.pdf> accessed 2 May 2022

NHS Wales, 'Putting the Citizen First' <https://nwssp.nhs.wales/a-wp/governance-e-manual/putting-the-citizen-first/> accessed 4 November 2024

NHS Wales, ' Suspected Cancer Pathway' <https://collaborative.nhs.wales/networks/wales-cancer-network/workstreams/single-cancer-pathway/> accessed 2 May 2022

NHS Wales, 'Waiting Times' <https://111.wales.nhs.uk/Waitingtimes/> accessed 30 December 2021

Ombudsman Wales, 'What We Do When We Get Your Complaint About a Public Service Provider in Wales' <www.ombudsman.wales/fact-sheets/complaints-against-public-bodies-our-procedure/> accessed 3 May 2024

Public Health England, 'Health matters: reducing health inequalities in mental illness', (2018) <www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness> accessed 3 May 2024

Ritchie J, 'The Report of the Inquiry into the Care and Treatment of Christopher Clunis' (1994) HMSO Norwich

Roberts J, 'Written evidence submitted by Ms Jo Robers supported by Adferiad Recovery' (MHB0036) (2022) <https://committees.parliament.uk/writtenevidence/111575/pdf/> accessed 1 September 2024

Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (Percy Commission) (1957) Cmnd 169 HMSO

Scottish Executive, 'New Directions. Report on the Review of the Mental Health (Scotland) Act 1984' January 2001 Scottish Executive

Scottish Government, 'The New Mental Health Act: A guide to consent to treatment - Information for Service Users and their Carers' (2005) <www.gov.scot/publications/new-mental-health-act-guide-consent-treatment-information-service-users-carers/> accessed 18 June 2022

Senedd Commission, 'Development of the Mental Health Standards of Care (Wales) Bill' (2023) <https://senedd.wales/senedd-business/legislation/proposed-member-bills/development-of-the-mental-health-standards-of-care-wales-bill/> accessed 28 January 2024

Senedd Cymru, Written Statement: Update on the development of the justice system and the legal sector in Wales 30th September 2021 Mick Antoniw MS Counsel General and Minister for the Constitution <https://gov.wales/written-statement-update-development-justice-system-and-legal-sector-wales> accessed 29 August 2022

Senedd Wales, 'Police response to people in mental health crisis' (2020) Senedd Research <https://research.senedd.wales/research-articles/police-responses-to-people-in-mental-health-crisis/> accessed 22 September 2024

Senedd Wales, 'Citizens' Assembly' <https://senedd.wales/how-we-work/devolution-20/citizens-assembly/> accessed 4 November 2024

Senedd Wales, 'Citizen Engagement' <https://senedd.wales/visit/across-wales/citizen-engagement-1/> accessed 4 November 2024

Senedd Wales, The Record of Proceedings (27 November 2024) <https://record.senedd.wales/Plenary/14184?lang=en-GB#A92440> accessed 28 November 2024

UK Parliament, 'Enforcing human rights' (2018) Tenth Report of Session 2017-19 of the Joint Committee on Human Rights

UK Parliament 'Mental health: Achieving parity of esteem' (2020) House of Commons Library <https://commonslibrary.parliament.uk/mental-health-achieving-parity-of-esteem/> accessed 2 May 2022

UK Parliament, 'Parity of Esteem for Mental Health' (2015) Research Briefing <https://post.parliament.uk/research-briefings/post-pn-485/> accessed 2 May 2022

UK Parliament, 'Financial Crisis in Pembrokeshire NHS' Early Day Motion EDM 1186 (9 May 1994)

UK Parliament, 'Welsh Devolution' Early Day Motion EDM 178 (7 December 2023)

UK Parliament, 'Joint Committee on the Draft Mental Health Bill Minutes of Evidence' (10 October 2004) <https://publications.parliament.uk/pa/jt200405/jtselect/jtment/79/4111014.htm> accessed 8 August 2024

UK Parliament, 'Welsh Affairs Committee, Proposed National Assembly for Wales (Legislative Competence) (Health and Health Services and Social Welfare) Order 2009 Fourteenth Report of Session 2008-09 HC 778 Examination of Witnesses Ev 12 (9 July 2009)

UK Parliament, 'Social Insurance and Allied Services Report by Sir William Beveridge' (1942) Cmd 6404 HMSO

United Nations, General Comment, Committee on the Rights of Persons with Disabilities Eleventh Session (2014) <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement> accessed 28 August 2023

United Nations Department of Economic and Social Affairs, Convention on the Rights of Persons with Disabilities (2006) Article 14 – Liberty and security of person <https://social.desa.un.org/issues/disability/crpd/article-14-liberty-and-security-of-person> accessed 1 September 2024

United Nations Human Rights Office of the High Commissioner, Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities, Committee on the Rights of Persons with Disabilities Fourteenth Session (2015) <https://www.ohchr.org/Documents/HRBodies/CRPD/14thsession/GuidelinesOnArticle14.doc#:~:text=Article%2014%20of%20the%20Convention%20is%20in%20esse

nce%20a%20non,on%20disability%20in%20its%20exercise> accessed 28 August 2023

Welsh Assembly Government, Mental Health Act 1983 Code of Practice for Wales (2008)

Welsh Assembly Government, Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness, Efficiency, Strategy Document (2001)

Welsh Assembly Government, Adult Mental Health Services: A National Service Framework for Wales (2002) <www.wamhinpc.org.uk/sites/default/files/adult-mental-health-nsf-april-02.pdf> accessed 11 August 2024

Welsh Assembly Government, Mental Health (Wales) Measure 2010: Implementing the Mental Health (Wales) Measure 2010 (2011) WAG 10-11316 <www.mentalhealthlaw.co.uk/media/Implementing_the_Mental_Health_(Wales)_Measure_2010.pdf> accessed 26 August 2024

Welsh Assembly Government, Mental Health (Wales) Measure 2010 Explanatory Memorandum (2010) <https://senedd.wales/media/rnpp2r2k/ms-ld8002-em-e-english.pdf> accessed 3 September 2023

Welsh Assembly Government, Raising the Standard: The Revised Adult Mental Health National Service Framework and an Action Plan for Wales (2005) <www.wamhinpc.org.uk/sites/default/files/adult-mental-health-raising-the-standard-oct-05.pdf> accessed 26 August 2024

Welsh Government, 'Citizen Voice Body for Health and Social Care' <www.gov.wales/citizen-voice-body-health-and-social-care> accessed 4 November 2024

Welsh Government, Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010 (2012) WG14643

Welsh Government, Delivering the Independent Mental Health Advocacy Service in Wales: Guidance for Independent Mental Health Advocacy Providers and Local Health Board Advocacy Service Planners (2011) WG14369

Welsh Government, Mental Health Act 1983 Code of Practice for Wales Revised (2016)

Welsh Government, Mental Health (Wales) Measure 2010 National Service Model for Local Primary Mental Health Support Services (2011) <www.wales.nhs.uk/sitesplus/documents/863/Mental%20Health%20Measure%20-%20Primary%20Care%20Model.pdf> accessed 16 June 2022

Welsh Government, NHS Wales Complaints and Concerns: Putting Things Right (2023) <www.gov.wales/nhs-wales-complaints-and-concerns-putting-things-right> accessed 3 May 2024

Welsh Government, Statistics. Mental Health (Wales) Measure 2010: October to December 2023 Part 2: Care and Treatment Plans (2024) <www.gov.wales/mental-health-wales-measure-2010-october-december-2023> accessed 7 May 2024

Welsh Government, The Duty to Review Interim Report, Post-Legislative Assessment of the Mental Health (Wales) Measure 2010 (2014) WG21588

Welsh Government, The Duty to Review Interim Report, Post-Legislative Assessment of the Mental Health (Wales) Measure 2010 (2016) WG27249

Welsh Government, Written Statement: The Future of Welsh Law: Classification, Consolidation, Codification (17 October 2019) <https://gov.wales/written-statement-future-welsh-law-classification-consolidation-codification> accessed 29 January 2023

Welsh Government, 'Written Statement – The One Wales Delivery Plan 2008-2011' (2011) <www.gov.wales/written-statement-one-wales-delivery-plan-2008-2011> accessed 11 August 2024

Welsh Government, Written Statement – Welsh Government Response to PricewaterhouseCoopers Review of the Financial Ring Fencing Arrangements for Mental Health Services in Wales (2016) <www.gov.wales/written-statement-welsh-government-response-pricewaterhousecoopers-review-financial-ring-fencing> accessed 26 August 2024

Welsh Government, Written Statement – World Mental Health Day 2015: 'Celebrating improvements to mental healthcare in Wales' Statement of Mark Drakeford, Minister for Health and Social Services 7 October 2015 <https://gov.wales/written-statement-world-mental-health-day-2015-celebrating-improvements-mental-healthcare-wales> accessed 29 August 2022

Welsh Office, A Voice for Wales (1997) Cm 3718

World Health Organisation, 'Statement for Healthcare Professionals: How COVID-19 Vaccines Are Regulated for Safety and Effectiveness' (Revised March 2022) <www.who.int/news/item/17-05-2022-statement-for-healthcare-professionals-how-covid-19-vaccines-are-regulated-for-safety-and-effectiveness> accessed 16 June 2022

Hansard

HC Deb 09 November 1920 vol 134 cols 1029-148

HC Deb 22 October 1953 vol 518 cols 2153-6

HC Deb 31 May 1956 vol 553 cols 489-506

HC Deb 26 January 1959 vol 598 cols 704-840

HC Deb 27 March 1969 vol 780 cols 1808-20

HC Deb 5 April 1973 vol 854 cols 745-75

HC Deb 17 January 1996 vol 269 cols 655-73

HC Deb 8 December 1998 vol 322 cols 145-58

HC Deb 20 December 2000 vol 360 cols 361-75

HL Deb 16 November 2006 vol 687 cols 19-100

Reports

Amnesty International, 'The State of the World's Human Rights' (2018) <www.amnesty.org/download/Documents/POL1067002018ENGLISH.PDF> accessed 28 July 2019

Burrows M, Greenwell S, The Other End of the Telescope: A Refocusing of Mental Health and Wellbeing for Service Users and Carers, Report of All Wales Review of Mental Health Services (2007) <https://webarchive.nationalarchives.gov.uk/ukgwa/20160426082522/http:/gov.wales/topics/health/publications/health/reports/2279017/?lang=en> accessed 26 August 2024

Care Quality Commission, Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2 Conclusions <www.cqc.org.uk/publications/nottinghamshire-healthcare-nhsft-special-review-part2> accessed 1 September 2024

The Commission on Justice in Wales, Justice in Wales for the People of Wales (2019).

Department of Health, 'Report of the Expert Committee Review of the Mental Health Act 1983' (1999)

Department of Health and Social Care, 'Report of the Independent Review of NHS Hospital Food' (2020) <https://assets.publishing.service.gov.uk/media/5f930458d3bf7f35e85fe7ff/independent-review-of-nhs-hospital-food-report.pdf> accessed 25 May 2024

Department of Health and Social Care, 'Independent Review of the Mental Health Act 1983: Advisory Panel' <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779055/MH_review_advisory_panel_independent_review.pdf> accessed 29 January 2023

Department of Health and Social Care, The Independent Review of the Mental Health Act, 'Interim Report' (2018) <https://assets.publishing.service.gov.uk/media/5ae82f6540f0b63154caac53/The_independent_Mental_Health_Act_review__interim_report_01_05_2018.pdf> accessed 25 May 2024

Department of Health and Social Care, Modernising the Mental Health Act: Final Report from the Independent Review (2018) <www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review> accessed 14 June 2022

Department of Health, Modernising Mental Health Services: Safe, Sound and Supportive (Department of Health 1998) <https://webarchive.nationalarchives.gov.uk/ukgwa/+/www.dh.gov.uk/prod_consum_dh/groups/dh/@en/documents/digitalasset/dh_4046660.pdf> accessed 6 August 2024

Department of Health Northern Ireland, 'Hospital Statistics. Inpatient and Day Case Activity Northern Ireland 2021/22' (2023) <www.health-ni.gov.uk/sites/default/files/publications/health/hs-inpatient-day-case-stats-21-22.pdf> accessed 14 July 2024

Equality and Human Rights Commission, Disability Rights in the UK: UK Independent Mechanism Updated Submission to the UN Committee on the Rights of Persons with Disabilities in Advance of the Public Examination of the UK's Implementation of the UN CRPD (2017) 4 <www.equalityhumanrights.com/sites/default/files/2021/disability-rights-UK-july-2017.pdf> accessed 1 September 2024

Dworkin, G, "Autonomy and Behavior Control" (1976) The Hastings Center Report 6 no 1

Equality and Human Rights Commission, Progress on Disability Rights in the United Kingdom: UK Independent Mechanism Update Report to the UN Committee on the Rights of Persons with Disabilities (2018) <www.equalityhumanrights.com/sites/default/files/2021/progress-on-disability-rights-in-the-uk-crpd-shadow-report-2018.pdf> accessed 1 September 2024

Griffiths R, Community Care: Agenda for Action. A report to the Secretary of State for Social Services (1988) London HMSO

Hywel Dda University Health Board, Mental Health Legislation Committee Report (2024) <https://hduhb.nhs.wales/about-us/governance-arrangements/board-committees/mental-health-legislation-committee-mhlc/mhlc-26-march-2024/item-6-scrutiny-group-update-and-mental-health-wales-measure/> accessed 30 April 2024

Hywel Dda University Health Board, Mental Health Scrutiny Group Report (2022) <https://hduhb.nhs.wales/about-us/governance-arrangements/board-committees/mental-health-legislation-committee-mhlc/mhlc-3-october-2022/item-7-the-mental-health-wales-measure-2010-report/> accessed 30 April 2024

Ministry of Justice, 'Court experience of adults with mental health conditions, learning disabilities and limited mental capacity Report 3: At court' (2010)

National Assembly for Wales, 'The Constitution – Legislative Competence Orders, Members' Research Service: Quick guide' (2009)

<https://senedd.wales/media/aytkg1yl/qg07-0058-english.pdf> accessed 26 August 2024

NHS Digital, 'Mental Health Act Statistics, Annual Figures' (2024) <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures> accessed 21 January 2024

NHS Digital, 'The Healthcare Ecosystem' <https://digital.nhs.uk/developer/guides-and-documentation/introduction-to-healthcare-technology/the-healthcare-ecosystem#primary-care> accessed 18 June 2022

NHS Education for Scotland, 'Learning Resource Mental Health (Care and Treatment) (Scotland) Act 2003' (2010) <www.nes.scot.nhs.uk/media/ryofw5zx/mental-health-care-and-treatment-scotland-act-2003.pdf> accessed 16 June 2022

NHS England, 'Bed Availability and Occupancy Data – Overnight' (Q4 2023-24) <www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2024/06/Beds-Open-Overnight-Web_File-Q4-2023-24-Final-1.xlsx> accessed 14 July 2024

Office of National Statistics, 'Excess Deaths in England and Wales: March 2020 to June 2022' (2022) <www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/excessdeathsinenglandandwalesmarch2020tojune2022/2022-09-20> accessed 25 May 2024

Public Health Scotland, 'Acute Hospital Activity and NHS Beds Information (Annual)', (Year Ending 31 March 2023) <https://publichealthscotland.scot/publications/acute-hospital-activity-and-nhs-beds-information-annual/acute-hospital-activity-and-nhs-beds-information-annual-annual-year-ending-31-march-2023/> accessed 14 July 2024

Salize HJ, Dreßing H, Peitz M, 'Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in EU-Member States' (2002) <http://ec.europa.eu/health/ph_projects/2000/promotion/fp_promotion_2000_frep_08_en.pdf> accessed 13 May 2014

Scottish Government, 'Inpatient Census 2022: Parts One and Two' (2022) <www.gov.scot/publications/inpatient-census-2022-part-1-mental-health-learning-

disability-inpatient-bed-census-part-2-out-scotland-nhs-placements/pages/3/> accessed 14 July 2024

Silk Commission, 'Empowerment and Responsibility: Legislative Powers to Strengthen Wales' (2014) Cardiff: Commission on Devolution in Wales

StatsWales, 'Section 135 and 136 Detentions by local health board, assessment outcome and quarter' <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/Detentions-under-Section-135-and-136-Mental-Health-Act/section135136-by-lhb-outcomeofassessment-quarter> accessed 22 September 2024

StatsWales, Monthly NHS beds data by measure, site and specialty, March 2014 onwards, (12 month figures from April 2023-March 2024) <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/nhsbeds-by-organisation-specialty-month> accessed 28 September 2024

StatsWales, 'NHS Beds by Organisation and Year' (2009-10 onwards) <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/nhsbeds-by-organisation-site> accessed 14 July 2024

StatsWales, Waiting times for a therapeutic intervention, by LHB, age and month, June 2024 <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/Mental-Health-Measure/Part-1/waitingtimesforatherapeuticinterventiont-by-lhb-month> accessed 22 September 2024

'Report of the War Office Committee of Enquiry into "Shell-Shock"' (1922) <https://wellcomelibrary.org/item/b18295496#?c=0&m=0&s=0&cv=99&z=0.4003%2C0.1794%2C0.5307%2C0.3333> accessed 20 September 2020

UK Government Ministry of Justice 'Pre-Action Protocol for Judicial Review' (2021) <www.justice.gov.uk/courts/procedure-rules/civil/protocol/prot_jrv> accessed 31 August 2025

Wales Audit Office, Adult Mental Health Services in Wales: A Baseline Review of Service Provision (2005) <https://senedd.wales/media/2wqdavkr/bus-guide-n00000000000000000000000000038346-english.pdf> accessed 31 August 2024

Wales Audit Office, Adult Mental Health Services Follow Up Report (7 July 2011) <www.audit.wales/sites/default/files/Adult_Mental_Health_Services_-_Follow_up_Report_English_2011_14.pdf> accessed 18 August 2024

Welsh Government Data, Freedom of Information Request 15305 <www.gov.wales/sites/default/files/publications/2021-08/atisn15305doc6.pdf> accessed 30 April 2024

Welsh Government, 'Delivering Justice for Wales' (2022) <www.gov.wales/sites/default/files/publications/2022-06/delivering-justice-for-wales-may-2022-v2.pdf> accessed 31 August 2025

Welsh Government, 'Written Statement: Preparing for the devolution of justice' (2025) <www.gov.wales/written-statement-preparing-devolution-justice-0> accessed 31 August 2025

Welsh Government, Mental Health Data Sources <https://gov.wales/mental-health-data-sources> accessed 2 May 2022

Welsh Government, Mental Health (Wales) Measure 2010: October to December 2023, Part 2: Care and Treatment Plans (2024) <www.gov.wales/mental-health-wales-measure-2010-october-december-2023> accessed 7 May 2024

Welsh Government, Welsh Government Policy Implementation Guidance on Local Primary Mental Health Support Services and Secondary Mental Health Services for the purposes of the Mental Health (Wales) Measure 2010 and related subordinate legislation (2019) <www.gov.wales/sites/default/files/publications/2019-06/welsh-government-policy-implementation-guidance-on-local-primary-mental-health-support-services-and-secondary-mental-health-services.pdf> accessed 2 May 2024

Welsh Government, Statistics for Wales, Patients in mental health hospitals and units in Wales at March 2019 <www.gov.wales/sites/default/files/statistics-and-research/2019-11/patients-mental-health-hospitals-units-31-march-2019-249.pdf> accessed 28 September 2024

Williams M, 'Iechyd Meddwl Cymru, A Well Being and Mental Health Service Fit For Wales' (2008) <https://webarchive.nationalarchives.gov.uk/ukgwa/20090711092025/http:/www.wales.nhs.uk/sites3/page.cfm?orgid=201&pid=32302> accessed 26 August 2024

Bibliography

Secondary Sources

Books

Beauchamp TL, and Childress JF, Principles of Biomedical Ethics (5th edn Oxford University Press 2001)

Berlin I, 'Two Concepts of Liberty' in Four Essays on Liberty (Oxford University Press 1969)

Cassin B, Apter E, Lezra J, Wood M, (eds), Dictionary of Untranslatables: A Philosophical Lexicon (Princeton University Press 2014)

Coid JW, The Christopher Clunis Enquiry (Routledge 1994)

Conly S, Against Autonomy (Cambridge University Press Cambridge UK 2013)

Crowcroft R, Theakston K, 'The Fall of the Attlee Government, 1951' in Heppell T, and Theakston K, (eds) How Labour Governments Fall: From Ramsay MacDonald to Gordon Brown (Palgrave Macmillan Houndmills Basingstoke Hampshire 2013)

Dator J, What is Fairness? In Dator J, Pratt D, Seo Y, Fairness, *Globalization, and Public Institutions: East Asia and Beyond* (University of Hawai'i Press 2006)

Davidson G and others, 'The Fusion Approach to Mental Capacity Law in Northern Ireland: Possibilities and Challenges' in Camillia Kong and others (eds) Capacity, Participation and Values in Comparative Legal Perspective (Bristol University Press 2023)

Dick PK, Minority Report (Gollancz 2009)

Dworkin G, The Theory and Practice of Autonomy (Cambridge University Press 1997)

Equality and Human Rights Commission, The United Nations Convention on the Rights of People with Disabilities. What does it mean for you (2010) ISBN 978 1 84206 278 4

Fennell P, Treatment Without Consent (Routledge, Oxfordshire 2014)

Fennell P, Mental Disorder in Gostin L, and others (ed) Principles of Mental Health Law and Policy (OUP 2010)

Fineman M, The Autonomy Myth: Lies We Tell Ourselves about Dependency and Self-Sufficiency (The New Press 2004 New York)

Gostin L, Mental Health Services: Law and Practice (Shaw and Sons Ed 18 June 2000)

Halsbury's Laws of England (5th edn 2010) 97 para 542 Lexis Library 3 August 2014

Hide L, 'Mental hospitals, social exclusion and public 'Scandals'' in Ikkos G, and Bouras, N (eds) Mind, State and Society: Psychiatry and Mental Health in Britain 1960-2010 (Cambridge University Press Cambridge 2022)

Herring J, 'Relational Autonomy and Family Law' in Julie Wallbank (ed) Rights, Gender and Family Law (Taylor and Francis Group ProQuest Ebook Central 2010)

Horsey K, and Rackley E, Tort Law (6th edn Oxford University Press 2019)

King James Bible, 'Matthew 7:1' <www.kingjamesbibleonline.org/Matthew-7-1/> accessed 14 June 2022

Jones K, Asylums and After (The Athlone Press Ltd London 1993)

Laurance J, Pure Madness: How Fear Drives the Mental Health System (Routledge 2003)

Locke J, Essay Concerning the True Original, Extent and End of Civil Government, in Social Contract: essays by Locke, Hume and Rousseau / with an introduction by Sir Ernest Barker (Oxford University Press 1971)

Mill JS, 'On Liberty' in On Liberty and Other Essays (Oxford University Press 1998)

Mill JS, 'Utilitarianism' in On Liberty and Other Essays (Oxford University Press 1998)

Miller EF, Hayek's The Constitution of Liberty: An Account of Its Argument (IEA 2010)

O'Neill O, Autonomy and Trust in Bioethics (Cambridge University Press 2002)

Rawls J, Theory of Justice (OUP 1999)

Raz J, The Morality of Freedom (Oxford University Press Incorporated 1988)

Reath A, Autonomy, Ethical, in The Shorter Routledge Encyclopedia of Philosophy, Ed. Craig E, (Routledge 2005)

Rousseau J-J, The Social Contract (St Ives Clays Ltd 1968)

Sassoon S, 'Survivors' (October 2017) <https://englishverse.com/poems/survivors> accessed 13 October 2024

Sensen O, (ed), Kant on Moral Autonomy (Cambridge University Press 2012)

W. Stubbs, The Constitutional History of England--in its Origin and Development Vol I (4th ed Clarendon Press 1883).

Szasz T, Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices (MacMillan Co 1963)

Szmukler G, Gostin LO, Mental Health Law: 'Legalism' and Medicalism' – 'Old' and 'New', in Ikkos G, Bouras N, (eds.), Mind, State and Society: Psychiatry and Mental Health in Britain 1960-2010, (2022 Cambridge University Press)

Turner T, in Puri B, and Treasaden I, (eds), Psychiatry: An Evidence-Based Text (CRC Press 2009)

Unsworth C, The Politics of Mental Health Legislation (Clarendon Press, Oxford 1987)

Velleman JD, A Brief Introduction to Kantian Ethics in Self to Self (Cambridge University Press New York 2006)

Wood AW, 'The Supreme Principle of Morality' in Guyer P, (ed), The Cambridge Companion to Kant and Modern Philosophy (Cambridge University Press Online version 2007)

Journals

Akther SF, and others, 'Patients' Experiences of Assessment and Detention under Mental Health Legislation: Systematic Review and Qualitative Meta-Synthesis' (2019) 5 BJPsych Open e37 6

Allen N, 'The Bournewood Gap (As Amended?)' (2010) Medical Law Review 18 Winter 2010 78

Bartlett P, ‘Beyond the liberal subject: challenges in interpreting the CRPD, and the CRPD’s challenges to human rights’ (2025) Human Rights Law Review 2025 25 1

Bartlett P, ‘The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law’ (2012) Modern Law Review Vol 75 No 5 (September 2012):752

Behan D, ‘Delayed Transfers of Care – An Early Review of Progress’ (2005) Journal of Integrated Care Vol 13 Iss 1 February 2005 43

Bennett D “No Lion can him Fright” (1995) Psychiatric Bulletin (1995) 19 565

Benning TB, 'No Such Thing as Mental Illness? Critical Reflections on the Major Ideas and Legacy of Thomas Szasz' (2016) 40(6) BJPsych Bulletin 292

Bogacz T, 'War Neurosis and Cultural Change in England, 1914-22: The Work of the War Office Committee of Enquiry into "Shell-Shock"' (Apr 1989) 24(2) Journal of Contemporary History 227

British Journal of Nursing, ‘Royal Commission on Lunacy and Mental Disorder’ (1926) British Journal of Nursing, September 1926 20

British Medical Journal Supplemental, ‘Mental Treatment Act 1930’ (20 September 1930) The British Medical Journal Vol 2 No 3637: 139

British Medical Journal, Voluntary Mental Health Services: The Feversham Committee’s Report BMJ Vol 2 No 4099 (Jul 29 1939) 239

British Medical Journal, Memorandum on the Future Organization of the Psychiatric Services' (1945) British Medical Journal Supplement 16 June 1945 111

British Medical Journal, 'The “liquid cosh” libel' (1983) 286 BMJ 153

British Medical Journal, 'Mental Hospital Commissioners' (1969) 2 BMJ 6

Broughton D, ‘The Welsh Devolution Referendum 1997’ (1998) 35 Representation 200

Brown D, ‘Draft Mental Health Bill Receives Frosty Reception from Professionals’ Community Care (London 4 July 2002)

Bryan K, ‘Policies for reducing delayed discharge from hospital’ (2010) British Medical Bulletin 2010; 95:33

Bulak B, Zysset A, 'Personal Autonomy and Democratic Society at the European Court of Human Rights: Friends or Foes?' (2013) 2 UCL Journal of Law and Jurisprudence 230

Burns JH, 'Happiness and Utility: Jeremy Bentham's Equation' (2005) 17(1) Utilitas 46 50

Butcher J, 'Controversial Mental Health Bill Reaches the Finishing Line' (2007) 370 The Lancet 117

Butler, B, ‘NGRI revisited: Venirepersons’ Attitudes Towards the Insanity Defense’ (2006) Journal of Applied Psychology 2006 36 8 1833

Canadian Medical Association Journal, 'From Nannyism to Public Disclosure: The BSE Report' (2001) 164(2) CMAJ 165

Callaghan D, 'Principlism and Communitarianism' (2003) 29 J Med Ethics 287

Carver CS, Scheier MF, 'Autonomy and Self-Regulation' (2000) 11(4) Psychological Inquiry 284

Chipidza FE, Wallwork RS, Stern TA, ‘Impact of the Doctor-Patient Relationship’ (2015) Prim Care Companion CNS Disord 2015 Oct 22; 17(5)

Crittenden J, 'The Social Nature of Autonomy' (1993) 55(1) The Review of Politics 35

Coggon J, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) 15 Healthcare Analysis 235

Coggon J, Miola J, 'Autonomy, Liberty, and Medical Decision-Making' (2011) 70(3) Cambridge Law Journal 523

Coid JW, 'The Christopher Clunis Enquiry' (1994) 18 Psychiatric Bulletin 449

Cook GC, 'Caring for “Incurables”: The 150th Anniversary of the Royal Hospital for Neuro-Disability, Putney' (2004) 80 Postgraduate Medical Journal 426

Crichton J, Darjee R, ‘New Mental Health Legislation’ (2007) 334 BMJ 596

Darwall S, 'The Value of Autonomy' (2006) 116 Ethics 263

Daw R, ‘The Mental Health Act 2007 – The Defeat of an Ideal’ (2007) Journal of Mental Health Law 131

Dekkers WJM, 'Autonomy and Dependence: Chronic Physical Illness and Decision-Making Capacity' (2001) 4 Medicine, Health Care and Philosophy 185

Devisch I, 'Oughtonomy in Healthcare: A Deconstructive Reading of Kantian Autonomy' (2010) 13(4) Med Health Care and Philosophy 303

Dijk S, Lok P, 'NICE Rejects Cannabidiol for Two Types of Treatment Resistant Epilepsy in Children' (2019) BMJ 366

Dinerstein RD, 'Implementing Legal Capacity Under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road from Guardianship to Supported Decision-Making' (2012) 19(2) Human Rights Brief 8

Dobson R, 'Wales to Scrap Health Authorities' (2001) 322 BMJ 318

Donald, K, 'The Vicious Circle of Poverty and Injustice' Open Democracy (25 August 2013)

Drakeford M, 'Social Justice in a Devolved Wales' (2007) 15(2) Benefits 171

Duggan C, 'Dangerous and Severe Personality Disorder' (2011) 198(6) British Journal of Psychiatry 431

Dworkin G, 'Autonomy and Behavior Control' (1976) 6(1) The Hastings Center Report 23

Eastman N, 'The Mental Health (Patients in the Community) Act 1995: A Clinical Analysis' (1997) 170 BJP 492

Eastman N, Peay J, 'Bournewood: An Indefensible Gap in Mental Health Law' (1998) 317 BMJ 94

Eccles A, '"Furiously Mad": Vagrancy Law and a Sub-Group of the Disorderly Poor' (2013) 24 Rural History 26

Eldergill A, 'Is Anyone Safe? Civil Compulsion under the Draft Mental Health Bill' (2002) Journal of Mental Health Law 331

Fallon RH, 'Two Senses of Autonomy' (1994) 46(4) Stanford Law Review 875

Feld AD, 'The American Journal of Gastroenterology' (2004) 99(6) 977

Fennell P, ‘Protection! Protection! Protection! Déjà Vu All Over Again: The Government Response to the Joint Parliamentary Scrutiny Committee’ (2005) Journal of Mental Health Law 114

Fenwick B, 'Editorial' (June 1930) No 1943 78 British Journal of Nursing

Finch J, 'Mental Health (Amendment) Act 1975' (1976) 39(1) The Modern Law Review 70

Fineman MA, ‘The Significance of Understanding Vulnerability: Ensuring Individual and Collective Well-Being’ (2023) Int J Smiot Law (2023) 36:1371

Fineman MA, 'Vulnerability and Social Justice' (2019) 53 Val U L Rev 341

Fitzpatrick B, Walker C, 'Holding Centres in Northern Ireland, the Independent Commissioner and the Rights of Detainees' (1999) European Human Rights Law Review

Ford A, ‘The Concept of Exceptionality: A Legal Farce’ (2012) 20(3) Medical Law Review 304 336

Frankfurt HG, 'Freedom of the Will and the Concept of a Person' (1971) 68(1) Journal of Philosophy 5

Freeman MC, and others, ‘Reversing Hard-Won Victories in the Name of Human Rights: A Critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities’ (2015) Lancet Psychiatry 2(9) July 2015

Friedman M, 'Autonomy and Male Dominance' (2004) 87 Soundings: An Interdisciplinary Journal 175 180

Gass M, ‘Kant’s Causal Conception of Autonomy’ (1994) 11(1) History of Philosophy Quarterly 53 70

Gensler HJ, 'A Kantian Argument Against Abortion' (1985) 48 Philosophical Studies 57

Gilbar, R, ‘Family Involvement, Independence, and Patient Autonomy in Practice’ (2011) Medical Law Review 19 Spring 2011

Gillon R, 'Autonomy and the Principle of Respect for Autonomy' (1985) 290 BMJ 1806

Gillon R, ‘Ethics needs principles—four can encompass the rest—and respect for autonomy should be “first among equals”’ (2003) J Med Ethics 2003; 29:307

Goldman B, Cropanzano B, ‘“Justice” and “fairness” are not the same thing’ Journal of Organizational Behavior 36 313

Gonzalez-Rodriguez A, Molina-Andreu O, Odriozola V, Ferrer C, Pendades R, Catalan R, ‘Delusional Disorder: An Overview of Affective Symptoms and Antidepressant Use’ (2013) 27(4) European Journal of Psychiatry 26

Gosney P, Bartlett P, ‘The UK Government Should Withdraw from the Convention on the Rights of Persons with Disabilities’ (2020) 216 BJPsych 296

Gostin L, Davies DR, ‘Consent to psychiatric treatment. Letter to the BMJ’ (1982), British Medical Journal Vol 284 (6333): 1945 Jun 26 1982

Grey DJR, 'Women’s Policy Networks and the Infanticide Act 1922' (2010) 21(4) Twentieth Century British History 442

Griffiths S, Evans P, ‘Constitution by Committee? Legislative Competence Orders under the Government of Wales Act (2007–2011)’ (2013) 66(3) Parliamentary Affairs 480

Hamilton JR, 'Mental Health Act 1983' (1983) 286 BMJ 1720

Hans VP, 'An Analysis of Public Attitudes Toward the Insanity Defence' (1986) 24(2) Criminology 393

Harper C, Davidson G, McClelland R, ‘No Longer ‘Anomalous, Confusing and Unjust’: The Mental Capacity Act (Northern Ireland) 2016’ (2016) International Journal of Mental Health and Capacity Law (22) 57

Harvey PD, and others, ‘Functional impairment in people with schizophrenia: focus on employability and eligibility for disability compensation’ (2012) Schizophr Res 2012 Sep;140(1-3):1

Hayry M, 'Prescribing Cannabis: Freedom, Autonomy, and Values' (2004) 30 Journal of Medical Ethics 333

Hilton C, 'Changes between the 1959 and 1983 Mental Health Acts (England & Wales), with Particular Reference to Consent to Treatment for Electroconvulsive Therapy' (2007) 18(2) History of Psychiatry 217

Hilton C, ‘Parity of esteem for mental and physical healthcare in England: a hundred years war?’ (2015) J R Soc Med 2015 Nov 25; 109(4):133

Howell A, 'Afghanistan's Price: By Downplaying PTSD, Our Government Makes Soldiers and Their Families Bear the Costs of War' The Literary Review of Canada (November 2011) vol 19 no 9 1

Lord Irving, 'The Spirit of Magna Carta Continues to Resonate in Modern Law' (2003) LQR 229

Ivbijaro G, 'Mental and Physical Health Parity: Not a Luxury but a Necessity' (2012) 9(4) Mental Health in Family Medicine 213

Keenan, J, ‘A concept analysis of autonomy’, Journal of Advanced Nursing, (1999), 29 (3)

Keller J, 'Relationality and Feminist Ethics' (1997) 12(2) Hypatia 152

Khosravi M, Azar G, Izadi R,’ Principles and elements of patient-centredness in mental health services: a thematic analysis of a systematic review of reviews’, (2024), BMJ Open Quality 2024; 13: e002719. doi:10.1136/ bmjoq-2023-002719 1 <https://pmc.ncbi.nlm.nih.gov/articles/PMC11227821/pdf/bmjoq-2023-002719.pdf> accessed 7 September 2025

Killaspy H, 'From the Asylum to Community Care: Learning from Experience' (2006) 79-80 British Medical Bulletin 249

Kmietowicz Z, ‘Rip Up Draft Mental Health Bill and Start Again, Says BMA’ (2005) 330 BMJ 326

Lawton-Smith S, Dawson J, Burns T, 'Community Treatment Orders Are Not a Good Thing' (2008) 193 BJP 96

Leung W-C, ‘Human Rights Act 1998 and Mental Health Legislation: Implications for the Management of Mentally Ill Patients’ (2002) 78 Postgrad Med J 178

Lepping P, ‘Ethical Analysis of the New Proposed Mental Health Legislation in England and Wales’ (2007) 2 Philosophy, Ethics, and Humanities in Medicine 1

Lieberman J, 'Solving the Mystery of Military Mental Health: A Call to Action' Psychiatric Times (18 December 2018)

Lushington SG, 'The Lunacy Act, 1890' (1890) 3 Cnty & Loc Gov't Mag 294

Lynch G, Taggart C, Campbell P, 'Mental Capacity Act (Northern Ireland) 2016' (2017) BJPsych Bulletin (2017) 41 353

Mackie PK, Thomas I, Bibbings J, 'Homeless Prevention: Reflecting on a Year of Pioneering Welsh Legislation in Practice' (2017) 11(1) European Journal of Homelessness

Macgregor A, Brown M, Stavert J, 'Are Mental Health Tribunals Operating in Accordance with International Human Rights Standards? A Systematic Review of the International Literature' (2019) 27 Health and Social Care in the Community e494

Majerus B, 'Making Sense of the "Chemical Revolution". Patients' Voices on the Introduction of Neuroleptics in the 1950s' (2016) 60(1) Medical History 54

Mallardi V, 'The Origin of Informed Consent' (2005) 25 Acta Otorhinolaryngol Ital 312

Matthews D, 'The Battle for the National Health Service: England, Wales, and the Socialist Vision', Monthly Review (2017) Mar 01 2017 <https://monthlyreview.org/2017/03/01/the-battle-for-the-national-health-service/> accessed 10 November 2024

Marshall M, 'Modernising Mental Health Services' (1999) 318 BMJ 3

McCallion M, O'Hare U, 'A new legislative framework for mental capacity and mental health legislation in Northern Ireland: an analysis of the current proposals' (2010) Journal of Mental Health Law 20:84

McCartney HB, 'The First World War Soldier and His Contemporary Image in Britain' (2014) 90(2) International Affairs 299

Millard C, Wessely S, 'Parity of Esteem Between Mental and Physical Health' (2014) BMJ 349

Miller BL, 'Science Denial and COVID Conspiracy Theories Potential Neurological Mechanisms and Possible Responses' (2020) JAMA 2020; 324(22):2255

Miller RA, 'Balancing Security and Liberty in Germany', (2010), Journal of National Security Law & Policy Vol 4:369 <http://jnslp.com/wp-content/uploads/2010/12/04_Miller_vol4no2.pdf> accessed 13 July 2014

Mitchell AJ, Hardy S, Shiers D, 'Parity of Esteem: Addressing the Inequalities Between Mental and Physical Healthcare' (2017) 23(3) BJPsych Advances 196

Moon DS, Evans T, ‘Welsh Devolution and the Problem of Legislative Competence’ (2017) 12(3) British Politics 335

Moran R, 'The Modern Foundation for the Insanity Defence: The Cases of James Hadfield (1800) and Daniel McNaughtan (1843)' (1985) 477 The Annals of the American Academy of Political and Social Science 32

O'Neill O, 'Paternalism and Partial Autonomy' (1984) 10(4) Journal of Medical Ethics 173

O’Neill O, 'The Inaugural Address: Autonomy: The Emperor's New Clothes' (2003) 77 Proceedings of the Aristotelian Society Supplementary Volumes 1

Oosterhuis H, Loughnan A, 'Madness and Crime: Historical Perspectives on Forensic Psychiatry' (2014) 37 International Journal of Law and Psychiatry 1 4

Oram S, and others, ‘Patterns of Use of the Mental Health Act 1983, from 2007-2008 to 2016-2017 in Two Major London Secondary Mental Healthcare Providers’ (2019) 5(6) British Journal of Psychiatry 3102

Owens J, Lovell K, Brown A, Bee P, ‘Parity of esteem and systems thinking: a theory informed qualitative inductive thematic analysis’ (2022) BMC Psychiatry (2022) 22:650

Page K, ‘The four principles: Can they be measured and do they predict ethical decision making?’ BMC Medical Ethics (2012) 13:10

Paris JJ, Elias-Jones AC, 'Do We Murder Mary to Save Jodie? An Ethical Analysis of the Separation of the Manchester Conjoined Twins' (2001) 77 Postgraduate Medical Journal 593

Pedersen R, Hofmann B, Mangset M, 'Patient Autonomy and Informed Consent in Clinical Work' (2007) 127 Nor Lægeforen 1644

Peppin JR, ‘Beliefs About Money in Families: Balancing Unity, Autonomy, and Gender Equality’ (2019) Journal of Marriage and Family 81 (April 2019)

Phull J, Bartlett P, ‘“Appropriate” Medical Treatment: What’s in a Word?’ (2012) 52 Medicine, Science and the Law 71

Pitkin HF, 'Are Freedom and Liberty Twins?' (1988) 16(4) Political Theory 523

Rapaport J, Manthorpe J, 'Fifty Years On: The Legacy of the Percy Report' (2009) 9(3) Journal of Social Work 251

Rawls J, 'Justice as Fairness' (1958) The Philosophical Review Vol 67 No 2 (Apr 1958) 164 <www.jstor.org/stable/2182612> accessed 14 June 2022

Rehse M, and others, 'Influence of Antipsychotic and Anticholinergic Loads on Cognitive Functions in Patients with Schizophrenia' (2016) Schizophrenia Research and Treatment Article ID 8213165

Richardson G, 'Mental Capacity in the Shadow of Suicide: What Can the Law Do?' (2013) 9(1) International Journal of Law in Context 87 105

Rivett G, 'Castles in the Air' Health Service Journal (20 October 2010)

Roberts JR, and others, '"It's a Postcode Lottery"; How do People Affected in Wales Experience Their Diagnosis and Post-Diagnostic Support, and How May These Be Improved?' (2024) Int J Environ Res Public Health 2024 21(6) 709

Rothmund T, Farkhari F, Ziemer C, Azevedo F, 'Psychological Underpinnings of Pandemic Denial—Patterns of Disagreement with Scientific Experts in the German Public during the COVID-19 Pandemic' (2022) 31(4) Public Understanding of Science 437

Röttgers HR, Lepping P, 'Treatment of the Mentally Ill in the Federal Republic of Germany' (1999) 23 Psychiatric Bulletin 601

Rossano MJ, 'The Essential Role of Ritual in the Transmission and Reinforcement of Social Norms' (2012) 138(3) Psychological Bulletin 529

Samuels A, 'The NHS Refuses Treatment' (2019) 87 Medico-Legal Journal 23

Samuel M, 'Mental Health Act Reform Ditched, King's Speech Confirms' Community Care (7 November 2023)

Scholten M, Gather J, 'Adverse Consequences of Article 12 of the UN Convention on the Rights of Persons with Disabilities for Persons with Mental Disabilities and an Alternative Way Forward' (2018) 44 Journal of Medical Ethics 226 233

Scott-Samuel A, and others, 'The Impact of Thatcherism on Health and Well-Being in Britain' (2014) 44 International Journal of Social Determinants of Health and Health Services 53

Shah A, The impact of the Community Care (Delayed Discharge) Act 2003 on the length of stay and bed occupancy in Old Age Psychiatry Units in England' (2007) Int J Geriatr Psychiatry 2007; 22: 1164

Shapland S, 'Scandal that Led to Hospital Closures' (Winter 2022) Community Living

Shen WW, 'A History of Antipsychotic Drug Development' (1999) 40(6) Comprehensive Psychiatry 407

Simpson A, Miller C, Bowers L, 'The History of the Care Programme Approach in England: Where Did It Go Wrong?' (2003) 12(5) Journal of Mental Health 489

Skeem JL, Louden JE, Evans J, 'Venirepersons's Attitudes Toward the Insanity Defense: Developing, Refining, and Validating a Scale' (2004) Law and Human Behavior 28(6) 623

Skowron P, 'The Relationship Between Autonomy and Adult Mental Capacity in the Law of England and Wales' (2018) 27 Medical Law Review 32

Skowron P, 'Giving Substance to "the Best Interpretation of Will and Preferences"' (2019) 62 International Journal of Law and Psychiatry 125

Strasburger LH, 'The Litigant-Patient: Mental Health Consequences of Civil Litigation' (1999) 27(2) Journal of the American Academy of Psychiatry and the Law 203

Stebbings C, An Effective Model of Institutional Taxation: Lunatic Asylums in Nineteenth-Century England (2011) Journal of Legal History 2011 April; 32(1): 31

Syrett K, 'Healthcare Resource Allocation in the English Courts: A Systems Theory Perspective' (2019) 70(1) Northern Ireland Legal Quarterly 115

Szawarski P, 'Classic cases revisited: The suicide of Kerrie Wooltorton' (2013) JICS Volume 14 Number 3 July 2013 211

Szmukler G, Daw R, Dawson J, 'A model law fusing incapacity and mental health legislation' (2010) Journal of Mental Health Law 20:9

Szmukler G, ‘The UN Convention on the Rights of Persons with Disabilities: “Rights, Will and Preferences” in Relation to Mental Health Disabilities’ (2017) 54 International Journal of Law and Psychiatry 90

Stanislawski K, ‘The Coping Circumplex Model: An Integrative Model of the Structure of Coping with Stress’, (2019), Frontiers in Psychology, 16 April 2019 <www.frontiersin.org/articles/10.3389/fpsyg.2019.00694/full> accessed 18 June 2022

Takabayashi A, 'Surviving the Lunacy Act of 1890: English Psychiatrists and Professional Development during the Early Twentieth Century' (2017) 61(2) Med Hist 246

Taylor L, ‘Covid-19: China Installs Fences and Alarms in Shanghai in Effort to Curb Cases’ (2022) 377 BMJ o1076

Taylor RS, 'Kantian Personal Autonomy' (2005) 33(5) Political Theory 602

Ten Have M, Nuyen J, Beekman A, de Graaf R, ‘Common Mental Disorder Severity and Its Association with Treatment Contact and Treatment Intensity for Mental Health Problems’ (2013) 43(10) Psychological Medicine 2203

Thagard P, ‘The Cognitive Science of COVID-19: Acceptance, Denial, and Belief Change’ (2021) 195 Methods 92

Thornicroft G, Szmukler G, ‘The Draft Mental Health Bill in England: Without Principles’ (2005) 29 Psychiatric Bulletin 244

Tobey RE, 'Advances in Medicine During Wars' Foreign Policy Research Institute (2018)

Twomey, M, ‘Why Worry about Autonomy?’ Ethics and Social Welfare (2015) Vol 9 No 3

Tyler TR, Blader SL, ‘Autonomous vs. comparative status: Must we be better than others to feel good about ourselves?’ (2002) Organizational Behavior and Human Decision Processes Vol 89 Iss 1 September 2002

Unsworth C, 'Mental Disorder and the Tutelary Relationship: From Pre- to Post-Carceral Legal Order' (1991) 18(2) Journal of Law and Society 254

Van Kleef GA, Gelfand MJ, Jolanda Jetten J, 'The Dynamic Nature of Social Norms: New Perspectives on Norm Development, Impact, Violation, and Enforcement' (2019) 84 Journal of Experimental Social Psychology 103814

Vatanabe IP, Manzine PR, Cominetti MR, 'Historic Concepts of Dementia and Alzheimer's Disease: From Ancient Times to the Present' (2020) 176 Revue Neurologique 140

Vos T, Global Burden of Disease Study 2016, 'Global, Regional, and National Incidence, Prevalence, and Years Lived with Disability for 328 Diseases and Injuries for 195 Countries, 1990–2016: A Systematic Analysis' (2017) 390 Lancet 1211

Walters S, Russell WB III, 'The World War II Era and Human Rights Education' (2012) 76(6) Social Education 301

Williams AR, Caplan, AL, 'Thomas Szasz: rebel with a questionable cause (2012) The Lancet Vol 380 Issue 985

Williams J, '1998 Human Rights Act: Social Work's New Benchmark' (2001) British Journal of Social Work (2001) 31 831

Williams J, 'A New Law on Adult Social Care: A Challenge for Law Reform in Wales' (2012) Statute Law Review 33(2) 304

Williams J, 'Social Work, Liberty and Law' (2004) British Journal of Social Work (2004) 34 37

Winter J, 'Shell-Shock and the Cultural History of the Great War' (Jan 2000) 35(1) Journal of Contemporary History 7

Wootton L, Fahy F, 'Dangerous Severe Personality Disorder: Beyond the Ethical Boundary of Psychiatry' (2007) 6 Psychiatry 52

Zielasek J, Gaebel W, 'Mental health law in Germany' (2015) BJPsych International Vol 12 Number 1 February 2015

Zigmond T, 'A New Mental Health Act for England and Wales' (2004) 10 Advances in Psychiatric Treatment 161

Newspapers and Online News Sources

Ables K, 'Now Seen as Barbaric, Lobotomies Won Him a Nobel Prize in 1949' Washington Post (9 October 2023)

Bakalar N, '1940: Electroshock Therapy' The New York Times (21 July 2024)

Batty D, 'Q&A: Dangerous and Severe Personality Disorder' The Guardian (London 17 April 2002)

Batty D, 'Opposition Calls for New Changes to Mental Health Bill' The Guardian (London 18 June 2007)

BBC News, 'Covid: Anti-Vax Campaigner Vandalised Vaccination Centres' (15 June 2022) <www.bbc.co.uk/news/uk-wales-61819325> accessed 16 June 2022.

BBC News, 'Covid: Arrests during Anti-Lockdown Protests in London' (20 March 2021) <www.bbc.co.uk/news/uk-56469687> accessed 25 May 2024

BBC News, 'Lisa Potts: Freedom of Wolverhampton Honour for Machete Heroine' (5 August 2024) <www.bbc.co.uk/news/uk-england-birmingham-60592123> accessed 5 August 2024

BBC News, Mental health patients 'let down' (2006) 19 July 2006 <http://news.bbc.co.uk/1/hi/wales/5193188.stm> accessed 22 September 2024

BBC News, 'Welsh NHS Pays £700k to Managers Who Lost Posts' (7 November 2011) <www.bbc.co.uk/news/uk-wales-15605671> accessed 11 August 2024

BBC News, 'Welsh referendum analysis: Wales 'united in clear vote'' (2011) <www.bbc.co.uk/news/uk-wales-12653025> accessed 13 October 2024

BBC Wales Referendum, 'The 1979 Referendums' <www.bbc.co.uk/news/special/politics97/devolution/wales/briefing/79referendums.shtml> accessed 11 August 2024

Berry K, 'Acute inpatient wards: Time to implement psychological therapies' (2021) Policy@Manchester <https://blog.policy.manchester.ac.uk/posts/2021/06/acute-inpatient-wards-time-to-implement-psychological-therapies/> accessed 24 August 2025

Betteley C, ‘Delayed transfer of care ‘putting lives at risk’’ (2024) 31st July 2024, Cambrian News

Bowcott O, 'Jayne Zito: Why It’s Time to End Campaign' The Observer (London, 17 May 2009)

Boyle F, ‘Briefing / Introduction to the NHS payment scheme’ (2024) Healthcare Financial Management Association <www.hfma.org.uk/publications/introduction-nhs-payment-scheme> accessed 7 August 2025

Brindley M, Health Correspondent (September 10 2002 Tuesday) ‘MENTAL HEALTH GROUPS OPPOSE DRAFT BILL; NHS: CRITICS OF OVERHAUL FEAR TREATMENTS WILL BE IMPOSED ON PATIENTS WITH CAPACITY TO CHOOSE FOR THEMSELVES’ Western Mail. <https://advance.lexis.com/api/document?collection=news&id=urn:contentItem:46ST-YY80-015B-331Y-00000-00&context=1519360> accessed 9 November 2024

Brivati B, 'Every Loser Wins' The Guardian (4 April 2005)

Busby M, and others, 'Dozens of Arrests as Thousands March in London against Covid Lockdown' The Guardian (20 March 2021)

Cabinet Office, ‘Section 141 of the Mental Health Act to Be Abolished’ (Press Release, 2011) <www.gov.uk/government/news/section-141-of-the-mental-health-act-to-be-abolished> accessed 14 June 2022

Cahill H, ‘Zero Tolerance: Shanghai Dystopian Covid Lockdown Drives Investors Away’ The Telegraph (London 24 April 2022)

Carey B, 'Dr Thomas Szasz, Psychiatrist Who Led Movement Against His Field Dies at 92' The New York Times (New York 11 September 2012)

Crown Prosecution Service, ‘“Coronavirus Coughs” at Key Workers Will Be Charged as Assault, CPS Warns’ (2020) <www.cps.gov.uk/cps/news/coronavirus-coughs-key-workers-will-be-charged-assault-cps-warns> accessed 13 June 2022

Crown Prosecution Service, ‘CPS Review Findings for First Year of Coronavirus Prosecutions’ (2021) <www.cps.gov.uk/cps/news/cps-review-findings-first-year-coronavirus-prosecutions> accessed 13 June 2022

Crown Prosecution Service, ‘6,500 coronavirus-related prosecutions in first six months of pandemic’ (2021) <www.cps.gov.uk/cps/news/6500-coronavirus-related-prosecutions-first-six-months-pandemic> accessed 6 August 2025

Curtice J, 'What British People Think About Brexit Now' BBC News (28 July 2019) <www.bbc.co.uk/news/uk-45520517> accessed 28 July 2019

Davies A, ‘Dangerous Offenders Scheme to Be Axed’ Channel 4 News (London, 15 February 2010) <www.channel4.com/news/dangerous-offenders-scheme-to-be-axed> accessed 5 August 2024

Deans D, ‘Wales’ Labour first minister says she’ll call out Starmer’ (2025) BBC Wales News 6 May 2025 <www.bbc.co.uk/news/articles/cy9v7gn9729o> accessed 7 July 2025

Drakeford M, 'Why the Ely Inquiry Changed Healthcare Forever' (WalesOnline 6 February 2012) <www.walesonline.co.uk/news/health/ely-inquiry-changed-healthcare-forever-2041200> accessed 20 July 2024

Expert Witness, ‘CPS review findings for first year of coronavirus prosecutions’ (2021) <www.expertwitness.co.uk/articles/news/cps-review-findings-for-first-year-of-coronavirus-prosecutions> May 14 2021 accessed 6 August 2025

Farmer P, 'Demonising the Mentally Ill’ The Guardian (1 July 2002)

Griffith H, ‘New health boards to control NHS’ BBC News (1 October 2009) <http://news.bbc.co.uk/1/hi/wales/8283265.stm> accessed 26 October 2024

Haslett E, 'Timeline: All the Lockdown Breaches by Politicians and Government Employees So Far' New Statesman (8 December 2021) <www.newstatesman.com/science-tech/coronavirus/2021/12/timeline-all-the-lockdown-breaches-by-politicians-and-government-employees-so-far> accessed 26 May 2024

Home Office, ‘New Rules Restricting the Use of Police Cells as Places of Safety Come into Effect’ (Press release, 11 December 2017) <www.gov.uk/government/news/new-rules-restricting-the-use-of-police-cells-as-places-of-safety-come-into-effect> accessed 11 August 2024

ITV News, '"Arrogant" Anti-Vaxxer Jailed for Smashing Windows of Two Vaccine Centres' (16 June 2022) <www.itv.com/news/wales/2022-06-16/arrogant-anti-vaxxer-jailed-for-smashing-vaccine-centre-windows> accessed 16 June 2022

Jones J, 'Care in the Community: Ben Silcock's Mauling by a Lion at London Zoo has Highlighted the Plight of the Mentally Ill' The Independent (10 January 1993)

Kale S, 'The Russell Murders: Is Michael Stone in Prison for a Brutal Crime He Didn't Commit?' The Guardian (London, 22 November 2023)

Lister J, 'When Margaret Thatcher Privatised Social Care' The Tribune (10 December 2020) <https://tribunemag.co.uk/2020/12/when-margaret-thatcher-privatised-social-care> accessed 5 August 2024

Lewis A, Beck A, Clark A, 'Psychological Therapies Review in North Wales' (2019) <https://bcuhb.nhs.wales/news/updates-and-developments/updates/archived-updates/psychological-therapies-review-in-north-wales/psychological-therapies-review/bcuhb-psychological-therapies-review/> accessed 5 January 2022

Loader G, 'Betsi Cadwaladr spends £1m a month on mental health treatment' (2024) BBC Wales News online <www.bbc.co.uk/news/uk-wales-68934000> accessed 6 May 2024

Macdonald V, "'It's like torture' – Patient with autism fears for his safety in mental health units" Channel 4 News 8 Nov 2023 <www.channel4.com/news/its-like-torture-patient-with-autism-fears-for-his-safety-in-mental-health-units> accessed 4 November 2024

Martin A-C, 'People Detained Under the Mental Health Act Dying at Three Times the Rate of Those Held in Prisons' The Independent (23 April 2024)

Masters A, 'First Minister accused of 'refusing to acknowledge a crisis in NHS'' (2025) ITVNews 21 January 2025 <www.itv.com/news/wales/2025-01-21/first-minister-accused-of-refusing-to-acknowledge-crisis-in-nhs> accessed 7 July 2025

Matthews A, 'Man Still in Jail 20 Years After Laptop Robbery' BBC News (5 August 2024) <www.bbc.co.uk/news/articles/c1e5154j4z0o#:~:text=A%20prisoner%20who%20has%20served,(IPP)%20sentence%20in%202005> accessed 5 August 2024

McShane M, ‘Parity of Esteem’ (2013) NHS England <www.england.nhs.uk/blog/parity-of-esteem> accessed 24 August 2025

Millward D, 'Currie "Was Right" on Salmonella' The Telegraph (26 December 2001)

Murray J, ‘Ministers to “Slow Down” Mental Health Changes After Vlado Calocane Report’ The Guardian (13 August 2024)

Murray J, ‘Nottingham Attacks: Series of Errors Led to Valdo Calocane Being Discharged, Review Finds’ The Guardian (13 August 2024)

Palmer M, ‘Welsh Government: Three Health Boards Under Increased Scrutiny’, BBC News (23 January 2024) <www.bbc.co.uk/news/uk-wales-68074515#:~:text=This%20means%20Betsi%20Cadwaladr%20University,in%20targeted%20intervention%20for%20performance> accessed 11 August 2024

Palmer M, Deans D, ‘Not priority to devolve probation says UK Minister’ (2025) BBC Wales News <www.bbc.co.uk/news/articles/c86gd41z39yo> accessed 31 August 2025

Parry RL, ‘Shanghai Lockdown: US Warns Citizens of Arbitrary Covid Detention in China’ Sunday Times (London 10 April 2022)

Pring J, '“Deep Concern” Over Funding for National Plan to Limit Mental Health Policing', Disability News Service (2023) <www.disabilitynewsservice.com/deep-concern-over-funding-for-national-plan-to-limit-mental-health-policing/> accessed 27 May 2024

Rawnsley A, ‘Brave new world: the search for peace after the second world war’ The Guardian, Sun 1 Sep 2019

Samuel M, ‘NHS Trusts have fined councils up to £280,000 for delayed discharges’ (2017) Community Care <www.communitycare.co.uk/2017/10/13/nhs-fined-councils-280000-delayed-discharges/> accessed 7 August 2025

Scott J, ‘Boris Johnson and Rishi Sunak Reject Calls to Resign over Lockdown Fines’ BBC News (London, 13 April 2022) <www.bbc.co.uk/news/uk-politics-61083402> accessed 2 May 2022

Senedd Wales, ‘Assembly Member’s First Clear Route to Better Mental Health Provision in Wales’ (2010) <https://prep.senedd.wales/senedd-now/news/assembly-

member-s-first-clear-route-to-better-mental-health-provision-in-wales/> accessed 26 August 2024

Sharma M, 'World War 1 and the Beginning of Modern Psychiatry in India' Times of India (21 September 2014)

Sharman J, 'Bed-blocking up by 52 per cent in three years, NHS figures show' (2017) The Independent Saturday 10 June 2017

Stadlen A, 'Thomas Szasz Obituary' The Guardian (Manchester 4 October 2012)

Sweeney S, 'Lest We Forget: The 306 "Cowards" We Executed in the First World War' The Guardian (14 November 1999)

Taylor H, 'Police Break Up Good Friday Church Service over Apparent Covid Rule Breaches' The Guardian (London 3 April 2021)

Taylor M, 'We cannot continue to neglect mental health funding' (2022) NHS Confederation <www.nhsconfed.org/articles/we-cannot-continue-neglect-mental-health-funding> accessed 24 August 2025

The Guardian, 'Protest against 'draconian' mental health bill' (2002) Wed 23 Oct 2002

The King's Fund, 'NHS waiting times: how are different service waiting times linked?' (2024) <www.kingsfund.org.uk/insight-and-analysis/data-and-charts/patient-waiting-times> accessed 17 August 2025

Thomas R, Cobham T, 'Infected Blood Inquiry: Politicians and Doctors Complicit in Cover-up Leading to Thousands of Deaths' The Independent (21 May 2024)

Thompson G, 'Welsh Labour could slump to historic low in 2026 Senedd elections, poll finds (2025) Independent 6 May 2025 <www.independent.co.uk/news/uk/home-news/plaid-cymru-welsh-government-senedd-welsh-labour-b2745861.html> accessed 7 July 2025

WalesOnline, 'Is Hart Really the Most Stylish?' (30 November 2005) <www.walesonline.co.uk/news/wales-news/hart-really-most-stylish-2370227> accessed 18 August 2024

WalesOnline, 'Stigma Warning over Single Mental Health Trust' (2008) <www.walesonline.co.uk/news/wales-news/stigma-warning-over-single-mental-2160110> accessed 26 August 2024

Wallace M, 'Ben's Life Outside the Lions' Den' (1993) The Times Dec 31 1993 16

Web-based Resources

Abreu L, The UN Convention on the Rights of Persons with Disabilities: UK Implementation (House of Commons Library Research Briefing, 2022) CBP07367 <https://researchbriefings.files.parliament.uk/documents/CBP-7367/CBP-7367.pdf> accessed 1 September 2024

Alexander C, 'The Shock of War' Smithsonian Magazine (September 2020) <www.smithsonianmag.com/history/the-shock-of-war-55376701/> accessed 20 September 2020

Argent V, 'Counter-Revolutionary Panic and the Treatment of the Insane: 1800' (1978) <http://studymore.org.uk/1800.htm> accessed 14 October 2018

Audit Wales, 'Postcode lottery for new 'front door' to adult social services' (2019) <www.audit.wales/news/postcode-lottery-new-front-door-adult-social-care-services> accessed 10 November 2024

Bailey S, Thorpe L, Smith G, 'Whole-person care: from rhetoric to reality: Achieving parity between mental and physical health' (2013) Royal College of Psychiatrists (Occasional Paper OP88) <www.ucl.ac.uk/core-study/sites/core-study/files/lester.pdf> accessed 1 August 2025

Baker C, Gheera M, 'Achieving "Parity of Esteem"' House of Commons Library (2020) <https://commonslibrary.parliament.uk/insights/mental-health-achieving-parity-of-esteem/> accessed 1 August 2020

Bank of England, 'Inflation Calculator' <www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator> accessed 14 October 2018

BBC, 'Human Rights: The European Convention' (2000) <http://news.bbc.co.uk/1/hi/uk/948143.stm> accessed 3 August 2014

Beard J, 'Sentences of Imprisonment for Public Protection' House of Commons Library Research Briefing (2023) 6086 <https://researchbriefings.files.parliament.uk/documents/SN06086/SN06086.pdf> accessed 24 April 2023

Bevan Commission, 'A Prudent Approach to Health: Prudent Healthcare Principles' (2015) <www.bevancommission.org/sitesplus/documents/1101/Final%20Prudent%20Health%20Principles.pdf> accessed 1 November 2015

Bethlem Royal Hospital, 'European Journeys: Asylums' <https://museumofthemind.org.uk/projects/european-journeys/asylums/bethlem-royal-hospital> accessed 14 October 2018

Blundell, D, 'Habeas Corpus' Westlaw Insight <http://login.westlaw.co.uk/maf/wluk/app/document?&srguid=i0ad69f8e000001479c1a66e4282a8da6&docguid=IC2A83CE0206811E39061D5F52664A015&hitguid=IC2A83CE0206811E39061D5F52664A015&rank=1&spos=1&epos=1&td=6&crumb-action=append&context=58&resolvein=true> accessed 29 June 2014

Bowel Cancer UK, 'State of the Nations: Patients Continue to See Increasing Delays in Diagnosis' (2021) <www.bowelcanceruk.org.uk/news-and-blogs/research-blog/state-of-the-nations-patients-continue-to-see-increasing-delays-in-diagnosis/> accessed 10 January 2022

Bowers P, House of Commons Library, Referendum in Wales (2011) SN/PC/05897 <https://researchbriefings.files.parliament.uk/documents/SN05897/SN05897.pdf> accessed 26 August 2024

British Library, 'Habeus Corpus Act (1679)' <www.bl.uk/learning/timeline/item104236.html> accessed 25 August 2019.

British Library, Minutes of Committee for Abolition of Slavery (1776) <www.bl.uk/onlinegallery/takingliberties/staritems/66minutesofcommitteeabolition.html> accessed 3 August 2014

BMA, 'Beyond Parity of Esteem – Achieving Parity of Resource, Access and Outcome for Mental Health in England' (2020) <www.bma.org.uk/media/2099/mental-health-parity-of-esteem-report-jan-2020-2.pdf> accessed 1 August 2020

British National Formulary 2024 <https://bnf.nice.org.uk/> accessed 21 July 2024

'British Soldier Harry Farr Executed for Cowardice' History.com (20 September 2019) <www.history.com/this-day-in-history/british-soldier-henry-farr-executed-for-cowardice> accessed 20 September 2020

Brown M, ‘Timing is Everything’ MentalHealthCop (4 November 2017) <https://mentalhealthcop.wordpress.com/2017/11/04/timing-is-everything/> accessed 11 August 2024

Cancer Research UK, ‘Your Urgent Referral Explained’ (2015) <https://clinical-pathways.org.uk/sites/default/files/leaflet/2WW%20Urgent%20Referral%20%28wallet%20sized%29.pdf> accessed 11 January 2022

Cavallaro F, and others, ‘Why are delayed discharges from hospital increasing? Seeing the bigger picture’ The Health Foundation (2003) <www.health.org.uk/publications/long-reads/why-are-delayed-discharges-from-hospital-increasing-seeing-the-bigger> accessed 28 September 2024

Centers for Disease Control and Prevention, ‘Motorcycle Safety’ (2022) <www.cdc.gov/transportationsafety/mc/index.html> accessed 29 January 2023

Centre for Mental Health, ‘Parity of Esteem’ (2021) <www.centreformentalhealth.org.uk/parity-esteem> accessed 2 May 2022 and 15 June 2025

Clements L, The Social Services & Well-being (Wales) Act 2014: An Overview (2022) <www.lukeclements.co.uk/wp-content/uploads/2022/02/Wales-SS-Well-being-Act-34-2022.pdf> accessed 22 January 2023

Collins English Dictionary, ‘Autonomy’ (HarperCollins) <www.collinsdictionary.com/dictionary/english/autonomy> accessed 4 November 2024

Cornell Law School Legal Information Institute, 'Comity' <www.law.cornell.edu/wex/comity> accessed 24 July 2019

Dinnerstein RD, "Implementing Legal Capacity Under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road From Guardianship to Supported Decision-Making" Human Rights Brief 19 no 2 (2012): 8 <https://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1816&context=hrbrief> accessed 28 August 2023

East London NHS Foundation Trust, 'Guidance Note of Voting Rights for People in Mental Health Units' (2019) <www.elft.nhs.uk/sites/default/files/2022-01/voting_rights_guidance.pdf> accessed 26 May 2024

Encyclopaedia Britannica, 'Statue of Liberty' (2019) <www.britannica.com/topic/Statue-of-Liberty> accessed 24 July 2019

Encyclopaedia Britannica, 'Libertas' (2008) <www.britannica.com/topic/Libertas-Roman-religion> accessed 24 July 2019

Equality and Human Rights Commission, 'The Human Rights Act' <www.equalityhumanrights.com/human-rights/human-rights-act#:~:text=The%20Human%20Rights%20Act%201998,the%20UK%20in%20October%202000> accessed 4 November 2024

Future Care Capital, 'Outsourcing mental health services is proving costly for the NHS' (2024) <https://futurecarecapital.org.uk/latest/outsourcing-nhs-mental-health-services-proving-costly/#:~:text=Beds%20often%20bought%20at%20short%20notice%2C%20increasing%20cost&text=The%20average%20cost%20of%20a,%C2%A314mn%20in%202022%2D23> accessed 7 May 2024

'Gains and Losses for Women after WWII' Striking Women (13 July 2024) <www.striking-women.org/module/women-and-work/post-world-war-ii-1946-1970> accessed 13 July 2024

General Medical Council, 'Legal Annex' <www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life/legal-annex> accessed 25 August 2019

General Medical Council, 'Prescribing Unlicensed Medications' (2020) <www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices/prescribing-unlicensed-medicines> accessed 5 January 2020

Gov.uk, 'Apply to the Mental Health Tribunal' <www.gov.uk/mental-health-tribunal> accessed 13 June 2022

Gov.UK, 'Detentions under the Mental Health Act' 16 August 2024 year to March 2023 <www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest/#main-facts-and-figures> accessed 4 November 2024

Greater Manchester Combined Authority, Census 2021 Briefing Total Population (2023) <www.greatermanchester-ca.gov.uk/media/7869/230514_population_final.pdf> accessed 26 August 2024

Greenburg D, 'Bill of Rights 1688' Westlaw Insight (2014) <http://login.westlaw.co.uk/maf/wluk/app/document?&srguid=i0ad8289e000001479ce47647715dca10&docguid=ID290B4503F9211E2824AEFB7D8791C65&hitguid=ID290B4503F9211E2824AEFB7D8791C65&rank=1&spos=1&epos=1&td=1&crumb-action=append&context=7&resolvein=true> accessed 3 August 2014

Gwent Safeguarding, 'The Liberty Protection Safeguards (LPS) explained' <www.gwentsafeguarding.org.uk/en/safeguarding-adults/deprivation-of-liberty-safeguards/the-liberty-protection-safeguards-explained> accessed 10 November 2024

Harvie C, 'Basket Case' <http://ww1centenary.oucs.ox.ac.uk/?p=3364> accessed 1 October 2018

Hilton C, '90 years ago: the Mental Treatment Act 1930 by Dr Claire Hilton' (2020) Royal College of Psychiatrists 9 September 2020 <www.rcpsych.ac.uk/news-and-features/blogs/detail/history-archives-and-library-blog/2020/09/09/90-years-ago-the-mental-treatment-act-1930-by-dr-claire-hilton> accessed 23 November 2024

History of Parliament – Williams Wynn MP <www.historyofparliamentonline.org/volume/1790-1820/member/williams-wynn-charles-watkin-1775-1850> accessed 2 August 2020

House of Commons Library, 'Coronavirus: The Lockdown Laws' (Research Briefing, 2021) <https://commonslibrary.parliament.uk/research-briefings/cbp-8875/> accessed 13 June 2022

Hunter DJ, 'Griffiths and community care: meeting the challenge' (1988) Kings Fund Institute London <https://archive.kingsfund.org.uk/concern/published_works/000002255?locale=es#?cv=9&xywh=-50,146,886,506> accessed 28 July 2024

Imperial War Museum, 'How Winston Churchill and the Conservative Party Lost The 1945 Election' <www.iwm.org.uk/history/how-winston-churchill-and-the-conservative-party-lost-the-1945-election> accessed 13 July 2024

Institute for Government, 'Timeline of UK Government Coronavirus Lockdowns and Restrictions' (2022) <www.instituteforgovernment.org.uk/sites/default/files/2022-12/timeline-coronavirus-lockdown-december-2021.pdf> accessed 25 May 2024

International Slavery Museum, 'European Traders' <www.liverpoolmuseums.org.uk/ism/slavery/europe/index.aspx> accessed 3 August 2014

'It's Broken. Doctors' Experiences on the Frontline of a Failing Mental Healthcare System' (BMA, 2024) <www.bma.org.uk/media/ddclsiii/bma-mental-health-report-2024-web-final.pdf> accessed 27 May 2024

Jones M, The Laws of Hywel Dda Harleian MS 4353 (V) with Emendations from Cleopatra A XIV (W) ca 1285 <www.maryjones.us/ctexts/laws_hywel_dda.html> accessed 12 October 2024

King Jr ML, 'Letter from a Birmingham Jail', 16 April 1963, African Studies Center – University of Pennsylvania <www.africa.upenn.edu/Articles_Gen/Letter_Birmingham.html> accessed 4 November 2024

King's College London, 'Professor Sir Simon Wessely' <www.kcl.ac.uk/people/professor-sir-simon-wessely> accessed 29 January 2023

Kings Fund, 'Has the government put mental health on an equal footing with physical health?' (2015) <www.kingsfund.org.uk/projects/verdict/has-government-put-mental-health-equal-footing-physical-health> accessed 2 May 2022

Lawton-Smith S, 'Mental Health Act 2007 Briefing' (The King's Fund 2008) <https://assets.kingsfund.org.uk/f/256914/x/6c4339a9f2/mental_health_act_2007.pdf > accessed 11 August 2024

LexisNexis, 'Duty of Care and Breach in Clinical Negligence Claims' <https://www.lexisnexis.com/uk/lexispsl/personalinjury/document/393875/564V-Y6M1-F18H-M2T8-00000-00?utm_source=psl_da_mkt&utm_medium=referral&utm_campaign=duty-of-care-and-breach-in-clinical-negligence-claims> accessed 31 January 202

Local Government Association, 'Managing Transfers of Care – Frequently asked questions' (2017) <www.local.gov.uk/sites/default/files/documents/2017-11-

27%20Delayed%20transfer%20of%20care%20data%20and%20what%20it%20all%20means%20%28Final%29.pdf> accessed 7 August 2025

'Lord Howe of Aberavon' (2024) UK Parliament MPs and Lords <https://members.parliament.uk/member/872/career> accessed 21 July 2024

Lowe D, 'Internment' (2014) <https://researchonline.ljmu.ac.uk/id/eprint/498/3/Internment.pdf> accessed 12 October 2024

Marston H, 'A Brief History of Psychiatric Drug Development' (2013) British Association for Psychopharmacology <www.bap.org.uk/articles/a-brief-history-of-psychiatric-drug-development/> accessed 14 July 2024

'Mental Health' (National Archives 2018) <www.nationalarchives.gov.uk/help-with-your-research/research-guides/mental-health/> accessed 7 October 2018

'Mental Health Law' (Middle Temple Library Blog 2 August 2020) <https://middletemplelibrary.wordpress.com/tag/mental-health-law/> accessed 2 August 2020

MentalHealthWales, 'Hart rejects all Wales mental health organization' (2008) <https://mentalhealthwales.net/2008/10/hart-rejects-all-wales-mental-health-organisation/> accessed 26 August 2024

MentalHealthWales, '"Finishing line in sight" for Jonathan Morgan's mental health LCO' (2009) <https://mentalhealthwales.net/2009/12/finishing-line-in-sight-for-jonathan-morgans-mental-health-lco/> accessed 7 April 2024

Mind, 'Hundreds of people in Wales wait more than a year for help with their mental health' (2021) <www.mind.org.uk/news-campaigns/news/hundreds-of-people-in-wales-wait-more-than-a-year-for-help-with-their-mental-health/> accessed 22 September 2024

Monaghan S, 'The State of Communicable Disease Law' (The Nuffield Trust, London 2002) <www.nuffieldtrust.org.uk/files/2017-01/state-of-communicable-disease-law-web-final.pdf> accessed 24 July 2019

National Archives, Ministry of Health: Mental Health Act 1959 General Policy, Registered Files (95,200 Series) Ref MH 140 <https://discovery.nationalarchives.gov.uk/details/r/C10978> accessed 14 July 2024

'Neurosurgery for Mental Disorder' Mind <www.mind.org.uk/information-support/drugs-and-treatments/neurosurgery-for-mental-disorder-nmd/> accessed 14 July 2024

NHS, 'Causes – Lung Cancer' <www.nhs.uk/conditions/lung-cancer/causes/> accessed 28 August 2023

NHS, 'Causes – Schizophrenia' (2019) <www.nhs.uk/mental-health/conditions/schizophrenia/causes/> accessed 18 June 2022

NHS, 'How to Access Mental Health Services' (2019) <www.nhs.uk/mental-health/nhs-voluntary-charity-services/nhs-services/how-to-access-mental-health-services/> accessed 11 January 2022

NHS Inform, 'Schizophrenia, Treatment' (2023) <www.nhsinform.scot/illnesses-and-conditions/mental-health/schizophrenia#treatment> accessed 7 May 2024

NHS Wales, 'About Us' <www.wales.nhs.uk/nhswalesaboutus> accessed 30 January 2022

NHS Wales, 'General Practice in Wales' <https://primarycareone.nhs.wales/careers/primary-care-roles-in-wales/general-practice-in-wales/general-practice/gms-contract/> accessed 10 January 2022

NHS Wales, Standard Primary Care Contract <www.wales.nhs.uk/sites3/Documents/480/Standard_Contract_2006.pdf> accessed 10 January 2022

NHS Wales, 'Structure' <www.wales.nhs.uk/nhswalesaboutus/structure> accessed 10 January 2022

Nuffield Trust, '1968-1977: Rethinking the National Health Service' (2024) <www.nuffieldtrust.org.uk/chapter/1968-1977-rethinking-the-national-health-service-1> accessed 20 July 2024

Office for Health Improvement & Disparities, 'Premature mortality in adults with severe mental illness (SMI)' 2023 <www.gov.uk/government/publications/premature-

mortality-in-adults-with-severe-mental-illness/premature-mortality-in-adults-with-severe-mental-illness-smi#introduction> accessed 24 August 2025

Office for National Statistics, 'Population and Household Estimates, Wales: Census 2021' <www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/populationandhouseholdestimateswales/census2021#:~:text=2.-,Population%20growth%20of%20Wales%20between%202011%20and%202021,through%20a%20census%20in%20Wales> accessed 26 August 2024

O'Loughlin A, 'Hidden Agendas: The Complicated Criteria Behind the Detainment of Offenders with Severe Personality Disorders' (2019) <www.york.ac.uk/research/themes/dspd/> accessed 16 June 2022

Open University, 'Timeline of Learning Disability History' (31 August 2020) <www.open.ac.uk/health-and-social-care/research/shld/timeline-learning-disability-history> accessed 31 August 2020

Osmond J, 'Making the "Red Water" Really Clear' Institute for Welsh Affairs (21 June 2010) <www.clickonwales.org/2010/07/making-the-%E2%80%98red-water%E2%80%99-really-clear/> accessed 21 June 2015

Parliamentary Office of Science and Technology, Reform of Mental Health Legislation (Postnote October 2003 Number 204) <www.parliament.uk/globalassets/documents/post/pn204.pdf> accessed 8 August 2024

Pies R, Pierre J, 'Believing in Conspiracy Theories is Not Delusional' (2021) Medscape <www.medscape.com/viewarticle/945290?reg=1> accessed 13 June 2022

Pennsylvania Psychiatric Institute, 'The Power of Early Intervention in Mental Health: A Pathway to Wellness and Recovery' <https://ppimhs.org/newspost/the-power-of-early-intervention-in-mental-health-a-pathway-to-wellness-and-recovery/> accessed 22 September 2024

Pomerleau WP, 'Western Theories of Justice' Internet Encyclopaedia of Philosophy <https://iep.utm.edu/justwest/> accessed 14 June 2022

Psychology Today, 'Delusional Disorder' (2022) <www.psychologytoday.com/us/conditions/delusional-disorder> accessed 13 June 2022

Rethink Mental Illness, 'Briefing: Early Intervention in Psychosis (EIP') <www.rethink.org/campaigns-and-policy/campaign-with-us/resources-and-reports/briefing-early-intervention-in-psychosis-eip/#:~:text=Reduced%20suicide%20rates%20%E2%80%93%20EIP%20services,on%20supporting%20people's%20physical%20health> accessed 22 September 2024

Rethink Mental Illness, 'Community Treatment Orders (CTOs)' <www.rethink.org/advice-and-information/rights-restrictions/mental-health-laws/community-treatment-orders-ctos-made-under-the-mental-health-act-1983/> accessed 8 August 2024

Roberts A, 'Mental Health History Words' <http://studymore.org.uk/mhhglo.htm> accessed 7 October 2018

Royal College of Psychiatrists, 'Hidden waits force more than three quarters of mental health patients to seek help from emergency services' (2022) <www.rcpsych.ac.uk/news-and-features/latest-news/detail/2022/10/10/hidden-waits-force-more-than-three-quarters-of-mental-health-patients-to-seek-help-from-emergency-services> accessed 22 September 2024

Royal College of Psychiatrists, 'The Convention on the Rights of Persons with Disabilities (CRPD): Implications for Psychiatrists and Mental Health Law' <www.rcpsych.ac.uk/docs/default-source/about-us/who-we-are/schr-convention-on-the-rights-of-persons-with-disabilities-q-and-a.pdf?sfvrsn=c8d1db87_2> accessed 1 September 2024

Royal College of Psychiatrists, 'Whole-person care: from rhetoric to reality. Achieving parity between mental and physical health' (2013) Occasional paper OP88 <www.drugsandalcohol.ie/19579/1/RCP_Occasional_paper_88.pdf> accessed 2 May 2022

Royal College of Nursing, 'Parity of Esteem' <www.rcn.org.uk/clinical-topics/Mental-Health/Parity-of-esteem> accessed 14 July 2024

Ryland H, Bunn S, ‘Reforming the Mental Health Act – Approaches to Improve Patient Choice’ POSTnote 695 UK Parliament 11 May 2023 <https://researchbriefings.files.parliament.uk/documents/POST-PN-0695/POST-PN-0695.pdf> accessed 3 November 2024

Salem O, ‘A Question of Justice: Exploring How the Civil Justice System Responds to Mental Health and Learning Disabilities’ (2021) <www.centreformentalhealth.org.uk/blogs/question-justice-exploring-how-civil-justice-system-responds-mental-health-and-learning-disabilities> accessed 21 August 2023

Salford City Council, ‘Commissioning Mental Health Services’ <www.salford.gov.uk/health-and-social-care/strategies-and-policies/integrated-commissioning/commissioning-mental-health-services/> accessed 26 August 2024

'Science Museum, Medicine in the Aftermath of War' (25 May 2024) <www.sciencemuseum.org.uk/objects-and-stories/medicine/medicine-aftermath-war> accessed 25 May 2024

'Scotland’s Unsustainable Health Service' Our Scottish Future (2023) <https://ourscottishfuture.org/wp-content/uploads/2023/12/Scotlands-Unsustainable-Health-Service.pdf> accessed 14 July 2024

Senedd Cymru, ‘Devolution 20 – are we a healthier nation (2019 – updated 2021)’ Senedd Research <https://research.senedd.wales/research-articles/devolution-20-are-we-a-healthier-nation/> accessed 2 May 2022

Senedd Cymru, ‘History of Devolution’ (7 October 2020) <https://senedd.wales/how-we-work/history-of-devolution/> accessed 11 August 2024

Senedd Research, ‘The UK Parliament and Law-Making in Wales’ (2024) <https://research.senedd.wales/research-articles/the-uk-parliament-and-law-making-in-wales/> accessed 26 August 2024

South London and Maudsley NHS Foundation Trust, 'About Us: Art and History' <www.slam.nhs.uk/about-us/who-we-are/art-and-history/our-history> accessed 14 October 2018

Stanford Encyclopedia of Philosophy, 'Paternalism' (2020) <https://plato.stanford.edu/entries/paternalism/> accessed 25 May 2024

Singh A, Webber F, 'Excluding Migrants from Justice: The Legal Aid Cuts' IRR Briefing Paper No 7 (Institute of Race Relations 2010) <www.bl.uk/britishlibrary/~/media/bl/global/social-welfare/pdfs/non-secure/e/x/c/excluding-migrants-from-justice-the-legal-aid-cuts.pdf> accessed 28 July 2019

The Electoral Commission, 'Voter Engagement Among Black and Minority Ethnic Communities' (2002)

The Health Foundation, 'Griffiths Report on Management in the NHS' (28 July 2024) <https://navigator.health.org.uk/theme/griffiths-report-management-nhs> accessed 28 July 2024

'The King's Fund, "Is There 'Parity of Esteem' Between Mental and Physical Health? Big Election Questions"' (2017) <www.kingsfund.org.uk/publications/articles/big-election-questions-parity-mental-physical-health> accessed 2 August 2020

The King's Fund, 'The Changing Role of Managers in the NHS' (28 July 2024) <www.kingsfund.org.uk/insight-and-analysis/articles/changing-role-managers-nhs> accessed 28 July 2024

The National Archives, National Assembly for Wales Acts, <www.legislation.gov.uk/anaw>

The National Archives, National Assembly for Wales Measures, <www.legislation.gov.uk/mwa>

'The Royal College of Psychiatrists, "Our History"' <www.rcpsych.ac.uk/about-us/exploring-our-history/our-history/the-rmpa> accessed 26 May 2024

'Through the Decades: A Deep Dive Through 75 Years of NHS History' Royal College of Psychiatrists (14 July 2024) <www.rcpsych.ac.uk/news-and-features/blogs/detail/history-archives-and-library-blog/2023/07/05/through-the-decades-a-deep-dive-into-nhs-history> accessed 14 July 2024

Tees, Est and Wear Valleys NHS Foundation Trust, 'Delayed Transfers of Care in the Non-Acute and Mental Health Sectors Protocol' (2020) <www.tewv.nhs.uk/wp-content/uploads/2021/11/Delayed-Transfers-of-Care-in-the-Non-Acute-and-Mental-Health-Sectors-Protocol.pdf> accessed 17 August 2025

UNESCO, ‘Statue of Liberty’ <https://whc.unesco.org/en/list/307> accessed 3 November 2024

UK Government, ‘Devolution Settlement: Wales’ <www.gov.uk/guidance/devolution-settlement-wales> accessed 26 August 2024

UK Parliament, 'General Election 2019: Turnout' Insight (7 January 2020) <https://commonslibrary.parliament.uk/general-election-2019-turnout/> accessed 26 May 2024

UK Parliament, '1942 Beveridge Report' (13 May 2024) <www.parliament.uk/about/living-heritage/transformingsociety/livinglearning/coll-9-health1/coll-9-health/> accessed 13 May 2024

United Nations Human Rights Office of the High Commissioner, ‘International Bill of Human Rights’ <www.ohchr.org/en/what-are-human-rights/international-bill-human-rights> accessed 14 July 2024

University of Wales Trinity Saint David, 'Geiriadur, search term “freedom”' (2019) <http://geiriadur.uwtsd.ac.uk/index.php?page=ateb&uni=y&prefLang=&term=rhyddid&direction=we&whichpart=exact&type=noun> accessed 23 July 2019

United Nations Treaty Collection, 'Status of Treaties: Chapter IV Human Rights' <https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&clang=_en> accessed 21 January 2024

'US Department of State Archive. The Atlantic Conference & Charter, 1941' <https://2001-2009.state.gov/r/pa/ho/time/wwii/86559.htm> accessed 13 July 2024

Velasquez M, and others, ‘Justice and Fairness’ (2014) Markkula Center for Applied Ethics <www.scu.edu/ethics/ethics-resources/ethical-decision-making/justice-and-fairness/> accessed 14 June 2022

Vickers L, ‘An English Duty to Have ‘Due Regard’ – An Effective Means of Upholding Children’s Rights?’ (2016) (OxHRH Blog 1 November 2016) <https://ohrh.law.ox.ac.uk/an-english-duty-to-have-due-regard-an-effective-means-of-upholding-childrens-rights/> accessed 29 August 2022

Welsh Government, 'Citizen Voice Body for Health and Social Care' <https://gov.wales/citizen-voice-body-health-and-social-care/what-we-do> accessed 30 January 2022

Welsh Government, 'Government of Wales Act 2006' (2021) Law Wales <https://law.gov.wales/constitution-and-government/constitution-and-devolution/government-wales-act-2006> accessed 11 August 2024

Wales Mental Health in Primary Care Network, The Welsh Declaration for Mental Health and Well-being (2007) <www.wamhinpc.org.uk/sites/default/files/5_%20Declaration%20-%20English%20Edition.pdf> accessed 26 August 2024

Stangor C, Walinga J, 'Introduction to Psychology – 1st Canadian Edition' (2014) Victoria BC: BC campus <https://opentextbc.ca/introductiontopsychology/> accessed 18th June 2022

Welch C, 'Universal Declaration of Human Rights: Why Does It Matter?' (2015) <www.buffalo.edu/ubnow/stories/2015/12/qa_welch_udhr.html> accessed 26 August 2019

Welsh Government, Wales Coronavirus guidance <https://gov.wales/coronavirus> accessed 2 May 2022

Weston T, 'The UK Economy in the 1980s' (UK Parliament House of Lords Library 29 May 2024) <https://lordslibrary.parliament.uk/the-uk-economy-in-the-1980s/> accessed 29 May 2024

'What You Need To Know About Rationing In The Second World War' Imperial War Museum (13 July 2024) <www.iwm.org.uk/history/what-you-need-to-know-about-rationing-in-the-second-world-war> accessed 13 July 2024

World Health Organisation, 'Schizophrenia: Key Facts' (2022) <www.who.int/news-room/fact-sheets/detail/schizophrenia> accessed 18 June 2022

World Health Organisation, 'Social Media & COVID-19: A Global Study of Digital Crisis Interaction among Gen Z and Millennials' (2021) <www.who.int/news-room/feature-stories/detail/social-media-covid-19-a-global-study-of-digital-crisis-interaction-among-gen-z-and-millennials> accessed 16 June 2022

Speeches, Dissertations, Theses, and Conference Papers

Ajoku C, 'The Insanity Defense, Public Anger, and the Potential Impact on Attributions of Responsibility and Punishment' (2015) PhD Submission to The City University of New York <https://academicworks.cuny.edu/cgi/viewcontent.cgi?article=1844&context=gc_etds> accessed 16 November 2024

Bagnoli C, 'Practical Necessity and Agential Autonomy' (Northwestern Ethics Conference 31 March 2009) <www.philosophy.northwestern.edu/community/nustep/09/papers/Bagnoli.pdf> accessed 29 February 2019

Bartlett P, 'The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England with special Emphasis on Leicestershire and Rutland' (1993) PhD Theses <http://discovery.ucl.ac.uk/1317954/1/307853.pdf> accessed 14 October 2018

Lady Brenda Hale, 'Psychiatry and the law: An enduring interest for Lord Rodger' The Lord Rodger Memorial Lecture 2014 <www.supremecourt.uk/docs/speech-141031.pdf> accessed 10 November 2024

The Rt Hon Norman Lamb, Minister for Care Services, 'Achieving parity of esteem between mental and physical health' Speech of 19 June 2013 <www.gov.uk/government/speeches/achieving-parity-of-esteem-between-mental-and-physical-health> accessed 29 August 2022

Mr Justice MacDonald, 'Do Children have a Right to Mental Health?' Annual lecture of the Wales Observatory on Human Rights of Children and Young People at the College of Law and Criminology Swansea University (2017) <www.swansea.ac.uk/media/2017-Observatory-Annual-Lecture-MR-JUSTICE-MACDONALD.pdf> accessed 14 January 2018

Morgan R, 'Clear Red Water Speech to the National Centre for Public Policy' (Swansea University 2002) <https://sochealth.co.uk/the-socialist-health-association/sha-country-and-branch-organisation/sha-wales/clear-red-water/> accessed 13 July 2024

Piffaretti E, Thomas A, ‘Getting the Measure of Mental Health’ (Public Law Conference paper 4 April 2012) <https://publiclawproject.org.uk/resources/getting-the-measure-of-mental-health/> accessed 28 August 2024

Powell JE, 'Address to the National Association of Mental Health Annual Conference' (9 March 1961) <www.nuffieldtrust.org.uk/sites/default/files/2019-11/nhs-history-book/58-67/powell-s-water-tower-speech.html> accessed 21 July 2024

Szmukler G, (2010), ‘How mental health legislation discriminates unfairly against people with mental illness’ speech to Gresham College Mon 15 Nov 2010 <www.gresham.ac.uk/watch-now/how-mental-health-law-discriminates-unfairly-against-people-mental-illness> accessed 15 June 2025

Thomas AH, 'Promoting Long Term Autonomy through Recovery – Is Short-Term Paternalism Justified If It Promotes an Increase in Autonomy in the Longer Term?' (2007) Dissertation submitted to Keele University