

**THE BAMFORD REVIEW OF MENTAL HEALTH AND
LEARNING DISABILITY (NORTHERN IRELAND)**

**HUMAN RIGHTS AND EQUALITY
OF OPPORTUNITY**

CONSULTATION REPORT

April 2006

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FOREWORD

Respect for human rights and promotion of equality of opportunity: these values underpin the work of the entire Bamford Review of Mental Health and Learning Disability (NI) – not only in the way in which we have conducted the exercise, but also in the underlying vision we have for the future strategic development of services in Northern Ireland for people with a mental health problem or learning disability.

The Review's Human Rights and Equality Group has been central to our work: with responsibility for examining the human rights and equality issues affecting people with a mental health problem or a learning disability; and in providing overarching principles and guidelines for our deliberations.

I thank Christine Eames and her Group for their detailed examination of these issues and for their informed support for colleagues within the Review.

I commend their report to you.

Roy J McClelland (Professor)
Chairman

April 2006

PREFACE

It was with great regret that the Human Rights and Equality Group learned of the death of Professor David Bamford in January. His commitment to the principles underpinning the work of the Group made our understanding of our task within the Review more clearly focused. From the outset of the Review, David was determined that standards required by Human Rights and Equality legislation should be central to the project. He understood very clearly that such principles are not an optional extra, but a requirement of present legislation as well as a signpost to future development. This was a reflection of his own belief in the dignity of each individual and the need for society to reflect this in its care for a person when he or she may be at their most vulnerable.

Thus a Sub Group was formed with the specific task of considering these issues. Membership comprised a wide diversity of people, with a considerable range of experience and expertise. Inevitably this shaped the nature of our discussions and enriched their outcomes. We did not always reach agreement, but we learned to view the issues under discussion through a much wider lens than we might previously have done.

Early in our proceedings we identified topics to be addressed. We agreed that members with relevant knowledge would present papers for discussion and that the outcome of these deliberations on which there was general agreement would form the substantive report. The discussion papers themselves would also be offered for wider readership.

We are conscious that during our work, other groups within the Review, often with whom we shared common issues, were also involved in their own tasks. We were grateful to share, where appropriate, in their work and we acknowledge the impact this work has and will have on our own recommendations. For example, we were grateful to attend the seminars conducted for the Legal Issues Committee by Professor Michael Gunn. We, in turn, offered a seminar on Advocacy to the wider Review.

This report now goes out for wider consultation, which we believe is a very important part of our remit. We look forward to considering the comments received from those who will read the report from the standpoint of their own experience.

The report would not have been completed without the hard work, skill and unfailing support given by Roy Keenan and Sean Ferrin. The Group records its deep appreciation and gratitude to both.

Finally, on my own behalf, I would like to thank all the Group members for their commitment to our task and for their willingness to see the issues both with experience and afresh. It is my hope that the report reflects our belief in underpinning principles for the way forward in the provision of services as envisaged by the mandate of the Review.

Lady Christine Eames

Sub Group Chair

ABBREVIATIONS

Throughout the report a number of abbreviations are used. These are:

ASW	-	Approved Social Worker
CAMHS	-	Child and Adolescent Mental Health Service
Children Order	-	The Children (NI) Order 1995
DDA	-	The Disability Discrimination Act 1995
DHSSPS	-	The Department of Health, Social Services and Public Safety
ECHR or the Convention	-	The European Convention on Human Rights
Equality Commission	-	The Equality Commission for Northern Ireland
European Court	-	The European Court of Human Rights
EU	-	The European Union
MHO or the Mental Health Order	-	The Mental Health (NI) Order 1986
NI	-	Northern Ireland
NICCY	-	Northern Ireland Commissioner for Children and Young People
Section 75	-	Section 75 of the Northern Ireland Act 1998
The Review	-	The Review of Mental Health and Learning Disability (NI)
UK	-	The United Kingdom
UN	-	The United Nations
UNCRC	-	The United Nations Convention on the Rights of the Child 1989
USA		The United States of America

CHAPTER 1

INTRODUCTION

THE REVIEW

1. In October 2002, the Department of Health, Social Services and Public Safety (DHSSPS) commissioned an independent Review of law, policy and practice relating to mental health and learning disability. One of the main factors influencing this decision was to ensure that this law, policy and practice was in accordance with human rights and equality law.

HUMAN RIGHTS AND EQUALITY SUB GROUP

2. The Human Rights and Equality Sub Group, whose membership is at Annex 1, is part of the wider Social Justice and Citizenship Expert Working Committee within the Review. The Sub Group's remit was to:
 - consider relevant legislative and other requirements, particularly relating to human rights, discrimination and equality, in relation to people with a mental health need and/or a learning disability; and
 - bring forward a set of principles, proposals and recommendations.
3. In addition, the Group played a key role within the wider Review, by formulating a set of overarching human rights and equality guidelines against which each Working Committee could test their discussions and recommendations.
4. To fulfil its remit, the Group initially agreed a work plan comprising a number of topics raising potential human rights and equality of opportunity questions in relation to the assessment, care and treatment of people with a mental health problem or a

learning disability. The plan took account of the comments made by a wide range of statutory, voluntary, community and other stakeholders, who responded in the Autumn of 2002 to Professor Bamford's request for initial submissions to the Review on the strengths and weaknesses of current legislation, policy and service delivery for people with a mental health problem or a learning disability.

5. Papers on most of these topics were provided by members for discussion and agreement. On the other issues identified, the Group contributed through the reports being prepared by relevant Working Committees.
6. Members of the Group also attended a Mental Health Tribunal hearing and have liaised with the Experts by Experience, Equal Lives and Carers' Reference Groups within the Review, whose contributions through their own experience of services have been invaluable.

STRUCTURE OF REPORT

7. The Group considered it was essential that the papers which informed its discussions were available in full in its report. Members were also conscious that some of the issues are complex and their essence needed to be distilled into short, concise papers. These short chapters comprise the body of the report and contain, for example, the key human rights and equality issues and any recommendations on the subjects considered. The discussion papers are included in the Annexes.

CONTEXT OF REPORT

8. It is important also to point out that the Sub Group's work was essentially to examine the human rights and equality issues arising (or potentially arising) from the operation of current legislation, mainly the Mental Health (NI) Order 1986. Many of the report's recommendations reflect this, but they also signify how a future legislative framework could address these issues. In this way, this report, therefore, foreshadows a substantial revision of legislation which will be proposed in the separate report from

the Review's Legal Issues Committee, which will be issued for consultation in the near future.

9. Similarly, many of the issues discussed by the Group overlap with and have implications for the Review's Promoting Social Inclusion report, which again will be issued for separate consultation in the near future. Examples of such issues are equality of access to education and employment opportunities.

ACCESSIBLE FORMATS

10. Accessible versions of this report, including a young person's accessible version, have also been produced. These can be obtained from the Review's Support Team, Annexe 6, Castle Buildings, BT4 3PP (Tel No 9052 3470) and are posted on the Review's website at www.rmhdni.gov.uk. Requests for copies in braille, audio cassette, Irish and Chinese (Mandarin) should also be sent to the Support Team at this address.

TERMINOLOGY

11. The report concerns people with a mental health problem or a learning disability, or both; and for convenience we use the phrases:
 - "mental health difficulties or a learning disability";
 - "a mental health problem or a learning disability"; or
 - "mental ill-health or a learning disability"

as broad, generic terms, interchangeably throughout the document, unless the issue under consideration relates specifically to people with a mental health problem or to people with a learning disability.

CHAPTER 2

LAW, STANDARDS, POLICY AND PRACTICE

LAW AND STANDARDS

1. The main sources of human rights and equality law and standards are:
 - the Human Rights Act 1998 (which made the European Convention on Human Rights (ECHR) enforceable in Northern Ireland courts);
 - equality legislation in place in Northern Ireland, including the Disability Discrimination Act 1995, Section 75 of the Northern Ireland Act 1998 and the Disability (NI) Order 2006;
 - the United Nations Declaration on the Rights of Disabled Persons;
 - the United Nations Declaration on the Rights of Mentally Retarded Persons 1971;
 - the United Nations Convention on the Rights of the Child (UNCRC) 1989;
 - the Mental Health Care Principles;
 - the European Social Charter; and
 - the International Covenant on Social, Economic and Cultural Rights.

CHILDREN AND YOUNG PEOPLE

2. Children are a particularly important and vulnerable group. Services and treatment to children and young people in both mental health and learning disability settings should be compliant with international standards (including the UNCRC) and ensure

that they enjoy the same rights and opportunities as other children.

3. It is also important to stress that the onset of severe mental illness often occurs in early adolescence, often transforming the lives of young people previously fully engaged in education, leisure and other social and cultural activities.

GUIDELINES

4. At the outset, informed by the Review's Strategic Vision, which emphasises, for example, non-discrimination, equality, justice and fairness, partnership with service users and carers, reciprocity and respect for autonomy, the Group drafted a set of overarching and more specific human rights and equality guidelines. These aimed to inform the conduct of **all** the Review's Expert Working Committees and their Sub Groups, and set the context for their work.
5. These guidelines highlighted the following:
 - The Review recognises that everyone has human rights and must be valued for his or her self-worth. States and international organisations have a duty to uphold and protect these rights.
 - Given that people live in social settings, the human rights of any individual have to be considered in the context of relevant and often competing rights.
 - Human rights, including the rights of people with a mental health problem or a learning disability, should not be arbitrarily diminished.
 - There are circumstances, however, when it may be appropriate to curtail a person's human rights, but this should be limited to the minimum extent necessary, and a person whose rights have been curtailed should be entitled to appropriate care and treatment (reciprocity of rights).
 - Adequate resources must be put in place to assist recovery.

- Those who deliver health and social care must uphold these human rights and equality duties in performing their functions. Ultimately, law and decision-makers, including members of this Review, have to strike the appropriate balance in relation to the relevant rights and interests.
- However, rights of themselves are of little use unless people enjoy the protection offered by human rights in their daily lives. It is important that people know about their rights and, where these appear to have been breached, are able to enforce them.
- To enable people with a mental health problem or a learning disability to exercise the same rights as others, additional support, information and training may be required to maximise understanding and participation.
- Ensuring equality of opportunity can also mean making structural changes, tackling discrimination and addressing the assumptions and attitudes of others about mental health or learning disability.
- People with a mental health problem or a learning disability should also enjoy the implementation of their right to education, as appropriate.
- Putting human rights and equality principles at the centre of law, policy and delivery of services for people with a mental health problem or a learning disability is a legislative imperative because of international and domestic law.
- However, these principles also need to be taken into account in professional codes of conduct and practice.

RESOURCES

6. Putting these principles into practice in the day-to-day delivery of services is not, therefore, an optional extra: and to do so may require additional resources.

7. The Sub Group recognises that expenditure on mental health and learning disability services in Northern Ireland compares poorly with other parts of the United Kingdom. Too often, these services are the "poor relations" in comparison with other programmes of care.
8. It is essential that resources are distributed equitably among Health and Social Services Boards and Trusts and that they are spent in the correct way. The Group acknowledges the continuing work of the Department of Health, Social Services and Public Safety on its Capitation Formula, by which the available resources are allocated among the four Boards. The Formula is also used by the Boards to inform the subsequent deployment of their resources to local areas.
9. The Group also acknowledges the Department's more recent introduction of a Strategic Resource Framework. This provides an analysis of the way in which the Boards plan to spend the resources available to them at the start of each year. It also enables the Department and the Boards to track resource deployment by locality. In this way it can influence the funding available to local areas and ensure that they are receiving (or will receive) a fair share.
10. Compliance with human rights and equality obligations is an integral part of the reform and modernisation of services for people with a mental health problem or a learning disability. To achieve this, additional resources must be made available, and must be distributed and spent in an equitable way.

CHAPTER 3

ACCESS TO RIGHTS

BARRIERS TO EXERCISING RIGHTS

1. People with mental health difficulties or learning disability experience a range of barriers which prevent them from exercising their rights, including:
 - assumptions made about their capacity;
 - lack of knowledge and/or support to exercise rights;
 - unequal access to services and opportunities in employment, education, transport, and access to and participation in the justice system; and
 - stigma and prejudice.

Assumptions about Capacity

2. Assumptions are often made by others about the capacity of people with mental health difficulties or a learning disability to participate in or contribute to the life of their community, or to make decisions. These assumptions are often due to ignorance and prejudice, arising from a lack of information and understanding about mental health or learning disability.

Lack of Knowledge about Rights and Support to Exercise Rights

3. Historically, people with mental health difficulties or learning disability have been viewed as individuals in need of care and protection rather than individuals with rights. Traditionally, this care has been provided in institutions which isolated and separated those involved from the life of their local community. More recently there has been a shift towards recognising that many of the difficulties experienced by people with disabilities arise from the structures and systems of society rather than in the person.

4. Most people with a learning disability need extra support to understand and to exercise their rights. The fact that information about rights is not produced in a range of formats that are accessible causes particular difficulties for them.

Unequal Access to Services and Opportunities

5. People with mental health difficulties or learning disability do not have access to the same range of services and opportunities as other people in Northern Ireland. (These issues are explored in the Review's forthcoming report on Promoting Social Inclusion). This is due, largely, to the failure of mainstream services to take into account their specific and distinctive needs when planning or delivering services. The introduction of anti-discrimination legislation, including the Disability Discrimination Act 1995 and the positive, pro-active obligation placed on public authorities to promote equality of opportunity through Section 75 of the Northern Ireland Act 1998, has gone some way to address the exclusion and disadvantage that people with mental health difficulties or learning disability experience.

Stigma and Prejudice

6. Ignorance, stigma and fear around mental health and learning disability can result in discrimination and lead some to erroneously believe that people with a mental health difficulty or learning disability do not have the same rights as others in society. Prejudice and ignorance can also mean that the participation of people with a mental health difficulty or learning disability is not sought or welcomed, and their contributions not adequately recognised or valued. Stigma may also inhibit people with mental health difficulties and learning disability from becoming included, and add to their isolation and exclusion.

Carers

7. The absence of services to support people with mental health difficulties and learning disability can add to the stress and anxiety experienced by carers. It can also result in

carers not having the same opportunities as others in their community to work, to rest and access services in their own right.

RECOMMENDATIONS

- 1. The Government, the Commissioners for Human Rights, Children and Equality should actively promote and provide information about rights to people with mental health difficulties or learning disability.**

- 2. Public, voluntary and independent sector staff, including front line staff and policy makers, should receive training on human rights and equality issues in relation to people with a mental health problem or learning disability. This requirement should be reflected in contractual arrangements.**

CHAPTER 4

THE RIGHT TO VOTE, TO FOUND A FAMILY AND TO LIFE

CHANGING PERCEPTIONS AND NEEDS

1. Over the last 20 years or so, there has been a shift away from perceiving people with disabilities as the recipients of care, protection and treatment, towards recognising them as individuals who have rights, but who may not fully enjoy these rights.
2. Linked to this has been an increasing emphasis on acknowledging the inherent value of disabled people, of empowering them, maximising their autonomy and self-determination and tackling the barriers that stop them enjoying the same rights as others.
3. There has also been a growing recognition that some groups of disabled people - such as children, women, older people and people from different ethnic backgrounds - experience particular difficulties.
4. The interdependence of civil, political, economic, social and cultural rights is particularly relevant for disabled people, since many will rely on additional supports to exercise their rights.

EXERCISING RIGHTS

5. Because a person has a mental health difficulty or a learning disability does not of itself mean that he or she is not capable of exercising his or her rights. The issues in each instance are whether:
 - the individual has the competence to understand the nature and purpose of the activity or decision in question; and
 - systemic barriers exist which prevent the individual from taking advantage of the rights they are afforded.

6. The Sub Group concentrated on these issues in relation to three particular rights:
 - entitlement to vote;
 - marriage, sexual relations and the right to found a family; and
 - the right to life.

ENTITLEMENT TO VOTE

Eligibility to Vote

7. Eligibility to vote in elections in Northern Ireland is restricted by criteria relating to age, citizenship and residency. To vote, a person must also be listed on the relevant Northern Ireland register of electors for a particular election.

Common Law

8. There are no references to people with mental health difficulties or learning disability in current electoral law. The only reference is in common law, which uses outdated terminology and states that "idiots" cannot vote and that "lunatics" can only vote in lucid intervals.
9. The Electoral Commission, which is responsible for encouraging public confidence and participation in the electoral process, recognises that the terms "idiots" and "lunatics" are "anachronistic" and "give no guidance to the Electoral Registration Officer".
10. The Commission adds, however, that common law incapacity cannot be disregarded and that it would be wrong to register a person if there were grounds to believe that he or she lacked the capacity to vote because of mental incapacity.
11. The guidance produced by the Commission states that the general assumption should be to register people with mental health difficulties or learning disability.

12. The Commission goes on to suggest that a person who is registered as an elector or entered in the list of proxies, cannot be refused a ballot paper or be excluded from voting on the grounds of mental incapacity.

Legal Incapacity to Vote

13. There are two factors which determine whether a person with a mental health difficulty or learning disability can vote:
 - whether he or she has a legal capacity to vote; and
 - whether he or she has a place of residence for voting purposes.
14. Legal incapacity to vote has been defined as “some quality inherent in a person which...either at common law or by statute deprives him of the status of a Parliamentary elector”.
15. If a person with a mental health difficulty is in hospital on an informal basis or is subject to guardianship, that fact in itself does not place him or her under a legal incapacity to vote. His or her competency is still a question of fact.

Place of Residence

16. Previously the legislation distinguished between detained and voluntary patients in hospital. In addition, detained patients were not able to treat the hospital where they were detained as their place of residence for the purposes of electoral registration, and whether they could register as resident at a place outside the hospital was a question of fact to be determined by the electoral officer.
17. A person who had been detained, therefore, for more than six months was likely to experience difficulties in registering as resident at their former address.
18. The Representation of the People Act 2000 enacted provisions which are designed to enable persons in psychiatric hospitals to register to vote whether they are detained or

voluntary patients (unless they are detained as a result of criminal activity in which case they are disfranchised).

19. Under the Act, a mental hospital is defined as meaning any establishment maintained wholly or partly for the reception or treatment of persons suffering from any form of mental disorder as defined by the Mental Health (NI) Order 1986.
20. A new concept introduced by the 2000 Act is the “declaration of local connection”. This enables patients in a hospital to register by treating them as resident at the address which they have declared, which may be an address where they would be living if they were not a patient, or an address in the UK where they have lived at any time.

The Electoral Fraud Act (NI) 2002

21. Research carried out by the Electoral Commission into the first year of operation of the Electoral Fraud (NI) Act 2002, highlighted concerns about the impact of the new registration process on people with a learning disability.
22. Provision had been made in the legislation for the registration form to be completed and signed by another person on behalf of the individual wishing to register. The person completing the form was asked to state the reason why the person wishing to register had not signed it. Where learning disability or mental health was given as the reason, a letter was sent from the Electoral Office, which is responsible for the management of elections in Northern Ireland, asking the person to confirm that the individual wishing to register had the mental capacity to vote.
23. The Electoral Commission concluded that "the individual registration process may have inadvertently impacted on people with learning disabilities, thus effectively disenfranchising hundreds of people who in the past may have voted".

Accessibility of Electoral Process

24. For many people with a learning disability the electoral rules and legislation are not the only barriers to taking part in the electoral process. Difficulties in getting to and gaining access to polling stations, the absence of information provided in a range of accessible formats, as well as the assumptions made by others about their capacity or interest in voting has militated against people with a learning disability exercising their right to vote.

MARRIAGE

Capacity to Enter into a Marriage

25. In considering whether a marriage is invalid on the ground that one of the parties was suffering from a mental disorder at the time it was entered into, the test to be applied is whether he or she is capable of understanding the nature of the contract of marriage.
26. To understand the contract of marriage, a person must be capable of appreciating that it involves the duties and responsibilities normally attaching to marriage. Only a broad understanding of the nature of marriage is necessary. A mere understanding of the promise exchanged is not sufficient if the nature of the contract is not understood. The presumption is in favour of marriage and the burden of proof is on the party attempting to show lack of consent.
27. The right of a person with a mental disorder to marry - even if detained under the mental health legislation - is the same as that of any other person. The person must understand the nature and purpose of the marriage contract, must be capable of giving consent and must not be under duress.

Voidance of a Marriage by Reason of Mental Disorder

28. Under the Matrimonial Causes (NI) Order 1978, a marriage is voidable if at the time of marriage either party, although capable of giving valid consent, was suffering (whether continuously or intermittently) from mental disorder within the meaning of the Mental Health (NI) Order 1986, of such a kind or an extent as to be unfitted for marriage. In order to succeed, a petitioner must establish mental disorder which rendered the person incapable of living in a married state and of carrying out the duties and obligations of marriage.

The Right to Found a Family

29. Article 12 of the ECHR guarantees to men and women of marriageable age the right to marry and to found a family. The European Commission on Human Rights has considered two cases which raise the question of how far the rights guaranteed by Article 12 can apply to prisoners. The Commission's opinion was that the right to marry was in essence a right to form a legally binding association between a man and a woman and that this right could not be denied on the grounds that, as one of the partners was detained, the couple would not be able to live together.
30. The Government, in enacting the Marriage Act 1983, considered that these principles applied also to persons with a mental illness detained for substantial periods. Prior to the 1983 Act, detained persons did not have ready access to authorised places of marriage. The marriage of a detained person can be solemnised at the place where that person usually resides. A further liberalisation has been effected by the Marriage Act 1994.

Sexual Relations

31. While the law enables persons with a mental illness to be married provided they understand the marriage contract, it is silent as to whether married couples have a right to have a private place for sexual intercourse while detained in hospital, although

such a right may be claimed under Articles 12 or 8 of the ECHR. The term “founding a family” in Article 12 has not been interpreted as referring to the consummation of marriage or having children.

32. Article 8 provides persons with the right to respect for their private and family life. This also applies to sexual life. The Department of Health advises that “given there is probably nothing in law to prevent a marriage from taking place, the hospital then has to consider whether facilities should be made available for consummation of the marriage, a matter raising questions about human rights. The decision whether to allow unsupervised visits should be based upon the following criteria:
- any risk one spouse may present to the other;
 - overall security within the hospital;
 - the social consequences of making available to certain patients privileges not available to others; and
 - the availability of suitable facilities."
33. Current mental health legislation does place limits on the capacity of certain groups to engage in sexual activity. Whilst the aim of the legislation is to protect people with mental disorder from exploitation and abuse, it can also interfere with the freedom of some people with a mental disorder from developing relationships, engaging in sexual activity and marrying.

RIGHT TO LIFE

34. The decision to impose or withdraw medical care or treatment raises complex ethical, legal and moral issues. Recent medical advances mean that many people of all ages are able to survive because of medical intervention and treatment. Doctors and other health care professionals are required to take into account the effects that a treatment might have on a person's "quality of life", even though the treatment itself might prolong an individual's life.

35. This already difficult decision is made more complicated in cases where a person has a severe or profound learning disability and where a person may be unable to express an opinion or make a decision.
36. A report by Mencap about the health care experiences of people with a learning disability drew attention to research which stated that "people with a learning disability were more likely to die before the age of 50 and that life expectancy is shortest for people who have the most support needs".

RECOMMENDATIONS

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| <ol style="list-style-type: none">3. The continued use of common law in current electoral practice should be reviewed.4. New capacity legislation should be based on the presumption of an individual's capacity to make a decision and place responsibility on those challenging or questioning capacity to provide evidence of incapacity. |
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CHAPTER 5

EDUCATION RIGHTS

1. The right to education is a fundamental right under the UNCRC and ECHR, as incorporated by the Human Rights Act 1998. A detailed analysis of this right and the associated jurisprudence is at Annex 4.
2. The Review emphasises the importance of recognising the right of every child and young person to have access to a practical and effective education. It is of fundamental importance to any analysis of human rights and equality issues and should be explicitly reflected and recognised in any new legislative framework.
3. A practical and effective education includes:
 - the need for a fully accessible curriculum and examinations or qualifications process;
 - Government policy or funding priorities not disadvantaging children or young people with a mental health problem or a learning disability by, for example, prioritising academic or vocational courses for funding student support, or by setting timescales for completion of certain qualifications; and
 - some redress to recognise the fact that children and young people with severe learning difficulties only received the right to education in 1986, which means that most adults with a learning disability did not enjoy the same rights as others in the community. [This is also a social inclusion issue, which will be picked up in the Review's separate report on Promoting Social Inclusion.]
4. Careful attention must be paid to the educational provision for any child or young person who is deprived of liberty, as this engages the child's rights under Article 5 of the ECHR. The right to education in this context extends beyond school leaving age and applies to all children and young people. The definition of education is broad, but provision should be detailed carefully in care/treatment plans and reviews.

5. Children and young people with a mental health difficulty or a learning disability have the right to an effective and practical education without discrimination under Protocol 1, Article 2 and Article 14 of the ECHR, as incorporated by the Human Rights Act 1998. These rights should be read in conjunction with those provided specifically for children and young people by Articles 2, 3, 12, 23, 28, 29 and 42 of the UNCRC.
6. The inappropriate placing of children and young people in adult hospital wards is a serious human rights and equality issue. In relation to the education rights of such inappropriately placed children and young people, the Review believes that these have been particularly adversely affected.
7. Article 14 of the ECHR, in conjunction with Protocol 1, Article 2 ECHR and Article 2 of the UNCRC require educational provision for children with a mental health problem or a learning disability to be provided on a non-discriminatory basis. It should promote equality. This is re-enforced by the new provisions introduced by the Special Educational Needs and Disability (NI) Order 2005.

RECOMMENDATION

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| <ol style="list-style-type: none">5. The right of every child and young person with a mental health problem or a learning disability to education should be explicitly recognised and reflected in any new legislative framework. |
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CHAPTER 6

CAPACITY, INCAPACITY AND HUMAN RIGHTS

1. This chapter deals with the law in relation to capacity in Northern Ireland governing:
 - (a) the management of patients' property and affairs; and
 - (b) medical treatment and welfare provision.

LAW GOVERNING THE MANAGEMENT OF PATIENTS' PROPERTY AND AFFAIRS

2. While there is a legal presumption of capacity, two categories of persons are considered to lack capacity for legal purposes (and are regarded as persons under a disability):
 - children; and
 - adults without capacity e.g. "patients" i.e. persons, who by reason of mental disorder (as defined in Part VIII of the Mental Health Order) are incapable of managing or administering their property and affairs, which includes engaging in the legal process.

Persons Without Capacity and Representation in Court

3. The Official Solicitor to the Supreme Court of Northern Ireland looks after the interests of and represents certain "persons under a disability" as defined by the legislation. Generally speaking, "persons under a disability" must engage in the legal process by bringing proceedings by a next friend, or defending proceedings against them by a Guardian ad Litem.

4. The Official Solicitor only acts as next friend or Guardian ad Litem of last resort in that such intervention only occurs if there is no one else suitable, willing or able to act.

LAW GOVERNING MEDICAL TREATMENT AND WELFARE PROVISION

5. Article 69 of the Mental Health Order enables non-consensual treatment of detained patients, subject to Article 62 (2). Special protection operates in relation to certain forms of treatment:

(a) surgical operations which destroy brain tissue or the functioning of brain tissue (and operations for the surgical implantation of hormones for the purpose of reducing the male sex drive), which require a patient's consent except in cases of urgent treatment.

(b) electro-convulsive therapy (ECT) and the administration of medicine by any means once three months has elapsed from the first time the patient was given medicine for his or her mental disorder, which require either consent (from a person certified as capable of consenting) or a second opinion.

THE ISSUES

6. One of the main issues in mental health law is the question of capacity, which in this context relates to a person's ability to understand, to make decisions and to manage his or her affairs. It is closely related to mental disorder, including mental illness and learning disability.

7. Assumptions made about the capacity or incapacity of an individual can impact on people with a mental health difficulty or learning disability and interfere in their right to make decisions in all aspects of their lives. This can include

making decisions about, for example, what to do during the day, opening a bank account, entering into personal relationships, getting married or voting (as discussed in Chapter 4).

8. This fundamental aspect of a person's "human rights" is known as autonomy. Formal or informal perceptions of incapacity can result in the removal of autonomy. Consequently the issue of capacity is central to a person's human rights.
9. From a human rights perspective, it does not inevitably follow that a person, including a child or a young person under 18, lacks capacity simply because he or she has some form of mental disorder. Moreover the position is complicated by the fact that a definition of "capacity" can vary according to the nature of the decision in question. Also, it should be remembered that a person's mental capacity will not necessarily remain static - this is known as intermittent capacity.
10. Under the ECHR, Articles 5, 8 and 11 provide protection for a person's autonomy. Article 5 protects against arbitrary detention; Article 8 protects a person's private life, including his or her physical or mental integrity; and Article 10 enshrines a modified freedom of expression. Article 14 seeks to guarantee equal treatment and proscribes discrimination in relation to any of the above mentioned rights.

POTENTIAL CONCERNS

11. The potential human rights concerns in this area focus on the inappropriate removal of a person's autonomy, both in relation to a person with capacity and a person without capacity. In broad terms, the issue to be addressed concerns the circumstances where a substitute decision-maker can validly make a decision on a person's behalf.

12. Substitute decision-making can potentially be contrary to human rights law in the following circumstances:
- (a) in relation to a person who is acknowledged to have capacity;
 - (b) in relation to a person who is deemed incapable but who actually has capacity; and
 - (c) inappropriate substitute decision-making in relation to a person who does not have capacity.

THE MENTAL CAPACITY ACT 2005

13. Mental health legislation has been undergoing reform throughout the United Kingdom. In April 2005, the Mental Capacity Act 2005 was enacted in England and Wales. The provisions of this legislation provide much greater protection for persons with mental disorder than the prevailing legislation in Northern Ireland. Moreover, the Act has adopted a number of principles established in common law and human rights law, which provide greater protection for persons with mental disorder.

HUMAN RIGHTS COMPLIANT LEGISLATION FOR NORTHERN IRELAND

14. Domestic legislation for children, young people and adults must be compliant with the Human Rights Act 1998 and in particular European Convention jurisprudence. The Review is addressing this issue in its work to develop a new legal framework.

RECOMMENDATION

- 6. Any new legal framework must include appropriate rules and procedures to govern:**
- (a) the determination of capacity or incapacity;**
 - (b) the circumstances when substitute decision-making can be lawful in relation to someone who is capable;**
 - (c) how to deal with persons with intermittent capacity; and**
 - (d) the appropriate mechanisms for dealing with persons who do not have capacity, including putting in place sufficient safeguards to protect such persons.**

CHAPTER 7

INVOLUNTARY DETENTION

THE ISSUES

1. The compulsory admission and detention of individuals in hospital constitutes an interference with their autonomy and liberty, and carries with it a risk of unlawful interference with their human rights. Considering whether to intervene in a person's life and involuntarily subject him or her to detention is often a complex and difficult task for the relevant authorities, which are charged with providing care and treatment, where appropriate. Moreover, the State has a duty to protect people from harm, including the person in question as well as others.
2. Liberty is a fundamental human right and the law safeguards individual autonomy. Involuntary detention raises a range of human rights concerns, including:
 - when a person's mental state does not warrant detention;
 - when a person's behaviour does not warrant detention;
 - failure to observe procedural requirements and due process;
 - continued detention when the legal criteria are no longer fulfilled;
 - the need for adequate inpatient provision for children and young people and provision for the education of detained children and young persons; and
 - the statutory role of relatives.
3. Decision-making in this area involves an assessment of the health of the person concerned and consideration of his or her rights and interests, as well as the interests of the wider community. There are a range of factors which must be taken into account when considering whether or not to intervene in a given situation. In every case, the State must be careful to act within the law, both prevailing domestic law and European Convention law.

DOMESTIC LAW

The Statutory Framework

4. The main statutory framework for the compulsory detention of individuals is the Mental Health (NI) Order 1986 (MHO). Compulsory detention under this Order (sometimes called formal detention) comprises two stages:
 - admission for assessment; and
 - detention for treatment.

Admission for Assessment

5. A person with a “mental disorder” can be compulsorily admitted to hospital for assessment. If he or she is living in the community, this process can be initiated by an approved social worker (ASW) or by the nearest relative on the recommendation of a medical practitioner. More particularly, a person can be admitted for assessment only if he or she is:
 - suffering from mental disorder of a nature or degree which warrants his or her detention in a hospital for assessment (or for assessment followed by medical treatment); and
 - failing to so detain him or her would create a substantial likelihood of serious physical harm to him or herself, or to other persons.
6. The Review, however, considers that the legislation is too narrow, in that, for example, it does not cover psychological harm.
7. A nearest relative or, more often, an approved social worker, can make an application for a person to be admitted to hospital. The ASW is required by law to make an application for assessment in respect of a patient for whom he or she has responsibility, where he or she:

- is satisfied that such an application ought to be made; and
 - is of the opinion, having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made.
8. The nearest relative can require the responsible authority to direct the responsible ASW to exercise this duty. If in these circumstances, the ASW decides against making an application for assessment, he or she must inform the nearest relative of the reasons in writing.
9. The Review has concerns that those with a personality disorder are excluded and recognises the importance that they receive treatment. A new legislative framework is required to ensure that people with a personality disorder are not excluded from accessing adequate treatment.

Application for Admission to Hospital by the Approved Social Worker

10. An application for assessment by an ASW will only be valid if he or she “has personally seen” the patient not more than two days before the date of the application. The ASW must consult with “the person appearing to be the nearest relative” before making an application, “unless it appears to the approved social worker that in the circumstances such consultation is not reasonably practicable or would involve unreasonable delay”. If a patient is admitted to hospital following an ASW’s application without such consultation, “it shall be the duty of that social worker to inform the nearest relative of the patient [of said admission] as soon as may be practicable”.

Admission of Children and Young People

11. Children and young people can be detained under the MHO. The Code of Practice provides guidance to assist practitioners involved in this. Whenever admission of a child or young person to hospital is a possibility, the Code highlights three issues which should always be considered:

- (a) what parent or guardian is legally responsible for the child, if any?
- (b) is the child capable of making his or her own decision? and
- (c) is the child subject to any court or other legal order?

Detention for Treatment

12. A patient may be detained for longer than 14 days only if his or her condition falls within the criteria contained in Article 12 (1) of the MHO, namely:

- (a) the patient is suffering from a mental illness or severe mental impairment of a nature or degree which warrants his or her detention in hospital for medical treatment; and
- (b) failure to detain the patient would create a substantial likelihood of serious physical harm to him or herself or to other persons.

13. A person can be initially detained for treatment for up to six months and can be further detained for a second period of up to six months. Thereafter, a patient can be detained for periods of up to one year. However, the MHO requires that once a person has been detained for a year, the authorisation of further detention must be made by two psychiatrists, of whom one must be “a person who is not on the staff of the hospital in which the patient is detained and who has not given either the medical recommendation on which the application for assessment in relation to the patient was founded or any medical report in relation to the patient under Article 9 or 12 (1)”.

The Children (NI) Order 1995

14. Provision is made under the Children (NI) Order 1995 for interventions concerning children who require psychiatric care and treatment. A supervision order can be imposed where a child requires care which his or her parents are unable to provide. A court can authorise the psychiatric examination of a child subject to a supervision order if it is satisfied, on the evidence of a medical practitioner, that the child may be suffering from a mental condition that requires treatment and that is medically treatable.

A court can also authorise the medical treatment of a child where appropriate. The child's consent is required under the Children Order.

Detention under the Health and Personal Social Services (NI) Order 1972

15. The Health and Personal Social Services (NI) Order 1972 makes provision for State intervention concerning persons who:

- (a) suffer from grave chronic disease or, being aged, infirm or physically incapacitated, are living in insanitary conditions; and
- (b) are unable to devote themselves, or to receive from persons with whom they reside, or from persons living nearby, proper care and attention.

Such intervention can include the non-consensual removal of such persons to other accommodation, where necessary.

16. A social worker (who may or may not be an ASW) may initiate proceedings to remove a person from his or her place of residence if he or she reasonably believes that removal is necessary in the interests of the person concerned or to prevent serious nuisance or injury to a third party. The social worker must initially consult with both the person's general medical practitioner and a medical officer designated by the Health and Social Services Trust. He or she may make a removal application based on the medical certification of the Trust's designated medical officer that this is necessary.

17. Thereafter, the Trust may apply to the magistrates court within the jurisdiction where the person resides for an order to remove him or her to a suitable hospital or other place, and be detained there for up to three months. The Trust must give the person's nearest relative three days' notice of its intention to apply to the court for a removal order, and it must inform the person managing the accommodation which is to receive the person that a removal hearing is to take place. At the hearing, the Trust must lead evidence to substantiate its application. The court also may hear evidence from the person concerned and/or his or her nearest known relative. The person concerned has the right to be legally represented at such a hearing.

Non-Statutory Detention

18. Many people with mental health problems receive care and treatment outside the statutory framework, particularly elderly people cared for in hospital, nursing or residential care homes. Informal extra-statutory, non-consensual intervention (including deprivation of liberty) in the lives of such persons has traditionally been justified under the common law principle of necessity. Since the decision of the European Court in the Bournemouth case (outlined below), however, such extra-statutory, informal interventions involving a deprivation of liberty may be unlawful.

RELEVANT HUMAN RIGHTS LAW: AN OVERVIEW

The Human Rights Act 1998

19. The Human Rights Act 1998 provides a mechanism whereby individuals who are aggrieved about a perceived breach of their rights under the European Convention on Human Rights may challenge the actions of the relevant public authority. This challenge can be by way of civil proceedings, a judicial review application, or by introducing the argument into other ongoing court or Tribunal proceedings. The Act has three important effects:
- (a) courts must construe primary and secondary legislation in accordance with the Convention;
 - (b) public authorities have a duty to comply with the rights outlined in the Convention. A “victim” of a breach of that duty can challenge this in the courts; and
 - (c) the superior courts can make a finding that domestic law is incompatible with the Convention and can make a “declaration of incompatibility”.

Article 5 (1)

20. The issue of detention of mentally disordered persons raises the prospect of a possible challenge to a public authority on the basis of a breach of Article 5 of the Convention, (the right to liberty and security of person).

The Scope of the Right to Liberty

21. This right to liberty and security of the person is a qualified rather than an absolute right, and can be abrogated where liberty is restricted “in accordance with law” or where the circumstances outlined in sub-paragraphs (a) to (f) apply. Detention, therefore, which is carried out in accordance with the Mental Health (NI) Order will prima facie not be in breach of Article 5. However, there is still considerable scope for a breach of Article 5 in the application of the legislation and, in some areas, aspects of the legislation may be incompatible with the Convention itself.
22. It is generally agreed that the core requirements of this Article are that a detention must take place in accordance with a procedure prescribed by law and that the detention must not be “arbitrary”. This Article is also the central provision in relation to the penal detention of mentally disordered adults, and for those detained under “civil” powers.

Detention

23. The structure of the Article 5 protections for the liberty and security of the person are contingent on there having been “detention”. If there is no detention, then the safeguards of Article 5 do not apply. Detention has been determined by factors such as duration, effect and the mode of restraint used.

On What Basis?

24. A pivotal factor in determining the legitimacy of a detention in the mental health context is a reliable finding of some mental disorder. The requirement outlined in Article 5 is a finding of “unsoundness of mind”. No detailed interpretation of this

concept has been developed by the European Court. This is consistent with that court's pragmatic approach to interpreting the Convention as a living instrument. The Court has, however, held that Article 5 will not permit the detention of a person simply because his or her apparently irrational views or behaviour deviates from the norm in society.

25. The question of detention on the basis of 'severe mental impairment' was recently considered in a judicial review application by North and West Belfast Trust. The Mental Health Review Tribunal had held that the patient in question should be conditionally discharged as she was not suffering from "severe mental impairment" or "mental illness". Although this case raises issues relating to Article 5, these arguments were not examined by the Court, which ruled that "severe impairment of intelligence and social functioning" was a disjunctive test which required both proof of severe impairment of intelligence and proof of severe impairment of social functioning.
26. The European Court has previously addressed the issue of detention in *Winterwerp v The Netherlands*, where three minimum conditions were outlined for the detention of mentally disordered persons:
 - (a) there must be objective medical evidence such as to establish a true mental disorder;
 - (b) the mental disorder must be of a kind or degree warranting compulsory confinement; and
 - (c) the mental disorder must persist throughout the period of detention.

The Court acknowledged that different considerations might apply in "emergency" cases.

Bournewood and Informal "Admission"

27. The *Bournewood* case concerned the informal detention of persons without capacity to consent to detention. A 48 year old autistic man was admitted to hospital following a minor incident at a day care centre. He was compliant and made no attempt to leave.

The House of Lords held that he was not detained and reversed a decision of the Court of Appeal, which had held that such patients could not be admitted informally.

28. The European Court found that the detention was a 'deprivation of liberty' pursuant to of Article 5 of the Convention. It also found that the detention was arbitrary and in contravention of Article 5 (1) because of the absence of procedural safeguards. The Court further found that there was a breach of Article 5 (4) in that there was not an available appropriate mechanism (such as a Mental Health Review Tribunal) to challenge the lawfulness of the detention: judicial review did not constitute an appropriate mechanism.

The Role of the Nearest Relative

29. Under the Mental Health Order, the nearest relative is afforded certain powers and rights in relation to the admission and detention of a patient. These powers raise issues under Article 5 and also Article 8 (the right to respect for private and family life) and were considered by the European Commission on Human Rights in *JT v United Kingdom*.
30. In that application, the detained person complained that the legislation did not include any formal mechanism whereby she could alter the identity of her nearest relative. The applicant complained that she did not want the nominated person to be her "nearest relative" and objected to this person being given confidential medical information. This case was settled on the basis that legislation would be introduced to permit reasonable objections to the nearest relative.
31. The Review agrees with the recommendation in the Human Rights Commission's report, "Connecting Mental Health and Human Rights" that the role of the nearest relative in relation to the compulsory detention of individuals should be discontinued.

Provision of Treatment

32. In *Aerts v Belgium*, the European Court held that where the applicant had not been provided with any treatment for the condition which had given rise to his detention then

there was a breach of Article 5 (1) (e). The applicant was detained in a psychiatric prison wing rather than a social protection centre. The Court held that as he had not been convicted of any criminal offence his detention could not be justified under Article 5 (1) (a). The only possible justification for his continued incarceration was Article 5 (1) (e).

33. The Court found that there must be some relationship between the ground of permitted detention and the location and conditions of that detention and, in principle, Article 5 (1) (e) detention could only be justified if the patient was held in an appropriately therapeutic setting.

Lack of Adequate Resources

34. The European Court has considered the Article 5 implications of continued detention in circumstances where an individual would be released, but for a lack of adequate treatment resources. In *Johnson v United Kingdom*, it found that where lack of placement facilities resulted in indefinite detention, this could constitute a breach of Article 5 (1) (e). The applicant had been found not to be suffering from any mental disorder and his conditional discharge was deferred pending the provision of suitable hostel accommodation.

Article 5 (4)

35. This Article introduces due process mechanisms which provide procedural support for the substantive Article 5 right to liberty. It is important to note that the protections of Article 6 may also be applicable in relation to detention in the mental health sphere. This article raises four discrete issues:
 - (a) a review of the lawfulness of detention;
 - (b) by a court;
 - (c) in a reasonably prompt manner; and
 - (d) with the power to release persons who are unlawfully detained.

36. Review in the mental health context must be periodic, because the lawfulness of the detention is contingent on the persistence of the illness. Excessive delay in the conduct of periodic review will be in breach of Article 5 (4).

Recall of Patients Conditionally Discharged

37. The Secretary of State has the power under Article 48 of the MHO to recall a person who has been discharged subject to a restriction order. There is no requirement for a further medical assessment prior to the exercise of this power. Some commentators have noted in relation to the English legislation, that “it is difficult to see how this power is compatible with the Convention”. Where a restricted patient is re-admitted for assessment or treatment, there is no mechanism for application to the Mental Health Review Tribunal unless the formal power under Article 48 (3) has been used. This anomaly is also likely to be in breach of Article 5 (4) of the ECHR.

Minors and Detention: Article 5 (1) (d)

38. The Sub Group also considered the rights of children and young people who are detained in the context of mental ill-health. The paper on this is at Annex 7.
39. The Convention envisages that detention of a minor will be lawful where it is done for the purposes of educational supervision. There is a clear tension between the terms of Article 5 (1) (d) and the use of accommodation orders under the Children (Secure Accommodation) Regulations 1995.
40. The European Court has taken a relatively broad view of the term ‘educational supervision’. In *Koniarska v United Kingdom*, the Court found that “the words ‘educational supervision’ must not be equated rigidly with notions of classroom teaching. In particular, in the present context of a young person in local authority care, education supervision must embrace many aspects of the exercise, by the local authority, of parental rights for the benefit and protection of the person concerned.”
41. In *DG v Ireland*, the Court found that educational supervision could apply beyond the statutory school leaving age. The applicant was a 17 year old who displayed indications

of a serious personality disorder. There was no secure unit available for his assessment in the jurisdiction and he was consequently detained in a penal facility. The Court found that the absence of any instruction, education or recreational facilities at the penal institution constituted a breach of Article 5 (1) (d).

42. It would appear, therefore, that detention in inappropriate facilities can constitute a breach of Article 5. Given the absence of appropriate facilities for mentally disordered young people in Northern Ireland, this is likely to be a continuing problem in relation to the detention and treatment of minors here. [Chapter 5 summarises the Review’s conclusions on deprivation of liberty and the right to education.]

CONCLUSIONS

43. The following constitute the Review’s conclusions on these issues:

- a new definition of mental disorder is needed;
- the criteria for detention should be broadened to include serious mental or psychological harm, and there should be adequate safeguards put in place to prevent misuse and abuse of such a broadened power. At the same time, the Review recognises the concerns that broadening the definition may affect a person’s right to liberty. To ensure that appropriate safeguards are put in place, there should be detailed guidance in a Code of Practice in relation to such an amendment;
- there is concern over the role of the nearest relative: the Review considers this current role in relation to compulsory detention should end;
- statutory authorities should provide information to and consult with the patient’s “named” or nominated person rather than the nearest relative;
- proper safeguards must be included to ensure that patient needs are properly accommodated: in particular, to properly protect children;
- there is concern over the adequacy of resource allocation to meet the needs, including the educational needs, of compulsorily detained children;
- if children are to be subject to detention, suitable and adequate resources should be available to protect their rights and best interests, including their educational needs and rights;

- there should be appropriate provision so that the disparate needs of diverse individuals and groups are adequately accommodated;
- potentially the anti-stigmatisation provision at Article 10 of the MHO should be strengthened to protect assessed and detained persons from post-detention discrimination; and
- the needs of people with severe personality disorder in relation to compulsory detention must be fully addressed.

RECOMMENDATIONS

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| 7. | The definition of mental disorder should be reviewed. |
| 8. | The criteria for detention should be broadened to include serious mental or psychological harm, with appropriate safeguards put in place to prevent misuse or abuse of this power. |
| 9. | The role of the nearest relative as applicant in the compulsory detention of patients should end. |
| 10. | There should be appropriate safeguards defined in legislation for “Bournewood detentions”, in accordance with the European Court’s ruling. |
| 11. | Proper safeguards should be put in place to ensure that patient needs are properly accommodated, particularly as regards children and young people, in accordance with the principle of reciprocity of rights. |
| 12. | Given the previous under-funding of services for children and young people, there must be adequate resources made available to protect the rights, needs and best interests of compulsorily detained children and young people, including their educational needs and rights. |
| 13. | Mental health and learning disability services must reflect and be sensitive to the different religious, ethnic, racial and cultural backgrounds of people and groups in Northern Ireland, and comply with the equality obligations of Section 75 of the Northern Ireland Act 1998. |
| 14. | The anti-stigmatisation provisions in the present legislation must be built upon to protect assessed and detained persons from post-detention discrimination. |

CHAPTER 8

REPRESENTATION AT MENTAL HEALTH REVIEW TRIBUNALS

THE ISSUES

1. One important human rights issue is the extent to which the law currently safeguards a patient's right to have his or her case properly aired before a Tribunal, a crucial dimension of a person's access to justice.
2. In cases before courts and tribunals, parties commonly retain lawyers and provide them with instructions as to their situation. On the basis of these instructions, the lawyer then presents the client's case to the court or tribunal.
3. Persons with mental health difficulties or learning disability may be potentially disadvantaged by reason of a reduced ability to make appropriate decisions in relation to representation, and/or by a reduced ability to provide coherent, rational and comprehensible instructions. In such circumstances, the human rights and equality issues for consideration are, what provision:
 - (a) does the law make to alleviate/prevent disadvantage and prejudice to the person concerned?
 - (b) should the law make to alleviate/prevent disadvantage and prejudice to the person concerned?

THE LEGAL BACKDROP

4. In the case of *Megyeri v Germany* (1993), Mr Megyeri was convicted of a number of criminal offences. The court ordered that he be detained in a psychiatric hospital. Although his detention was reviewed periodically, in two sets of review proceedings he did not ask for representation and the review body did not appoint a lawyer to assist him. He claimed that this failure to appoint a lawyer contravened Article 5 (4) of the ECHR.

5. The European Court found that the absence of representation in his case constituted a breach of Article 5 (4): that the national authorities should have ensured that he was legally represented at all hearings.
6. European Convention Law does not appear to guarantee a right to legal representation in every case. However, the implications of the *Megyeri* decision appear to be that:

"even if a right to representation funded by the State is not (yet) a general right, a court which reviews detention must always consider whether a particular person is capable of acting for himself, for example, whether he is able to marshal arguments and points in his favour, and understand any legal issues arising. If not, then legal representation must be provided and must be paid for by the State."
7. In Northern Ireland, the Mental Health Review Tribunal (NI) Rules 1986 do not guarantee a patient legal representation. Rule 10 (1) permits a patient to authorise any person to act for him or her as long as the nominee is not *"a person liable to be detained or subject to guardianship under the Order or a person receiving treatment for mental disorder at the same hospital as the patient"*.
8. Where the patient does not want to conduct his or her own case and has not authorised a representative to act for him or her, the Tribunal may appoint a representative to act. (Rule 10 (3)). This apparently was originally intended by the legislator to be a discretionary power. Notwithstanding, pursuant to the Human Rights Act 1998, the Mental Health Review Tribunal should interpret and apply the Mental Health Review Tribunal (NI) Rules 1986 in light of the *Megyeri* decision.

PREVALENT CONCERNS

9. A number of concerns in relation to compulsorily detained mentally ill patients and their access to justice (and, in particular, liberty) can be identified. Specifically, how many such patients are able to organise their thoughts sufficiently coherently to enable them to "marshal arguments and points in [their] favour and understand any legal issues

arising"? More specifically, how many patients are able to make considered decisions in relation to representational issues, such as:

- the arguments they want to put forward;
- whether they ought to appear in person or obtain representation; and
- whether it is in their interests to obtain legal representation?

POTENTIAL PROBLEMS IN RELATION TO PATIENT REPRESENTATION

10. Mental Health Review Tribunal hearings focus on a patient's "right" to liberty and, in particular, the statutory criteria governing compulsory detention. The subject matter of these hearings ranks high in legal terms given the importance attached by the law to individual liberty. Such hearings are often contentious by reason of the conflicting views of the Health and Social Services Trust and the patient. It is fundamental to both a patient's health and welfare and his or her human rights that he or she is properly represented at these Tribunals.
11. From a patient perspective, there are arguably a number of shortcomings in the current system of representation at Mental Health Review Tribunals, creating obstacles which can serve to abrogate his or her human rights (eg. the right to liberty and/or a fair hearing) including:
 - No automatic access to legal advice and assistance. Often decisions in relation to representation are left in the hands of the patient, who is not always fully capable of acting in his/her best interests, by reason of, inter alia, the medical condition and/or medication;
 - Some patients seek legal assistance and obtain non-expert assistance. For example, junior barristers and junior and/or generalist solicitors are often involved in representation notwithstanding their lack of the requisite knowledge, skill, experience and/or expertise; and

- Some patients refuse legal assistance and represent themselves or obtain non-legal representation. This can detrimentally affect their prospects of having their arguments and submissions properly presented and fully aired.
12. Such factors undermine a patient's right to have his or her case properly presented to a Tribunal, which, in turn, can abrogate a patient's human rights, including the important right to liberty.

COMPETING RIGHTS, INTERESTS AND OBLIGATIONS

13. All of the above issues concern the interplay between a patient's interests, a patient's rights and the responsibility of the State. Two of the main underlying ethical issues are:
- in what circumstances should a patient's rights outweigh his or her perceived best interests? (For example, if the patient refuses to nominate a representative or instruct a representative who has been appointed to act on his behalf, should the patient be entitled to dispense with representation and, if so, when?); and
 - what policies, procedures and practices should the State put into place to ensure a patient's access to justice and the patient's right to have his or her case properly aired? (For example, should the State ensure that every patient receives legal representation, or that legal representation is always provided in specified circumstances?).

CONCLUSIONS

14. The Review reached the following conclusions:
- a patient should have an entitlement to expert legal representation at a Mental Health Review Tribunal;
 - such representation should be provided by experienced lawyers with an expertise in the area of mental health and compulsory detention. There are different models of specialist legal provision, including a publicly-funded specialist who

might operate out of a law centre, and a specialist and accredited panel of practising lawyers;

- such provision should be available to all, irrespective of a person's income or savings;
- there may be situations where it would also be useful for a patient advocate to play a role in assisting the patient;
- as a general rule, a patient should be able to represent him or herself, or appoint a representative of his or her choice to represent him or her;
- there may be circumstances where the requirements of justice (including the patient's right to a fair hearing) demand that a suitable lawyer is appointed to act on the patient's behalf, whether or not the patient consents to such a course; and
- in relation to children, dual or tandem representation should be considered, wherein a lawyer and a Guardian ad Litem would be appointed to act for the child. Such a tandem approach will ensure that proper representations are made to the decision-making body on both the child's rights and best interests.

RECOMMENDATIONS

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| <p>15. A patient, irrespective of his or her income or savings, should have an entitlement to expert legal representation at an independent Tribunal, provided by experienced lawyers with expertise in mental health and compulsory detention.</p> <p>16. A patient should be able represent him or herself or appoint a representative of his or her choice for this purpose. Where appropriate, a patient advocate may play a role in assisting the patient.</p> <p>17. Where the requirements of justice demand it (including the patient's rights to a fair hearing) a suitable lawyer should be appointed to act on the patient's behalf, whether or not the patient consents to such a course.</p> <p>18. In relation to children, dual or tandem representation should be considered, whereby a lawyer and a Guardian ad Litem would be appointed to act for the child.</p> |
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CHAPTER 9

ADVOCACY

INTRODUCTION

1. People with a mental health problem or a learning disability are particularly vulnerable to human rights violation. Their rights and interests must be identified specifically under the legislation and within regional policy mandates. For human rights to be a reality, they must be accompanied by accessible and effective enforcement mechanisms.
2. Advocacy seeks to support individuals to express and have their views heard. It aims to redress any imbalance of power between the individual and professional. It is concerned with empowerment, autonomy and self-determination, the safeguarding of citizenship rights and the inclusion of otherwise marginalised people.
3. There are a range of different approaches to providing advocacy, including:
 - identifying someone to represent the interests of another individual, or to support an individual to represent him or herself;
 - the provision of independent information and advice about rights and services; or
 - supporting people to come together as a group to have a greater say in the issues which concern them and to bring about change.

RELEVANT HUMAN RIGHTS AND EQUALITY LAWS AND STANDARDS

4. The main human rights and equality laws and standards applicable to advocacy are:
 - the European Convention on Human Rights 1950;
 - the Disability Discrimination Act 1995;

- the Northern Ireland Act 1998 (Section 75);
- the Race Relations (NI) Order 1997;
- the Children (NI) Order 1995;
- the Mental Health (NI) Order 1983;
- the UN Convention on the Rights of the Child 1989;
- the UN Declaration of the Rights of Mentally Retarded Persons 1971;
- and
- Standard Rules on the Equalisation of Opportunities of Persons with Disabilities.

THE NEED FOR ADVOCACY

5. The ECHR is intended to guarantee not rights that are theoretical and illusory, but rights that are practical and effective.
6. Article 6 guarantees everyone the right to a fair hearing. Article 5 guarantees everyone the right to liberty and security of a person and Article 8 guarantees everyone the right to family and private life.
7. Articles 1 and 14 provide a duty to guarantee effective rights to everyone without discrimination. Strasbourg jurisprudence has been highly influential in the development of both the substantive and the procedural aspects of the rights of those subject to compulsion. The Court's emphasis on procedural aspects of Convention rights has extended its scope and is of great practical significance in the field of compulsion under mental health law. In the case of children, it acknowledges the requirement for special consideration for young people in detention and supports the need to have the lawfulness of detention reviewed in compliance with Article 37 (b) of the UNCRC.
8. Different types of advocacy may be needed by different people at different times of their lives and to respond to different circumstances. Children, older people, people from diverse ethnic communities, individuals with profound and multiple disabilities and people involved with forensic services are likely to need additional, specific support to address their needs.

9. Advocacy services are unevenly and poorly developed in Northern Ireland. The recently articulated and increasing demand for advocacy support is an indication of the need to promote and support the rights of people with a mental health problem or with a learning disability. A range of different models of advocacy has developed in response to accepted needs in the rest of Europe and internationally.
10. Health and social care staff and relatives often act as advocates for individuals with mental health problems or learning disability. However, the possibility of conflict of interest has increased the demand for independent advocacy services to ensure that the voice and interests of the individual are heard.
11. Carers, too, may need separate advocacy services, to support them in accessing independent information and in expressing their views about their own distinct needs. Advocacy services can also support carers in their role as advocates for the person they care for.
12. It is important that people with mental health problems or learning disability can choose if they want to use an advocacy service, and be able to choose the model of advocacy support that best suits their preferences and needs. Carers should also be offered choice in advocacy support.
13. Particular consideration must be given to the principles, procedures and models of advocacy available to individuals who may not be able to exercise this choice to ensure that they enjoy equality of opportunity and are not disadvantaged.

ISSUES EXAMINED

14. The Sub Group looked at:
 - the need for advocacy;
 - human rights principles involved;
 - models of advocacy;
 - advocacy in other jurisdictions;

- advocacy support for:
 - people with mental health problems;
 - people with a learning disability;
 - people with a learning disability who have experienced mental health problems; and
 - the distinct needs of vulnerable groups including children, older people, people from diverse ethnic communities, individuals with profound and multiple disabilities and people involved with the criminal justice system.

15. In addition to the papers and presentations made at meetings, the Group organised a seminar on advocacy for the Review members.

CONCLUSIONS

16. The consensus was that there should be clear provisions within a legislative and policy framework to enable people with mental health problems or learning disability:

- to understand the proceedings in which they are involved; and
- to participate in their ongoing care and the accompanying decision-making process, to the greatest extent possible.

17. The objective should be to have in place:

- a range of independent advocacy support services delivered by a range of providers;
- support for people with mental health difficulties or learning disability in exercising their rights;
- services which are compliant with all legal requirements in Northern Ireland;
- a coherent, co-ordinated, regional strategic framework which will provide people with mental health difficulties or learning disability with access to advocacy support;
- an advocacy support service which is available both in hospital and in community

settings;

- advocacy support services that will extend to those undergoing assessment and treatment voluntarily and involuntarily and which will reflect the diverse needs of people with mental health difficulties or learning disability;
- advocacy support services which will pay particular attention to the circumstances where the autonomy and self-determination of individuals may be restricted or denied.

18. A strategy to achieve these objectives should be developed with the involvement of all stakeholders, including users, carers and families and should:

- set explicit deadlines and targets for implementation; and
- ensure the development of agreed quality standards and consistent monitoring of advocacy support.

RECOMMENDATIONS

- | |
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| <p>19. There should be a statutory right to independent advocacy support, embracing a range of different models.</p> <p>20. There should be a regional strategy for the development and funding of independent advocacy support in Northern Ireland. This will involve a number of Northern Ireland Departments and should be co-ordinated by the Department of Health, Social Services and Public Safety.</p> |
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ANNEXES

MEMBERSHIP OF THE HUMAN RIGHTS AND EQUALITY SUB GROUP

Lady Christine Eames (Chair)	Human Rights Commission
Ms Tara Caul	Children's Law Centre
Miss Brenda Donnelly	Royal Courts of Justice
Mr Bill Halliday	Equality Commission; now Praxis Care Group
Dr Raman Kapur	Threshold
Dr Caroline Marriott	North and West Belfast Trust
Ms Patricia Monaghan	LAMP
Dr May McCann	CAUSE (and a Carer)
Miss Jane McConnell	Royal Courts of Justice
Miss Joanne McDonald	Strule Buzz Group
Professor Tony McGleenan	University of Ulster
Mr Paddy McGowan	Irish Advocacy Network
Dr Paschal McKeown	Mencap and LEAD (the Northern Ireland Coalition on Learning Disability)
Dr Angela O'Rawe	Queen's University
Mr Michael Potter	Royal Courts of Justice
Mr Sean Ferrin) Mr Roy Keenan)	Secretariat

THE HUMAN RIGHTS AND EQUALITY CONTEXT

INTRODUCTION

It is important to set the work of the Sub Group within a human rights and equality context. Three particular themes which are relevant are addressed in this paper. These are:

1. A rights-based approach with an emphasis on societal changes, to include and accommodate the needs of all persons, including people with disabilities.
2. Current equality issues, including concerns about the Disability Discrimination Act (DDA) definition of disability.
3. Specific issues for people with a learning disability.

A context for each theme is set out below together with points for discussion.

A RIGHTS-BASED APPROACH

European Dimension

During the Spanish presidency of the European Union (EU), the first European Congress of People with Disabilities was held in Madrid in March 2002. The conference concluded with the adoption of the Madrid Declaration, which expresses the view that disability is a human rights issue, because people with disabilities are holders of the same fundamental rights as other citizens. Furthermore, disabled people want equal opportunities, not charity, to achieve their full integration into society. The Declaration proposes to foster an inclusive society, which not only will benefit people with disabilities but also society at large.¹ It can be downloaded from www.madriddeclaration.org/en/dec/dec.thm.

¹ The Madrid Declaration, "Non-Discrimination plus Positive Action Results in Social Inclusion" Madrid 20 to 23 March 2002

A Rights-Based Perspective

“The approach to the concept of “disability” has gradually evolved over the last three decades from a paternalistic, medical perception which focused on the actual disability, to a social perception which appreciates that people are disabled due to the attitudes, prejudices and barriers created by society and that prevent them from enjoying opportunities equal to those of non-disabled people.”²

“Action is shifting from an emphasis on rehabilitating the individual so they may “fit in” to society towards a global philosophy of modifying society to include and accommodate the needs of all persons, including people with disabilities.”³

The EU rights-based approach was set out in the Commission’s 1996 Communication on Equality of Opportunity for People with Disabilities: “The old medical - centred approach is now giving way to a social one which puts much stronger emphasis on identifying and removing the various barriers to equal opportunities and full participation in all aspects of life for people with disabilities.”⁴

The EU now accepts disability as a human rights issue. The European Charter of Fundamental Rights prohibits any discrimination on grounds of disability in Article 21, while Article 26 recognises “The right of persons with disabilities to benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community.” The general anti-discrimination Article 13 of the EC Treaty enables the EU to take initiatives to combat discrimination on the grounds of disability.

This issue has also been addressed by the United Nations.

² Taken from information note on disability policy (European Parliament) Committee on Employment and Social Affairs, October 2003

³ The Madrid Declaration

⁴ Communication from the Commission, “Equality of Opportunity for People with Disabilities,” Com (1996) 406 final, <http://europa.eu.int/comm/employment>

Suggested “Rights” for the Group to Adopt

The European context outlined above gives some indication of the areas of life which might be considered in the development of specific rights for disabled people. In the context of the Review, these could be made more specific. Using the recently published Disability Rights Manifesto 2003:⁵

- The right of every person with a learning disability or mental ill-health to be recognised first and foremost as a human being and, therefore, entitled to the same human rights as every other citizen.
- The right of people with learning disabilities and mental ill-health to live their lives free and independently unless this would pose a serious threat to themselves or their community.
- The right to full participation by people with learning disabilities and mental ill-health in the social, economic, cultural and political life of Northern Ireland.
- Children and young people with learning disabilities or mental ill-health should have the same rights to education, play and other social activities as other children.

Questions for Discussion

- Is it appropriate to set principles and rights within a European context in this way?
- Is it relevant to the Review, or a distraction?
- Are the few rights proposed:
 - useful and appropriate?

⁵ Disability Rights Manifesto 2003 – jointly produced by Disability Action and NIPSA in the lead up to the 26 November election

- a useful basis for others to be added?

CURRENT EQUALITY ISSUES

This section highlights the difficulties of people who have experienced mental ill-health in achieving equality and social inclusion. In particular, it addresses the shortcomings of the DDA, especially concerning the definition of disability used. It also proposes changes to the current legislation which the Sub Group may wish to endorse.

Definition of Disability

Although the Equality Commission and the Disability Rights Commission (DRC) have only had enforcement powers under the DDA since 25 April 2000, it is already apparent that the Act has significant limitations.

There is clear evidence that the complex and restrictive nature of the definition of disability presents a hurdle for many applicants who seek redress through the Act. Professor Brian Doyle commented in the Cambridge Review of Anti-Discrimination legislation that, “evidence suggests that defendants in disability discrimination litigation have every strategic reason and encouragement to challenge the status of the claimant as a disabled person. This not only adds to the potential length and cost of litigation but has a considerable psychological effect on the willingness of a disabled person to mount or to continue litigation under the 1995 Act. The evidence from our research pointed to a higher than average rate of settlement and withdrawal of cases under the DDA 1995, indicative of the observation just made.”

This is also the experience of the Equality and the Disability Rights Commissions. Under the Act, a person has a disability if he or she has a physical or mental impairment, which has a substantial and long term adverse effect on his or her ability to carry out normal day to day activities. The guidance to the Act suggests that the disability should have been evident for at least 12 months. This was to prevent individuals with a short term injury (a broken arm, for example) claiming that they were disabled.

To claim protection under the Act, a claimant must first establish that he or she is (or has been) “disabled”. This contrasts with the Sex Discrimination (NI) Order 1976 and the Race Relations (NI) Order 1997 which prohibit discrimination against anyone on the grounds of gender or race.

The definition used does cause problems for people who have experienced mental ill-health, for example:

- Some mental illnesses are not continuous. A person may have episodes of depression which seriously affect their day-to-day activities but don't last for a full 12 months.
- There have been disputes over the definition of “substantial”.
- Day-to-day activities have been defined (under schedule 1, paragraph 4 (1)) as: mobility; manual dexterity; physical co-ordination; continence; ability to lift; carry or move every day objects; speech; hearing; sight; memory; the ability to learn, understand or concentrate the perception of risk or physical danger. This list of day-to-day activities would appear to address physical disabilities rather than mental ill-health. There is evidence to show that people with mental ill-health have not met the definition of “a disabled person” because their illness does not affect these particular day-to-day activities. They may, however, have other difficulties in carrying out normal activities which centre more on communicating and interacting with other people, as in the case of severe depression. Other conditions typically have an impact on thinking, feeling or social interaction which are not specified capacities under the DDA definition.
- The wording of the category “perception of physical risk” needs to be revised to ensure that it covers people who self harm, for example through cutting themselves, anorexia or bulimic behaviour. At present, the argument can be successfully made that an individual who has a clear intellectual perception of the risk of harm but chooses to ignore this, is not covered by the Act. The Sub Group may wish to consider, particularly in the light of previous discussions on mental incapacity, whether or not the law as it stands disadvantages individuals who self harm.

- The DDA states that a mental ill-health condition must be “clinically well recognised” before it is considered to be a disability under the Act. There is no similar requirement for other forms of mental or physical impairment. There is evidence to show that the requirement to prove that a condition is clinically well recognised is disadvantaging some people with genuine mental ill health. It is always possible that someone with even severe mental ill-health may not have a clear diagnosis or may have a different diagnosis at different times.
- Also, a “clinical recognition” of a mental illness continues to promote a medical model of disability which is something the Commission is trying to move away from. More often than not, it is society which disables individuals so we would advocate a social model of disability. This clearly has relevance to this aspect of the DDA and the Review is discussions.

Proposed Changes to the Legislation

Taking these early experiences of the DDA into account, the Equality Commission and the Disability Rights Commission recommend that the law be changed. The proposed changes are that:

1. The list of normal day-to-day activities be revised to include “the ability to communicate and interact with others’ and to ensure that self harming behaviour is covered.
2. That the requirement that a mental illness be “clinically well recognised” should be removed.
3. The requirement that the effects last 12 months or more should be removed.
4. Should the Review take a view on the issue of normal day-to-day activities, particularly with regard to “the perception of risk or physical danger”.

POINTS FOR DISCUSSION

If the law is changed in the way proposed, it will not affect any need to protect the individual, but will increase their rights in terms of employment and/or service provision. Is this an issue for the Sub Group?

Should the Review recommend that work be done with employers on preventing mental ill-health in the workplace and generally raising awareness of mental health issues? Should the Sub Group be as specific in its recommendations, or support of the recommendations of others, as proposed?

ISSUES FOR PEOPLE WITH A LEARNING DISABILITY

Summary of Issues

So far, approximately 8% of the Commission's contacts have been with people with learning disabilities or their families or advocates. This compares with 11% for mental ill-health and over 35% for people with a physical disability (this figure doesn't include sensory disabilities). This in itself is significant, as people with learning disabilities may have difficulty accessing bodies such as the Equality Commission.

Some of the key areas where discrimination is particularly noticeable have been:

- Access to financial services, particularly banking where there is often a need for proof of identity (utility bills, driving licence etc). This is potentially a major problem as the Government clearly intends to pay most benefits directly to bank accounts.
- Voting – again, potentially a problem over identity; accessibility of electoral information (by political parties as well as the Electoral Office); accessibility to the voting process and the degree of assistance permitted.

Mencap has given a detailed response to the Electoral Office's consultation on its Equality Scheme.

- Access to health services - being refused treatment that other people would be able to get routinely. Also assumption is being made about an individual's quality of life based on their disability. 3% of women with learning disabilities have smear tests compared to 85% of the general population and 17% have breast screening compared to 76% in the general population.
- Employment opportunities – there are high levels of unemployment amongst people with learning disabilities, many are in poorly paid jobs without contracts, are not members of Trade Unions, and have little job security when in employment. A positive action duty would encourage employers to transfer someone on a Government scheme or on a work placement to a full time vacancy, should one arise.
- Definition – this applies equally to mental ill-health and learning disability. Would everyone be clear that “physical and mental impairments” cover a person with a learning disability?
- Inaccessibility of current legal processes, including industrial tribunals and the lack of tribunal powers to direct that someone can be given his/her job back. This is usually the most common form of redress requested rather than financial compensation.
- The fact that the current Building Regulations do not cover adjustments that might make buildings more accessible to people with learning disabilities, ie clear signage, signposting and directions. Access to buildings is not just about ramps and stair lifts.

There is very little case law available to assist with the interpretation of the Disability Discrimination Act and even less for situations involving learning disability.

There have been some cases settled in Great Britain which were supported by the Disability Rights Commission. Some of these also involve individuals with multiple disabilities including a learning disability. Summaries are available in easyread format.

One which received a high profile was the case of an applicant who was refused a drink in a pub. The paper for this case shows that two other people with learning difficulties had also been refused service and the note of the case shows how “reasonable adjustments” were made to assist the applicants give evidence at court. The Sub Group may wish to consider how these arrangements could be turned into recommendations for all industrial tribunal and court cases within this jurisdiction.

POINTS FOR DISCUSSION

- 1 Given the breadth of the areas of discrimination highlighted, does the Sub Group consider that the areas are within its remit?
- 2 Could the problems identified be turned into Sub Group recommendations, ie women with a learning disability should have equal access to cervical smearing and breast screening?
- 3 Given the urgency of several of the areas of discrimination identified, ie voting, building regulations etc, could specific recommendations be put forward at this stage as ongoing recommendations?

The issues raised in this paper are offered to the Sub Group as areas for discussion and to raise awareness amongst all group members of the importance of a specific human rights and equality base for the Review.

CITIZENSHIP

INTRODUCTION

Over the last 20 years or so, there has been a shift away from perceiving people with disabilities as the recipients of care, protection and treatment, towards recognising them as individuals who have rights, but who may not fully enjoy these rights.

There has also been an increasing emphasis on acknowledging the inherent value of disabled people, of empowering them, maximising their autonomy and self-determination and tackling the barriers that stop them enjoying the same rights as others.

There has also been a growing recognition that some groups of disabled people - such as children, women, older people and people from different ethnic backgrounds - experience particular difficulties.¹

The interdependence of civil, political, economic, social and cultural rights is particularly relevant for disabled people, since many will rely on additional supports to exercise their rights.

PEOPLE WITH MENTAL HEALTH DIFFICULTIES OR LEARNING DISABILITY AND THEIR RIGHTS

The fact that a person has a mental health difficulty or a learning disability does not of itself mean that he/she is not capable of exercising his or her rights. The issues in each instance are:

- whether the individual has the competence to understand the nature and purpose of the activity or decision in question; and

¹ Quinn G, Degener T, “*The current use and future potential of United Nations human rights instruments in the context of disability*” Human rights and disability, Paper presented at the Expert Group Meeting on the Comprehensive and Integral International Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities, Mexico, June 2002

- whether systemic barriers exist which prevent the individual from taking advantage of the rights they are afforded.

This paper looks at these issues in relation to the following rights:

- entitlement to vote;
- marriage, sexual relations and the right to found a family; and
- the right to life.

BARRIERS TO EXERCISING RIGHTS

People with mental health difficulties or learning disability experience a range of barriers which prevent them from exercising their rights, including:

- assumptions made about capacity;
- lack of knowledge and/or support to exercise rights; and
- unequal access to services and opportunities in employment, education, transport, and access to and participation in the justice system.

Assumptions about Capacity

Assumptions are often made by others about the capacity of people with mental health difficulties or a learning disability to participate in or contribute to the life of their community or to make decisions. These assumptions are often due to ignorance and prejudice, arising from a lack of information and understanding about mental health or learning disability.

Lack of Knowledge about Rights and of Support to Exercise Rights

Historically, people with mental health difficulties or learning disability have been viewed as individuals in need of care and protection rather than individuals with rights. Traditionally, this care has been provided in institutions which isolated and separated those involved from the life of their local community. More recently there has been a shift towards recognising

that many of the difficulties experienced by people with disabilities arise from the structures and systems of society rather than in the person.

Most people with a learning disability need extra support to understand their rights and to exercise their rights. The fact that information about rights is not produced in a range of formats that are accessible causes particular difficulties for people with a learning disability.

Unequal Access to Services and Opportunities

People with mental health difficulties or learning disability do not have access to the same range of services and opportunities as other people in Northern Ireland. This is due, largely, to the failure of mainstream services to take into account their specific and distinctive needs when planning or delivering services. The introduction of legislation, including Disability Discrimination Act and Section 75 of the Northern Ireland Act, has gone some substantial way to help address the exclusion and disadvantage that people with mental health difficulties or learning disability experience.

ENTITLEMENT TO VOTE

Eligibility to Vote

Eligibility to vote in elections in Northern Ireland is restricted by criteria relating to age, citizenship and residency. To vote, a person must also be listed on the relevant Northern Ireland register of electors for that particular election.²

Common Law

There are no references to people with mental health difficulties or learning disability in current electoral law. The only reference is in common law, which uses outdated terminology and states that "idiots" cannot vote and that "lunatics" can only vote in lucid intervals.

² Relevant legislation: The Representation of the People Act 1983 as amended by the Representation of the People Act 2000

A number of late 18th century cases indicated that a severely mentally ill person may not appear on the electoral register and such a person may not vote (although a mentally ill person may vote during lucid intervals).

The Electoral Commission, which is responsible for encouraging public confidence and participation in the electoral process, recognises that the terms "idiots" and "lunatics" are "anachronistic" and "give no guidance to the Electoral Registration Officer".³

The Commission adds, however, that common law incapacity cannot be disregarded and that it would be wrong to register a person if there were grounds to believe that he or she lacked the capacity to vote because of mental incapacity.

The guidance produced by the Commission states that the general assumption should be to register people with mental health difficulties or learning disability.

The Commission goes on to suggest that a person who is registered as an elector or entered in the list of proxies, cannot be refused a ballot paper or be excluded from voting on the grounds of mental incapacity.

Legal Incapacity to Vote

There are two factors which determine whether a person with a mental health difficulty or learning disability can vote:

- whether he/she has a legal capacity to vote; and
- whether he/she has a place of residence for voting purposes.

Legal incapacity to vote is “*some quality inherent in a person which either at common law or by statute deprives him of the status of a Parliamentary elector*”.⁴

³ Electoral Commission Appendix xiv: Access to the voting process for people with learning disabilities or mental health problems

⁴ *Stowe v Jolliffe* [1874] LR 9 CP 750)

If a person with a mental health difficulty is in hospital on an informal basis or is subject to guardianship, that fact in itself does not place him or her under a legal incapacity to vote. His or her competency is still a question of fact.

Place of Residence

Previously the legislation distinguished between detained and voluntary patients. In addition, detained patients were not able to treat the hospital where they were detained as their place of residence for the purposes of electoral registration and whether they could register as resident at a place outside the hospital was a question of fact to be determined by the electoral officer.

A person who had been detained, therefore, for more than six months was likely to experience difficulties in registering as resident at their former address.

The 2000 Act enacted provisions which are designed to enable persons in mental hospitals to register to vote whether they are detained or voluntary patients (unless they are detained as a result of criminal activity in which case they are disfranchised).

Under the Act, a mental hospital is defined as meaning any establishment maintained wholly or partly for the reception or treatment of persons suffering from any form of mental disorder as defined by the Mental Health Order.

The “declaration of local connection” is a new concept introduced by the 2000 Act and enables patients in a hospital to register by treating them as resident at the address which they have declared, which may be an address where they would be living if they were not a patient, or an address in the UK where they have lived at any time.

Electoral Fraud Act (NI) 2002

Research carried out by the Electoral Commission into the first year of operation of the Electoral Fraud (NI) Act 2002, highlighted concerns about the impact of the new registration process on people with a learning disability.

Provision had been made in the legislation for the registration form to be completed and signed by another person on behalf of the individual wishing to register. The person completing the form was asked to state the reason why the person wishing to register had not signed the form. Where learning disability or mental health was given as the reason, a letter was sent from the Electoral Office, which is responsible for the management of elections in Northern Ireland, asking the person to confirm that the individual wishing to register had the mental capacity to vote.

The Electoral Commission concluded that "the individual registration process may have inadvertently impacted on people with learning disabilities, thus effectively disenfranchising hundreds of people who in the past may have voted".⁵

Accessibility of Electoral Process

For many people with a learning disability the electoral rules and legislation are not the only barriers to taking part in the electoral process. Difficulties in getting to and gaining access to polling stations, the absence of information provided in a range of accessible formats, as well as the assumptions made by others about their capacity or interest in voting has militated against people with a learning disability exercising their right to vote.⁶

MARRIAGE

Capacity to Enter into a Marriage

In considering whether a marriage is invalid on the ground that one of the parties was suffering from a mental disorder at the time it was entered into, the test to be applied is whether he or she is capable of understanding the nature of the contract of marriage.

⁵ The Electoral Commission, The Electoral Fraud (NI) Act 2002; an assessment of its first year in operation, 2003

⁶ See Disability Action, Polls Apart, Northern Ireland Assembly Elections; Disability Access Review, final report, 2004 for information about the experiences of disabled people in Northern Ireland

To understand the contract of marriage a person must be capable of appreciating that it involves the duties and responsibilities normally attaching to marriage. Only a broad understanding of the nature of marriage is necessary. The contract is a simple one which is easy to understand (Re Parks Estate [1952] 2 AER 1411). A mere understanding of the promise exchanged is not sufficient if the nature of the contract is not understood. The presumption is in favour of marriage and the burden of proof is on the party attempting to show lack of consent (Harrod v Harrod [1854] 1 K&J 4).

The right of a person with a mental disorder to marry - even if detained under the mental health legislation - is the same as that of any other person. The person must understand the nature and purpose of the marriage contract, must be capable of giving consent and must not be under duress.

Voidance of a Marriage by Reason of Mental Disorder

Under the Matrimonial Causes (NI) Order 1978, a marriage is voidable if at the time of marriage either party although capable of giving valid consent was suffering (whether continuously or intermittently) from mental disorder within the meaning of the Mental Health Order, of such a kind or an extent as to be unfitted for marriage. In order to succeed, a petitioner must establish mental disorder which rendered the person incapable of living in a married state and of carrying out the duties and obligations of marriage.

The Right to Found a Family

Article 12 of the ECHR guarantees to men and women of marriageable age the right to marry and to found a family. The European Commission on Human Rights has considered two cases which raise the question of how far the rights guaranteed by Article 12 can apply to prisoners. The Commission's opinion was that the right to marry was in essence a right to form a legally binding association between a man and a woman and that this right could not be denied on the grounds that, as one of the partners was detained, the couple would not be able to live together.

The Government, in enacting the Marriage Act 1983, considered that these principles applied also to persons with a mental illness detained for substantial periods. Prior to this Act detained persons did not have ready access to authorised places of marriage. The marriage of a detained person can be solemnised at the place where that person usually resides. A further liberalisation has been effected by the Marriage Act 1994.

Sexual Relations

While the law enables persons with a mental illness to be married provided they understand the marriage contract, it is silent as to whether married couples have a right to have a private place for sexual intercourse while detained in hospital, although such a right may be claimed under Articles 12 or 8 of the ECHR.

The term “founding a family” in Article 12 has not been interpreted as referring to the consummation of marriages or having children.

Article 8 provides persons with the right to respect for their private and family life. This also applies to sexual life. The Department of Health (London) advises that “given there is probably nothing in law to prevent a marriage from taking place, the hospital then has to consider whether facilities should be made available for consummation of the marriage, a matter raising questions about human rights. The decision whether to allow unsupervised visits should be based upon the following criteria:

- any risk one spouse may present to the other;
- overall security within the hospital;
- the social consequences of making available to certain patients privileges not available to others; and
- the availability of suitable facilities."

Current mental health legislation does place limits on the capacity of certain groups to engage in sexual activity. Whilst the aim of the legislation is to protect people with mental disorder from exploitation and abuse, it can also interfere with the freedom of some people with a mental disorder from developing relationships, engaging in sexual activity and marrying.

RIGHT TO LIFE

The decision to impose or withdraw medical care or treatment raises complex ethical, legal and moral issues. Recent medical advances mean that many people of all ages are able to survive because of medical intervention and treatment. Doctors and other health care professionals are required to take into account the effects that a treatment might have on a person's "quality of life", even though the treatment itself might prolong an individual's life.

This already difficult decision is made more complicated in cases where a person has a severe or profound learning disability and where a person may be unable to express an opinion or make a decision.

A report by Mencap about the health care experiences of people with a learning disability drew attention to research which stated that "people with a learning disability were more likely to die before the age of 50 and that life expectancy is shortest for people who have the most support needs".⁷

⁷ Mencap, Treat me right, better health care for people with a learning disability, June 2004

EDUCATION RIGHTS

OVERVIEW

This paper provides a summary of the right to education under the UNCRC and the ECHR, as incorporated by the Human Rights Act 1998.

It emphasises the importance of recognising the fundamental right of every child and young person in the context of the Review to have access to a practical and effective education. It is submitted that any new legislative framework must protect this fundamental right.

THE UNCRC

Background

The United Nations General Assembly adopted the UNCRC on 20th November 1989. The United Kingdom Government ratified it in December 1991 and as such has given a firm commitment to ensure that legislation, policy and practice relating to children is in conformity with the UNCRC rights.

In relation to the right to education, the key general provisions of the UNCRC are Articles 2, 3, 12 and 23. These are set out below for ease of reference.

Article 2: Non Discrimination

“State parties shall respect and ensure the rights set forth in the present convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child’s or his parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.”

Article 3: The Child's Best Interests

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

Article 12: The Child's Opinion

“ State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.”

Article 23: The Rights of Children with a Disability

“State parties recognise that a mentally or physically disabled child should enjoy a full and decent life, in conditions, which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

Recognising the special needs of a disabled child, assistance extended.... shall be designed to ensure that the disabled child has effected access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his/her cultural and spiritual development.”

Article 28: Right to Education

“State Parties recognise the right of the child to education and with a view to achieving this right progressively and on the basis of equal opportunity, they shall in particular -

- a) *Make primary education compulsory and available free to all. Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child and take*

appropriate measures such as the introduction of free education and offering financial assistance in cases of need;

- b) Make higher education available to all on the basis of capacity;*
- c) Make educational and vocational information and guidance available to children;*
- d) Ensure that school discipline is administered in a manner which is consistent with the child's human dignity and worth."*

Article 29: Aims of Education

"State Parties agree that education shall be directed to the –

- a) development of the child's personality, talents, mental and physical disabilities to their fullest potential;*
- b) development of respect for human rights;*
- c) development of respect for their parents, cultural identity, language, national values and civilisations different from his or her own;*
- d) preparation of the child for responsible life in a free society;*
- e) development of respect for the environment."*

Article 42: Promoting an Awareness of Convention Rights

"State Parties shall make the provisions of the Convention widely known to both adults and children."

THE ECHR AS INCORPORATED BY THE HUMAN RIGHTS ACT 1998

The right to education is provided under the ECHR by Article 2 of the First Protocol, as follows:

“No person shall be denied the right to education. In the exercise of any functions which it assumes in relation to education and to teaching, the State shall respect the right of parents to ensure such education and teaching is in conformity with their own religious and philosophical convictions.”

The right to education set out in the first sentence of Article 2 is that of the child. The parents’ right to respect for their convictions in the second sentence is subsidiary to this.¹ It has been established in European case law that the parental right under Article 2 is not absolute and will not preclude the child’s right to receive an education.

The United Kingdom Government has entered a *reservation* to the right to education:

“In view of certain provisions of the Education Acts in the United Kingdom, the principle affirmed in the second sentence of Article 2 is accepted by the United Kingdom only in so far as it is compatible with the provision of efficient instruction and training, and the avoidance of unreasonable public expenditure.”

The design and effect of this reservation is to limit the obligation upon educational authorities to uphold parental convictions.

It is necessary to refer to precedent case law in the European Court to assess how the ECHR right to education has been interpreted and applied.

Protocol 1, Article 2, provides a right to education, but does not require states to establish institutions which may offer education of a particular type. In the case of *X v United Kingdom*² the European Commission refused to bind the Government to provide funding for a non-denominational school in Northern Ireland in spite of the parents’ argument that this breached their religious and philosophical convictions. The Commission was of the opinion that this parental right and preference could be accommodated within the existing educational system. The primary objective of Protocol 1, Article 2 is to guarantee a right of equal access to the means of instruction existing at a given time.³

¹ *Campbell & Cosans v UK*, Series A no 48, 4 EHRR 293

² *X v United Kingdom* (1978) 14 D.R. 179

³ *Belgian Linguistic Case* (No 2)(1968) 1 E.H.R.R. 252

Parents' Religious Convictions

The requirement to respect a parent's religious convictions in education should be considered in the context of the ECHR as a whole, with particular reflection upon the right to respect for family life (Article 8), the right to religious freedom (Article 9), as well as the right to freedom of expression (Article 10).⁴

In the case of *Kjeldsen, Busk Madsen and Pedersen v Denmark*,⁵ Danish parents challenged the manner in which sex education in state primary schools had been integrated into the school curriculum and made compulsory. They argued on the ground of their religious conviction that it was the obligation of parents rather than schools to give sexual instruction to their children.

The European Court did not find in favour of the parents in this case, maintaining that the setting of the curriculum was for the State and that the parents' rights were not breached where their children were given instruction "of a directly or indirectly religious or philosophical kind...".⁶ The manner in which the instruction was provided was of the essence in this case, as it did not attempt to indoctrinate a particular moral attitude, and information was "...conveyed in an objective, critical and pluralistic manner.."⁷ Parents who did not wish their children to attend sex education classes were required to send them to private schools (which in Denmark were largely subsidised by the Government) or to educate them at home.

Parents' religious convictions arose again in the case of *Valsamis v Greece*.⁸ In this case, a 12 year old girl was suspended from school for failing to attend a school parade on a national holiday. Her parents were Jehovah's Witnesses and pacifists and objected to their child attending the parade as it was often attended by the military.

The European Court stressed that the parents were entitled to require the authorities to respect their religious convictions, in line with Articles 8 and 10. However, it disagreed with the

⁴ See Kilkelly (1999) "*The Child and the European Convention on Human Rights*" p.72

⁵ (1976) 1 E.H.R.R. 711

⁶ *ibid.* at 730

⁷ *ibid.* at 731

⁸ (1996) 24 E.H.R.R. 294

applicants about the military nature of the event, and did not find that the rights of the child or parents had been violated under Article 2. It is interesting to note that eight members of the Commission objected to the mandatory nature of participation in the procession. They indicated that this interfered with the child's freedom of religion under Article 9.⁹

Parents' Philosophical Convictions

An attempt was made to define philosophical convictions in the Scottish corporal punishment case of *Campbell & Cosans v United Kingdom*.¹⁰ The European Court distinguished between mere parental preferences and parents' deeply held views in respect of their children's schooling, which the State may be compelled by the ECHR to take into account. Convictions were defined as "views that attain a certain level of cogency, seriousness, cohesion and importance".¹¹ Furthermore, the Court has defined philosophical convictions as "such convictions as are worthy of respect in a 'democratic society' and are not incompatible with human dignity; in addition, they must not conflict with the fundamental right of the child to education, the whole of Article 2 being dominated by its first sentence".¹²

This case resulted in the abolition of physical punishment in State schools, in independent schools which receive public funds and in Government-assisted private places in the UK. The threat of corporal punishment was held not to be inhuman or degrading punishment, contrary to Article 3, however the case succeeded under Protocol 1, Article 2.

In the similar case of *Costello-Roberts v United Kingdom*,¹³ which involved a young boy who attended a private boarding school, the applicant claimed that he had been subjected to torture, inhuman and degrading treatment as a result of receiving corporal punishment. Although the boy lost the case by a slim majority, the European Court sent a clear message to the UK Government that corporal punishment could potentially amount to a breach of Article 3.

⁹ See Kilkelly (1999) "The Child and the European Convention on Human Rights" p.74

¹⁰ (1980) 4 E.H.R.R.293

¹¹ *ibid.* at 304

¹² *ibid.* at 305

¹³ (1993) 19 E.H.R.R. 112

Special Educational Needs

The European Commission on Human Rights has considered some cases in relation to children who suffer from disabilities and special educational needs. The Commission has stated that it is in keeping with current educational thinking to ensure that children with special educational needs are educated in an integrated setting, provided that this is compatible with their own needs, the provision of an effective education for other children at the school and also represents efficient use of public funding and resources.¹⁴

Decisions about how to assess the suitability of a child with a disability to attend mainstream school are in practice left to the discretion of the State authorities (in the form of Education and Library Boards). Emphasis is placed on the need for proper assessments to be carried out in respect of each child's individual needs and also to ensure that the placements adopted for every child are consistent with that assessment.

HOW DOES THE UK RESERVATION IMPACT UPON CHILDREN WITH DISABILITIES AND/OR SPECIAL EDUCATIONAL NEEDS?

In the case of *Simpson v United Kingdom*,¹⁵ a child who was dyslexic was denied access to a special school because the view was taken that the child could adequately be educated in a local mainstream school, which had a special needs department.

Conversely, in the cases of *PD v United Kingdom*¹⁶ and *Graeme v United Kingdom*¹⁷ the Commission held that the Local Education Authority (LEA) had the discretion to refuse to

provide special facilities for a child in a mainstream school, in spite of the parent's philosophical convictions about the education of the child. The Board's discretion was reserved on the basis that such a placement was incompatible with efficient instruction and training and in refusing access to the parent's school of choice, the State would avoid unreasonable (public funding and resources) expenditure.

¹⁴ See Kil Kelly "The Child & the European Convention on Human Rights" p.80 & *McIntyre v UK* unreported decision 21/10/98 29046/95

¹⁵ (1993) 19 E.H.R.R. 112

¹⁶ (1989) 62 D.R.292 .

¹⁷ (1990) 64 D.R. 158.

The Principle of Proportionality

In the case of *McIntyre v United Kingdom*,¹⁸ the European Commission considered legal argument in relation to the effectiveness of the education provided to a child with special educational needs in a mainstream school. Here, a case was constructed employing the non-discrimination clause at Article 14, together with the right to education under Article 2, Protocol 1. Article 14 is not free-standing and must be argued in conjunction with other articles. It reads as follows:

“... the enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or other social origin, association with a national minority, property, birth or other status”.

This clause is very important in terms of children and young people with mental health difficulties or learning disabilities. The right to education has been argued, together with Article 14, to challenge freedom from discrimination on the grounds of disability in the school environment.

The case concerned a young girl with muscular dystrophy who had been assessed as capable of attending mainstream school. The medical report annexed to her statement recorded “She walks with difficulties, will require transport to school and should not have to climb stairs”. In September 1992, the child’s mother expressed a parental preference for her child to be educated at a mainstream school rather than in a special school and she commenced her schooling in Sudbourne School in England.

In December 1993, her statement was reviewed and her physical condition had deteriorated to the extent that she was now more dependent on her wheelchair for mobility throughout the day.

¹⁸ *McIntyre v. UK* unreported Commission decision 231/10/98 29046/95

She was due to move into the first of her two senior years of study, which would involve the use of the science laboratory and the library, located on the first floor of the school. Her parent's requested that a lift be installed to facilitate access to the first floor.

The LEA investigated this request and found that it would cost over £47,000 to make such improvements. The LEA said that this was not an efficient use of resources. The child was, therefore, unable to participate in classes in the science laboratory or study in the library. She was supervised by a care assistant when her peers were attending these classes. Library books were brought to her on request and the LEA also provided her with a laptop computer and printer.

The child's mother began Judicial Review proceedings in respect of the refusal by the LEA to install the lift. These were dismissed and leave was refused to bring the case to the Court of Appeal. The child's legal representatives took the case before the European Commission, arguing that she was being denied her right to an effective education.

The European Commission held that the cost of installing a lift for one pupil was disproportionate to the benefit she would receive. They noted that the LEA had provided the child with a number of other resources and had minimised any disruption to her education. The fact that her statement included the requirement of "full access to the curriculum" did not necessitate the installation of a lift, provided the applicant received an adequate education.

The Commission also considered it relevant that Sudbourne School was one of a number of schools in the area, which had been targeted by the LEA for funding to improve access for pupils with limited mobility and that £15,000 had recently been spent on improving access ramps and toilet facilities at the school. Given that the school in question was relatively small and that other helpful measures had been employed by the LEA, the sum of £47,000 was found to be excessive, particularly when balanced with the demands of other schools within the Board area. The Commission held that the complaint was inadmissible.

Although this case was not successful on the facts, it is likely that future cases may be taken on similar grounds. It is clear from the judgment delivered that the issue of proportionality shall be the key to a successful application. For example, the decision may have been swayed had the lift been less costly, the school larger, or if no other measures had been taken to assist children with special educational needs.

Arguments grounded on Protocol 1, Article 2 and Article 14 on behalf of children and young people are likely to be strengthened by the introduction in September 2005 of the Special Educational Needs and Disability (NI) Order 2005 and associated guidance and regulations.

Suspension from School and the Right to Education under Article 2, Protocol 1

It has already been established in *Yanasik v Turkey*¹⁹ that suspensions and expulsions *per se* do not breach Article 2, Protocol 1.

In this case, the applicant complained to the European Commission about being expelled from a college because he had participated in a Muslim fundamentalist movement. The Commission found as follows:

“It would not be contrary to Article 2, Protocol 1 for pupils to be suspended or expelled, provided that the national regulations did not prevent them from enrolling in another establishment to pursue their studies”.

However, where a pupil is below statutory school-leaving age and is excluded from school, whether it be through the regulated expulsions procedure, or an illegal exclusion (where a child is taken off the schools register without compliance with domestic legislation and appropriate notice is not given to the Education and Library Board) the child is entitled to receive an effective education elsewhere.

If any exclusion prevents a child from receiving a continuing education elsewhere, this should be treated with great caution. The Department of Education and the relevant Education and Library Board may be at risk of breaching their statutory duties and, indeed, their obligations under the Human Rights Act 1998.

It is clear from the European Court’s interpretation of Article 2, Protocol 1, that education must be practical and effective and that an individual must have the benefit of drawing profit

¹⁹ (1993) 74 DR14

from the education received.²⁰ This means that a pupil is entitled to receive accreditation or certification for any courses completed or examinations sat. For example, if no suitable alternative educational provision is available either at another school, a Pupil Referral Unit, or through Education Other than at School (EOTAS); if home tuition provided by an Education and Library Board is insufficient in the number of hours received; or the Northern Ireland Curriculum cannot reasonably be accessed by an excluded child, it is perceived there may be a breach of Article 2, Protocol 1. This remains open to further challenge in the Northern Ireland Courts.

The Duty upon School Principals and Boards of Governors to Protect a Pupil's Right to Education under Article 2, Protocol 1

In the case of *Ali v Head Teacher and Governors of Lord Grey School*,²¹ there has been a significant Court of Appeal judgement in England in respect of a school's responsibility under Article 2, Protocol 1 to a pupil who was unlawfully excluded from school. The Court also considered whether the school's head teacher and governing body were liable under Section 8 of the Human Rights Act to pay damages for a breach of the pupil's rights under Article 2, Protocol 1. The facts of the case may be summarised as follows:

Facts:

- A was suspended from school following an allegation of arson at the school;
 - A's parents were not informed of their right of appeal to the school Board of Governor;
 - during the initial period of suspension, work was sent home from school for completion by A;
 - after 45 days, A's parents were invited to attend a reintegration meeting at the school;
 - A's parents did not attend;
 - A was taken off the school roll;
 - by the time he was admitted to another school, A had missed 11 months of schooling;
- and

²⁰ The Belgian Linguistic Case (1968) 1. EHRR 252

²¹ EWCA Civ 382 (29/03/04); [2004] ELR 169 – 198

- A's legal representatives argued that the school's actions were unlawful and were in breach of Article 2, Protocol 1.

Key issues arising from the Court of Appeal judgment may be highlighted as follows:

- the initial exclusion was unlawful as the period of suspension was indefinite and correct procedures had not been adopted;
- the claimant had been given self-assessing work home in preparation for his Standard Assessment Tests (SATs) examinations;
- on the basis of evidence provided that appropriate work had been sent home by the school for completion by A, there was no breach of A's Convention Rights under Article 2, Protocol 1, by the school, during the first 45 days of suspension;
- once the permitted period of 45 days temporary exclusion had expired, the school governors had an obligation to make a decision whether to re-admit A to school or to exclude him permanently;
- there were no lawful grounds for removing A's name from the school roll;
- continuing exclusion of A from school after 45 days was unlawful;
- the removal of A's name from the roll did not terminate the school's legal responsibility to educate A;
- A's Convention right to education under Article 2, Protocol 1 was denied, notwithstanding that the school was still offering to provide him work at home. The breach continued until A was placed in a new school;
- the Court considered whether the legal duty to educate A passed to the Local Education Authorities under Section 19 of the Education Act 1996 (England);
- it was found that Section 19 did not relieve the school head teacher and governing body of their obligations or from the legal consequences of failing to discharge their statutory duties. It was held by Sedley L J that *"It was the head teacher and governing body who in law bore the primary duty to educate a child who had been accepted in their school and, as a corollary, not to exclude that child except as authorised by law"*; and
- the appeal was dismissed in respect of the first 45 days of exclusion. However, an appeal was allowed in relation to the remainder period of exclusion. The respondents

were liable to pay damages to A for the breach of Article 2, Protocol 1, under Section 8 of the Human Rights Act 1998. The case was referred for assessment of damages.

Further legal arguments could also be raised in circumstances where a school makes a decision to suspend a child with a statement of special educational needs, who consequentially does not receive an effective education, taking account of the child's individual needs and the provision detailed in their statement of special educational needs.

DEPRIVATION OF LIBERTY AND THE RIGHT TO EDUCATION

Article 5 (1) (d) clearly states that the deprivation of liberty from a child or young person will only be justified in circumstances where the detention is for the purposes of educational supervision. The relevant case law is as follows.

The case of *Bouamar v Belgium*²² concerned a young boy of 16 who was remanded on nine successive occasions to a remand prison, due to the lack of another suitable alternative placement. The Government contended that it was “materially impossible” to find a more suitable placement for the child, due to a simple lack of appropriate accommodation and from the nature of the young person's personality and behaviour. The applicant challenged this. The Government stated in its submission that the placements complained of were part of an overall educative programme initiated by the courts, and that the young person's behaviour during the relevant time enabled them to gain a clearer picture of his personality.

The European Court did not share this view. They were of the opinion that the detention of a young man in a remand prison in conditions of virtual isolation and without the assistance of staff with educational training could not be regarded as furthering the educational aim and that the Belgian state, having chosen the system of educational supervision with a view to carrying out its policy on youth justice, was under an obligation to put in place appropriate institutional facilities which met the demands of security and educational objectives. The Court found that the nine placement orders were incompatible with Article 5 (1) (d), as the placements did not provide “educational supervision”.

²² *Bouamar v Belgium*, EurCtHR, App. No. 9106/80, (29 February 1988)

In *Koniarska v United Kingdom*,²³ a decision was made by the European Court as to the admissibility of a complaint by the 17 year old applicant in relation to the use of secure accommodation. The applicant argued that her rights had been breached under Articles 5, 3 and 8 of the ECHR on the following grounds:

1. that she was now beyond school leaving age and had received no education while detained; therefore, her detention was not compatible with Article 5 1 (d);
2. that her detention amounted to intense mental suffering amounting to inhuman and degrading treatment; and
3. that the further detention period was in breach of her right to family life, in that her ability to make home visits was limited.

The Court was of the opinion that the applicant was deprived of her liberty within the meaning of Article 5 (1). Therefore her detention had to fall within one of the exceptions under Article 5 (1) (a)-(f). The Court considered (although this was not argued by the Government) the relevance of the exception under Article 5 (1) (e) and stated:

“The applicant has been diagnosed as suffering from a psychopathic disorder and there is no suggestion that at the time of the making of the secure accommodation orders that this condition did not exist any more. Further her detention was found to be needed, as there was a danger that she would injure herself or others. There could thus be said to be medical and social reasons for her detention.”

Unfortunately the European Court did not give a formal ruling under Article 5 (1) (e), but considered the 5 (1) (d) exception. In considering the point raised that the applicant was over school leaving age, the Court stated that Article 5 (1) (d) applied to “minors” (i.e. those under 18) and not just those below official school age. They were of the view that detention could still be for the purposes of educational supervision. The applicant argued that her detention was not for the purposes of educational supervision and that any education she received was incidental. The Court stated as follows:

²³ Unreported admissibility decision, App. No. 33670/96, (12 October 2000)

“The Court considers that, in the context of the detention of minors, the words “educational supervision” must not be equated rigidly with notions of classroom teaching. In particular, in the present context of a young person in local authority care, educational supervision must embrace many aspects of the exercise, by the local authority, of parental rights for the benefit and protection of the person concerned”.

The Court was of the view that the secure accommodation orders made were capable of constituting part of educational supervision. It is important to note, however, that the Court looked in detail about the reality of the educational supervision provided at the specialist facility where the young person resided and was of the view that in this particular case extensive educational provision was made and that the fact that the applicant chose not to go to some of the classes did not alter this fact.

The Court distinguished the case of *Bouamar v Belgium* and found that the applicant’s detention was justified under Article 5 (1) (d) on the grounds of educational supervision. The Court found that although the applicant was very unhappy, there was nothing to indicate that her treatment had amounted to the threshold required for inhuman and degrading treatment. Ultimately, it found that the interference with the applicant’s family life was justified.

The case of *W Borough Council v DK, DIK, AK (a minor) and David Delahunty (GAL)*²⁴ involved an appeal on behalf of a 15 year old boy against the making of a secure accommodation order. The Court of Appeal made the following findings:

1. secure accommodation was a deprivation of liberty under Article 5. Therefore, it had to fall within one of the exceptions under Article 5 (1) (a)–(f) to be justified;
2. on the facts of the appeal, the young person was receiving education, which was carefully supervised, although there was criticism about the lack of provision of appropriate therapy;
3. the duty of the English Court under the Human Rights Act is to try and find a compatible interpretation;
4. in each case, where a secure accommodation order is applied for, the English Court, at any level, must have the requirements of Article 5 (1) (d) in mind when it is

²⁴ 15 November 2000, Court of Appeal

considering the relevant criteria, and thereby ensure the compatibility of the section with the Convention right; and

5. the case of *Koniarska* was followed. In the context of minors, the words educational supervision must not be equated rigidly with notions of classroom teaching...educational provision embraced many aspects of the exercise of parental authority of parental rights.

The minor applicant in the case of *DG v Ireland*²⁵ challenged the legality of his detention without charge or conviction in a penal institution between 27 June and 28 July 1997. The facts of the case were that the young person concerned was released from St Patrick's Institution in March 1997. He slept rough on the first night of his release and thereafter resided on a temporary basis in a homeless hostel. The applicant's solicitor wrote five times to the Board asking for proper provision to be made.

At a case conference it was agreed that the applicant needed to be placed in a high support therapeutic unit for 16-18 year olds, but that no such unit existed in Ireland and could not be put in place in time to meet the applicant's assessed needs. It was decided that the Board would look into placements outside Ireland and into interim options in Ireland.

The applicant's solicitor applied for judicial review in April 1997, requesting the immediate provision of suitable care and accommodation for the applicant. The High Court, on evidence

²⁵ *DG v Ireland* (ECtHR), App. No. 39474/98, (16 May 2002)

presented to it, concluded that the applicant was not mentally ill, but that he had a personality disorder; that he was a danger to himself and others, that he had a history of criminal activity, violence and arson, that he had absconded from non secure institutions, that he had failed to co-operate with staff and with a psychiatric assessment and that it was “common case” that the young person needed to be placed in a secure unit where he could be looked after, but that no such unit existed in Ireland. The applicant was ultimately sent to St Patrick’s (a penal institution) due to the lack of any other facility. On 27 June 1997 he was brought to St Patrick’s and placed in a padded cell overnight.

The High Court had ordered that he was to be subject to the normal discipline of the institution and was to have a full psychiatric evaluation. It requested the fullest co-operation between the institution and the Board in terms of allowing professionals already involved with the young person to continue to have an input and, in particular, recommended that normal visiting restrictions be waived as much as possible in the 24 hour period after his detention.

The wide range of services which were available at St Patrick’s was outlined in a booklet which was given to the applicant on admission. He was asked if he wished to attend education classes, but he made no request to do this and at no time took part in the educational programme available. The applicant made submissions to the European Court that his detention at St Patrick’s from 27 June 1997 to 28 July 1997 was not in accordance with the procedures prescribed by law, nor was it for the purposes of educational supervision within the meaning of Article 5 (1) (d). He contended that he was a minor in need of special care and protection, but that he had been detained in a penal institution where his unique status caused other detainees to believe that he was a serious sexual offender pursuant to which he was threatened and abused. He argued that this was in contravention of Article 5 (1).

The European Court considered that the applicant, who was 17 years of age and, therefore, over the age of compulsory education, was still a minor for the purposes of “educational supervision” in the context of Article 5, as he was under 18. The Court stated as follows:

“The Court does not consider ...that St Patrick’s penal institution itself constituted educational supervision. As noted above, it is a penal institution and the applicant was

subject to its disciplinary regime. The education and other recreational services were entirely voluntary and the applicant's history was demonstrative of an unwillingness to co-operate with authorities; indeed the government itself accepts that the applicant did not avail of the educational facilities. There is no entry in the applicant's prison file, in the medical or psychiatric reports submitted or any specific submission by the government detailing any instruction received by the applicant during his detention at St Patrick's. The only indication of his participation in recreational facilities is a brief reference to playing football...Most importantly the High Court itself was convinced that St Patrick's could not guarantee his constitutional educational rights or provide the special care he required; even with the special conditions the High Court attached to his detention, the High Court considered St Patrick's to be the best of four inappropriate options and that his detention there should be temporary."

The Court recalled that the applicant's detention could be compatible if it was an interim custody measure for the purpose of putting in place an educational supervisory regime, which was followed speedily by implementation of this regime. The Court was not of the view that this was such an interim measure and found that there had been a violation of Article 5 (1) (d) in respect of the applicant's detention at St Patrick's from 27 June to 28 July 1997. The applicant was detained in breach of Article 5 (1).

CAPACITY, INCAPACITY AND HUMAN RIGHTS

INTRODUCTION

One of the main issues in mental health law is the question of capacity. Capacity in this context relates to a person's ability to understand, to make decisions and to manage his or her affairs. The question of capacity is closely related to mental disorder including mental illness and learning disability.

One fundamental aspect of a person's "human rights" involves the power of an individual to make decisions for him or herself: known as autonomy. Formal or informal perceptions of incapacity can result in the removal of autonomy. Consequently the issue of capacity is central to a person's human rights.

From a human rights perspective, it does not inevitably follow that a person lacks capacity simply because he or she has some form of mental disorder. Moreover the position is complicated by the fact that a definition of "capacity" can vary according to the nature of the decision in question: e.g. whether to purchase chocolate or have psychosurgery. Also it should be remembered that a person's mental capacity will not necessarily remain static: this is known as intermittent capacity.

Under the ECHR, Articles 5, 8 and 11 provide protection for a person's autonomy. Article 5 protects against arbitrary detention; Article 8 protects a person's private life including his or her physical or mental integrity; and Article 10 enshrines a modified freedom of expression. Article 14 seeks to guarantee equal treatment and proscribes discrimination in relation to any of the above mentioned rights.

CONCERNS

The human rights concerns in this area focus on the inappropriate removal of a person's autonomy, both in relation to a person with capacity and a person without capacity. In broad terms, the issue to be addressed concerns the circumstances where a substitute decision-maker can validly make a decision on a person's behalf.

Substitute decision-making can potentially be contrary to human rights law, in the following circumstances:

- (a) in relation to a person who is acknowledged to have capacity;
- (b) in relation to a person who is deemed incapable but who actually has capacity;
and
- (c) inappropriate substitute decision-making in relation to a person who does not have capacity.

KEY ISSUES

In devising a human rights compliant legal framework, appropriate rules and procedures must be put in place to govern:

- (a) the determination of capacity or incapacity;
- (b) the circumstances when substitute decision-making can be lawful in relation to someone who is capable;
- (c) how to deal with persons with intermittent capacity; and
- (d) the appropriate mechanisms for dealing with persons who do not have capacity, including putting in place sufficient safeguards to protect such persons.

Any domestic legislation must be compliant with the Human Rights Act 1998 and in particular European Convention jurisprudence.

THE CURRENT LAW IN NORTHERN IRELAND: A BRIEF OVERVIEW

Law in relation to capacity falls into two main categories governing:

- (a) the management of patients' property and affairs; and
- (b) medical treatment and welfare provision.

Law Governing the Management of Patients' Property and Affairs

There is a legal presumption of capacity. Two categories of persons are considered to lack capacity for legal purposes (and are regarded as persons under a disability):

- children; and
- adults without capacity e.g. "patients" i.e. persons, who by reason of mental disorder (as defined in Part VIII of the Mental Health Order) are incapable of managing/administering their property and affairs, which includes engaging in the legal process.

Persons Without Capacity and Representation in Court

The Official Solicitor to the Supreme Court of Northern Ireland looks after the interests of and represents certain "persons under a disability" as defined by the legislation. Generally speaking "persons under a disability" must engage in the legal process by bringing proceedings by a next friend, or defending proceedings against them by a Guardian ad Litem. The Official Solicitor only acts as next friend or Guardian ad Litem of last resort in that such intervention only occurs if there is no one else suitable, willing or able to act.

One large area work is that of representing the interests of "persons under a disability" in proceedings under the Children (Northern Ireland) Order 1995 and under the Adoption (Northern Ireland) Order 1987.

Adults and older children who are thought to lack "capacity" due to a "mental disorder", as referred to in the Mental Health Order, raise very complex and difficult issues for those concerned in protecting their rights. In particular, preserving their autonomy as far as possible and ensuring that if there is any intervention into their affairs, it is the least possible in the circumstances, it is necessary, justifiable and in their best interests. Indeed the issue of failing to intervene in certain circumstances can be regarded as a failure to protect rights.

The "measurement" of a person's capacity can lead to different opinions: for example:

- in some cases one psychiatrist may consider a person "incapable", yet another may consider the person "capable". Whilst there will be borderline cases, to ensure consistency of practice there should be guidelines for assessing "capacity".
- in some cases one psychiatrist may think a person is "capable" in relation to certain legal issues, but "incapable" in relation to others. This raises the issue of "capacity" being function-specific. The more complicated the decision, the greater the mental ability required to properly make that decision.

A relatively recent English case has given considerable assistance regarding the issue of "capacity" in legal proceedings. In the case of *Masterman-Lister v Jewell and another*, [19th December 2002] the English Court of Appeal held that:

"The test to be applied for the purpose of determining whether a claimant was a patient incapable of managing his own property and affairs within the meaning of [the current legislative provisions] in respect of commencing and compromising litigation was issue-specific and depended on the nature and complexity of the transaction...."

Lord Justice Kennedy said that there was no definition in the current Mental Health Legislation or the court rules to assist as to the meaning of “incapable” of managing and administering his...affairs.

“There was no reported English decision directly concerned with the capacity to litigate and compromise but the courts had considered capacity in other contexts, for example the capacity to make a will. What seemed to be of some importance was the issue-specific nature of the test; that was to say the requirement to consider the question of capacity in relation to the particular transaction (its nature and complexity) in respect of which the decisions as to the capacity fell to be made. It was not difficult to envisage claimants in personal injury actions with capacity to deal with all matters and take all "lay client" decisions related to their actions up to and including a decision whether or not to settle, but lacking capacity to decide (even with advice) how to administer a large award. In such a case there could be seen no justification for the assertion that the claimant was to be regarded as a patient from the commencement of proceedings. The conclusion that in law capacity depends on time and context means that inevitably a decision as to capacity in one context did not bind a court which had to consider the same issue in a different context. A person might be a patient for the purpose of [one legislative provision] but not for the purpose of [another]. The court would need medical evidence to guide it. It would help if the initiating court forms or the personal injuries protocol were to contain some material drawing attention to the issue of capacity, and it certainly seemed desirable for some change to be made so that a person could not, as at present, become a patient for the purpose of [a particular legislative provision] without knowing what was going on. That could be achieved by requiring that, unless the court otherwise ordered, anyone intending to become a [next] friend without a court order should serve on the intended patient notice of his intention to act as his [next] friend, and a copy of the certificate of suitability, so that the intended patient was then in the same position that he would be in if there were to be an application for a [next] friend to be appointed by order of the court ...”.

This decision makes it very clear that the presumption of capacity must be adhered to unless there is clear evidence to the contrary. There is to be no “broad brush” label of incapacity. Rather, each decision to be made must be viewed in light of its complexity. From a human rights perspective, this is of enormous significance.

Practical Implications of Incapacity in the Legal Process

A potential problem is if persons who do not have the requisite experience become involved in cases and assume that persons who are not conforming to their idea of “normal” are in fact “incapable”. This would offend the presumption of capacity and could amount to a human rights breach, as a person could effectively be stripped of their autonomy without proper enquiry. The Masterman-Lister case reiterates the importance of making the proper enquiry.

The following are examples of when a psychiatric opinion will be sought to establish a person's “capacity”:

- (a) where the High Court is considering appointing a financial “controller” to manage a person’s property and affairs under Part VIII of the Mental Health Order it must be satisfied that the person is incapable by reason of mental disorder (as defined by the Order) of managing or administering his property and affairs;
- (b) where it needs to be ascertained if a person has the “testamentary capacity” to make a will. In many cases persons who are incapable of managing their property etc have testamentary capacity;
- (c) where a person’s capacity to instruct a solicitor is in question. For example, is the person capable of understanding all the details he or she is given in relation to applications to the court in respect of their children? Does the person have capacity to consent to various matters in family proceedings, the most striking example being whether the person is able to consent to their child being freed for adoption? In these circumstances, if the person is incapable they would

have to bring proceedings by a next friend and defend proceedings by a Guardian ad Litem.

In such situations, difficult issues arise including:

- whether people who are merely eccentric and non-conformist are regarded as incapable;
- people who do not come within the strict legal definition of “person under a disability” but who do require some appropriate assistance. Good examples are persons with personality disorders, learning difficulties or disabilities or other vulnerable adults; and
- confusion about the role of a next friend and particularly a Guardian ad Litem acting for a "mentally incapacitated parent" or other person lacking capacity.

Law Governing Medical Treatment and Welfare Provision

Autonomy and capacity lie at the heart of human rights. Conceptually, liberty asserts that capable persons should have the right to govern their own lives. Persons incapable of making determinations should have their rights protected. Consequently capacity is a very important issue in relation to psychiatric treatment.

As a general rule of law, any person with mental capacity can consent or refuse to consent to medical treatment. However, in the psychiatric sphere this raises complex questions.

Under Part IV of the Mental Health Order, detained patients, and in certain circumstances all patients, can be treated without their consent.

The general rule is found in Article 69, subject to Article 62(2).

Special protection operates in relation to certain forms of treatment:

- (a) surgical operations which destroy brain tissue or destroy the functioning of brain tissue (and operations for the surgical implantation of hormones for the purpose of reducing male sex drive) require a patient's consent except in cases of urgent treatment.(Articles 63 and 68 and the Mental Health (Hospital, Guardianship and Consent to Treatment Regulations (NI) 1986). Consequently a capable person can be compulsorily treated in urgent situations.
- (b) electro-convulsive therapy (ECT), and the administration of medicine by any means once three months has elapsed from the first time the patient was given medicine for his or her mental disorder, require either consent (from a person certified as capable of consenting) or a second opinion. (Article 64 and the Mental Health (Hospital, Guardianship and Consent to Treatment Regulations (NI) 1986) Consequently, a Part IV psychiatrist can compel treatment in circumstances where a capable person does not consent, by certifying that "having regard to the likelihood of its alleviating or preventing a deterioration of [a].. condition, the treatment should be given. (Article 64(3)(b)).

These provisions raise human rights issues for patients and, in particular, detained patients.

- (a) the right to consent to treatment is compromised by these provisions: as regards almost every kind of treatment (excepting the former identified above) detained patients can be treated without their consent;
- (b) detained patients can be treated with ECT without their consent. This power is particularly invasive. In urgent circumstances, psycho-surgery can be performed on patients.

Human rights are engaged under the ECHR: in particular Article 3 (prohibition of inhuman and degrading treatment) and Article 8 (the right to physical and mental integrity).

The House of Lords has recently re-iterated the rights of mentally-ill patients in relation to treatment in the case of *R (on the application of B) v Ashworth Hospital Authority* (2005) 2 AER 289.

Prevailing law, policy and/or practice in Northern Ireland arguably falls short of the requirements of the Human Rights Act 1998. For example, the application of ECT is a matter of concern. Following its review of mental health legislation, policy and practice in Northern Ireland, the Human Rights Commission has considered commissioning a more detailed study on psychiatric treatment in Northern Ireland.

The current Northern Ireland legal framework raises concerns under other human rights instruments, particularly the United Nations Mental Health Care Principles. It is questionable whether current law, policy and practice meets the requirements of Principle 11 thereof. For example, the application of ECT on non-consenting capable detained patients seems at variance with Principle 11(14) of the Mental Health Care Principles.

THE MENTAL CAPACITY ACT 2005

Mental health legislation has been undergoing reform throughout the United Kingdom. In April 2005, the Mental Capacity Act 2005 was enacted in England and Wales. The provisions of this legislation provide much greater protection for persons with mental disorder than the prevailing legislation and legal framework in Northern Ireland. Moreover, the legislation has adopted a number of principles established in common law and human rights law.

It is useful to highlight some of the important developments contained in this legislation:

- (a) the underlying principles (section 1);
- (b) the new definition of capacity (sections 2-3);

- (c) the statutory adoption of the concept of a person's best interests;
- (d) the power to make partial declarations of incapacity;
- (e) the appointment and restrictions placed on Deputies;
- (f) a statutory power to make advance directives;
- (g) specific provision for consultation with carers;
- (h) the appointment of independent mental capacity advocates; and
- (i) the establishment of a superior court of protection.

Undoubtedly many of these statutory innovations provide greater protection for persons with mental disorder.

Northern Ireland legislators must take cognizance of developments in other parts of the United Kingdom and provide at least as much protection for people in this jurisdiction and ensure compliance with the requirements of human rights law.

INVOLUNTARY DETENTION

INTRODUCTION

The compulsory admission and detention of individuals in hospital constitutes an interference with their autonomy and liberty, and carries with it a risk of unlawful interference with their human rights. Considering whether to intervene in a person's life and involuntarily subject him or her to detention is often a complex and difficult task for the relevant authorities. Health authorities are charged with providing care and treatment, where appropriate. Moreover, the State has a duty to protect people from harm, including the person in question as well as others.

Liberty is a fundamental human right and the law safeguards individual autonomy. Involuntary detention raises a range of human rights concerns, including the following:

- detention of persons whose mental state does not warrant detention;
- detention of persons whose behaviour does not warrant detention;
- failure to observe procedural requirements and due process in the detention of persons;
- continued detention of patients who no longer fulfil the legal criteria for detention;
- adequate provision for the education of detained children and young persons; and
- the statutory role of relatives in the detention of patients.

Decision-making in this area involves an assessment of the health of the person concerned and consideration of his or her rights and interests, as well as the interests of the wider community. There are a range of factors which must be taken into account when considering whether or not to intervene in a given situation. In every case, the State must be careful to act within the law, both prevailing domestic law and European Convention law. This paper seeks to outline the relevant domestic law and European Convention jurisprudence and to highlight concerns identified by the Sub Group.

DOMESTIC LAW

The Statutory Framework

The main statutory mechanism for the compulsory detention of individuals is the Mental Health (NI) Order 1986 (MHO). Compulsory detention under the MHO (sometimes referred to as formal detention) comprises two stages:

- admission for assessment; and
- detention for treatment.

Admission for Assessment

A person with a “mental disorder” can be compulsorily admitted to hospital for assessment. If he or she is living in the community, the involuntary admission can be initiated by an approved social worker (ASW) or by the nearest relative on the recommendation of a medical practitioner. More particularly, a person can be admitted for assessment only if he or she is:

- suffering from mental disorder of a nature or degree which warrants his or her detention in a hospital for assessment (or for assessment followed by medical treatment); and
- failing to so detain him or her would create a substantial likelihood of serious physical harm to him or herself, or to other persons.

The legislation, however, could be regarded as too narrow, in that it does not cover, for example, psychological harm.

A nearest relative, or an approved social worker, can make an application for a person to be admitted to hospital. Most hospital admissions are founded upon a social worker’s application.¹ The ASW is required by law to make an application for assessment in respect of a patient for whom he or she has responsibility, where he or she:

¹ In 2001-2002 over one half of admissions were social worker applications. See *The Mental Health Commission for Northern Ireland Sixth Annual Report and Accounts 2001/2*; page 27

- is satisfied that such an application ought to be made; and
- is of the opinion, having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made by him or her.

The nearest relative can require the responsible authority to direct the responsible ASW to exercise this Article 40 (1) duty. Where such a direction is issued, but the ASW decides against making an application for assessment, he or she must inform the nearest relative of the reasons for this decision in writing.

Application for Admission to Hospital by the Approved Social Worker

An application for assessment may be made by an ASW. This will only be valid if the applicant “has personally seen” the patient not more than two days before the date on which the application is made. The social worker must consult with “the person appearing to be the nearest relative” before making an application, “unless it appears to the approved social worker that in the circumstances such consultation is not reasonably practicable or would involve unreasonable delay”.²

If a patient is admitted to hospital following an application for assessment made by an ASW, without consultation with the person appearing to be the nearest relative, “it shall be the duty of that social worker to inform the nearest relative of the patient [of said admission] as soon as may be practicable”.³

Admission of Children and Young People

Children and young people can be detained under the MHO. The Code of Practice provides guidance to assist practitioners involved in the detention of children and young people.⁴

Whenever admission of a child or young person to hospital under Part II of the MHO is a possibility, the Code highlights three issues which should always be considered:

² Article 5(3)

³ Article 5(5)

⁴ Paragraphs 2.31 to 2.36

- (a) what parent or guardian is legally responsible for the child, if any?
- (c) is the child capable of making his or her own decision? and
- (d) is the child subject to any court or other legal order?

Detention for Treatment

A patient may be detained for longer than 14 days, only if his or her condition falls within the criteria contained in Article 12 (1) of the MHO, namely:

- (a) the patient is suffering from a mental illness or severe mental impairment of a nature or degree which warrants his or her detention in hospital for medical treatment; and
- (b) failure to detain the patient would create a substantial likelihood of serious physical harm to him or herself or to other persons.⁵

A person can be initially detained for treatment for up to six months and can be further detained for a second period of up to six months. Thereafter, a patient can be detained for periods of up to one year. One safeguard introduced by Article 13 (4) of the MHO requires that once a person has been detained for a year, the authorisation of further detention must be made by two psychiatrists, of whom one must be “a person who is not on the staff of the hospital in which the patient is detained and who has not given either the medical recommendation on which the application for assessment in relation to the patient was founded or any medical report in relation to the patient under Article 9 or 12 (1)”.⁶

The Children (NI) Order 1995

Provision is made under the Children (NI) Order 1995 for interventions concerning children who require psychiatric care and treatment. A supervision order can be imposed where a child requires care that his or her parents are unable to provide.⁷ A court can authorise the psychiatric examination of a child subject to a supervision order if it is satisfied, on the

⁵ MHO; Article12(1)(a) and (b))

⁶ (Art.13(4)(c))

⁷ Article50

evidence of a medical practitioner, that the child may be suffering from a mental condition that requires treatment and that is medically treatable. The child's consent is required. A court can also authorise the medical treatment of a child where appropriate.⁸

Detention under the Health and Personal Social Services (NI) Order 1972

The Health and Personal Social Services (NI) Order 1972 makes provision for State intervention concerning persons who:

- (a) suffer from grave chronic disease or, being aged, infirm or physically incapacitated, are living in insanitary conditions; and
- (b) are unable to devote themselves, or to receive from persons with whom they reside, or from persons living nearby, proper care and attention.⁹

Such intervention can include the non-consensual removal of such persons to other accommodation, where necessary.¹⁰

A social worker (who may or may not be an ASW) may initiate proceedings to remove a person from his or her place of residence if he or she reasonably believes that this is necessary in the interests of the person concerned, or to prevent serious nuisance or injury to a third party. The social worker must initially consult with both the general medical practitioner of the person concerned and a medical officer designated by the health authority. He or she may make a removal application based on the medical certification of the health authority's designated medical officer that such removal is necessary.

Thereafter, the health authority may apply to the magistrates court within the jurisdiction where the person resides for an order to remove him or her to a suitable hospital or other place, and be detained there for up to three months. The health authority must give the nearest relative of the person concerned three days' notice of its intention to apply to the court for a removal order, and it must inform the person managing the accommodation which

⁸ Schedule 3, paragraph 5

⁹ Article 37

¹⁰ Schedule 6

is to receive the person that a removal hearing is to take place. At the hearing, the authority must lead evidence to substantiate its application. The court also may hear evidence from the person concerned and/or his or her nearest known relative. The person concerned has the right to be legally represented at such a hearing.

Non-Statutory Detention

Many people with mental health problems receive care and treatment outside the statutory framework, particularly elderly people cared for in hospital and nursing or residential care homes. Informal, extra-statutory, non-consensual intervention (including deprivation of liberty) in the lives of such persons has traditionally been justified by reference to the common law principle of necessity. Since the decision of the European Court in the *Bournewood* case (outlined below), such extra-statutory, informal interventions involving a deprivation of liberty may be unlawful.

RELEVANT HUMAN RIGHTS LAW: AN OVERVIEW

The Human Right Act 1998

The Human Rights Act 1998 patriated the ECHR into the domestic law of the UK. In practical terms this provides a mechanism whereby individuals who are aggrieved about a perceived breach of their rights under the European Convention may challenge the actions of the relevant public authority. This challenge can be made by way of civil proceedings, a judicial review application or by introducing the argument into other ongoing court or Tribunal proceedings. The Act has three important effects:

- (a) courts must construe primary and secondary legislation in accordance with the Convention;¹¹

¹¹ Sections 2 and 3. Human Rights Act 1998

- (b) public authorities have a duty to comply with the rights outlined in the Convention. A “victim” of a breach of that duty can challenge this in the courts;¹² and
- (c) the superior courts can make a finding that domestic law is incompatible with the Convention and can make a “declaration of incompatibility.”¹³

Article 5 (1)

The issue of detention of mentally disordered persons raises the prospect of a possible challenge to a public authority on the basis of a breach of Article 5 of the Convention. Article 5 (1) provides that:

“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;*
- (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;*
- (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; and*
- (f) 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.”*

¹² Section 6. Human Rights Act 1998 s.6(1) “It is unlawful for a public authority to act in a way which is incompatible with a Convention right”

¹³ Section 4. Human Rights Act 1998

The Scope of the Right to Liberty

The right to liberty and security of the person under Article 5 is a qualified right. The right to liberty is not, therefore, absolute and can be abrogated where liberty is restricted “in accordance with law” or where the circumstances outlined in sub-paragraphs (a) to (f) apply. As Clayton and Tomlinson note that:

“The right to physical liberty is not absolute. It must give way where vital community interests are at stake. Accordingly, a person may be deprived of his or her liberty, but only if the exercise of powers of arrest and detention by state authorities is governed by due process of law and consistent with recognised standards.”¹⁴

Therefore, detention which is carried out in accordance with the Mental Health (NI) Order will prima facie not be in breach of Article 5. However, there is still considerable scope for breach of Article 5 in the application of the legislation and, in some areas, aspects of the legislation may be incompatible with the Convention itself. It is generally agreed that the core requirements of Article 5 (1) are that a detention takes place in accordance with a procedure prescribed by law and that the detention must not be “arbitrary”. In relation to the penal detention of mentally disordered adults, Article 5 (1) (a) is the central provision. The detention of those under “civil” powers engages issues under Article 5 (1) (e).

Detention

The structure of the Article 5 protections for the liberty and security of the person are contingent on there having been “detention”. If there is no detention then the safeguards of Article 5 do not apply.¹⁵ Detention has been determined by factors such as duration, effect and the mode of restraint used. In *Ashingdane v United Kingdom*, the European Court held that a patient was detained because his liberty had been circumscribed even though he had been permitted to leave the hospital in question.¹⁶

¹⁴ Section 6. Human Rights Act 1998. s.6(1) “It is unlawful for a public authority to act in a way which is incompatible with a Convention right.” ee Gostin, L. “Human Rights of Persons with Mental Disabilities.” 23 *International Journal of Law and Psychiatry* 125 (2000) at 137

¹⁵ See also the discussion of *Bournemouth* below

¹⁶ *Ashingdane v United Kingdom* 7 EHRR 528 (1985)

On What Basis?

A pivotal factor in determining the legitimacy of a detention in the mental health context is a reliable finding of some mental disorder.¹⁷ The requirement outlined in Article 5 (1) (e) is a finding of “unsoundness of mind”. No detailed interpretation of the concept of “unsound mind” has been developed by the European Court. This is consistent with that court’s pragmatic approach to interpreting the Convention as a living instrument.

The Court has, however, held in *Winterwerp* that Article 5 (1) (e) will not permit the detention of a person simply because his or her apparently irrational views or behaviour deviates from the norm in society.¹⁸

The question of detention on the basis of “severe mental impairment” was recently considered by Weatherup J in a judicial review application by *North and West Belfast Trust*.¹⁹ The Mental Health Review Tribunal had held that the patient in question should be conditionally discharged as she was not suffering from “severe mental impairment” or “mental illness”.

Although this case raises issues relating to Article 5 (1) (e), these arguments were not examined by the Court which ruled that “severe impairment of intelligence and social functioning” was a disjunctive test which required both proof of severe impairment of intelligence and proof of severe impairment of social functioning. The European Court has previously addressed the issue of detention in *Winterwerp v The Netherlands* where three minimum conditions were outlined for the detention of mentally disordered persons:

- (a) there must be objective medical evidence such as to establish a true mental disorder;
 - (b) the mental disorder must be of a kind or degree warranting compulsory confinement;
- and
- (c) the mental disorder must persist throughout the period of detention.

¹⁷ See Gostin, L. “Human Rights of Persons with Mental Disabilities.” 23 *International Journal of Law and Psychiatry* 125 (2000) at 141

¹⁸ *Winterwerp v The Netherlands* [1979] 2 EHRR 387

¹⁹ *In the matter of an application by North and West Belfast Health and Social Services Trust* (unreported WEAC3928 28th May 2003). There appears to have been no specific reference to Article 5 issues in argument before the Court and no Convention jurisprudence is referred to in the judgment

The Court acknowledged that different considerations might apply in “emergency” cases.

Bournewood and Informal “Admission”

The *Bournewood* case concerned the informal detention of persons without capacity to consent to detention (5 October 2005). L, a 48 year old autistic man, was admitted to hospital following a minor incident at a day care centre. He was compliant and made no attempt to leave. The House of Lords held that the patient was not detained and reversed a decision of the Court of Appeal, which had held that such patients could not be admitted informally.

The European Court found that the detention was a “deprivation of liberty” pursuant to Article 5 of the Convention. The detention was arbitrary and in contravention of Article 5 (1) because of the absence of procedural safeguards. The Court further found there to be a breach of Article 5 (4) in that there was not an available appropriate mechanism (such as a Mental Health Review Tribunal) to challenge the lawfulness of the detention. The Court specifically held that judicial review did not constitute an appropriate mechanism.

The Role of the Nearest Relative

Under the Mental Health Order, the nearest relative is afforded certain powers and rights in relation to the admission and detention of a patient. These powers raise issues under Article 5 and also Article 8 (the right to respect for private and family life) and were considered by the European Commission on Human Rights in *JT v United Kingdom*.²⁰

In that application, the detained person complained that the legislation did not include any formal mechanism whereby the detained person could alter the identity of the nearest relative. The applicant complained that she did not want the nominated person to be her “nearest relative” and objected to this person being given confidential medical information. This case was settled on the basis that legislation would be introduced to permit reasonable objections to the nearest relative.

²⁰ *JT v United Kingdom* [1999] EHRLR 443

Provision of Treatment

In *Aerts v Belgium*, the Court held that, where the applicant had not been provided with any treatment for the condition which had given rise to his detention, then there was a breach of Article 5 (1) (e).²¹ The applicant was detained in a psychiatric prison wing rather than a social protection centre. The Court held that, as he had not been convicted of any criminal offence, his detention could not be justified under Article 5 (1) (a). The only possible justification for his continued incarceration was Article 5 (1) (e).

The Court found that there must be some relationship between the ground of permitted detention and the location and conditions of that detention and, in principle, Article 5 (1) (e) detention could only be justified if the patient was held in an appropriately therapeutic setting. It has been suggested by academic commentators that this ruling, following the decision in cases such as *Ashingdane*, heralded the tentative beginnings of a jurisprudence of positive rights for the mentally disordered patient.²²

Lack of Adequate Resources

The European Court has considered the Article 5 implications of continued detention in circumstances where an individual would be released, but for a lack of adequate treatment resources. In *Johnson v United Kingdom*, the Court found that where lack of placement facilities resulted in indefinite detention, this could constitute a breach of Article 5 (1) (e).²³ The applicant had been found not to be suffering from any mental disorder and his conditional discharge was deferred pending the provision of suitable hostel accommodation.

Article 5 (4)

This Article introduces due process mechanisms which provide procedural support for the substantive Article 5 right to liberty. It is important to note that the protections of Article 6 may also be applicable in relation to detention in the mental health sphere. Article 5 (4) provides that:

²¹ *Aerts v Belgium* [1998] 29 EHRR 50

²² See Fennell n.9

²³ *Johnson v United Kingdom* [1999] 27 EHRR 296. See also decision of Court in *DG v Ireland* (16th May 2002)

“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.”

This Article raises four discrete issues:

- (a) a review of the lawfulness of detention;
- (b) by a court;
- (c) in a reasonably prompt manner; and
- (d) with the power to release persons who are unlawfully detained.

Review in the mental health context must be periodic, because the lawfulness of the detention is contingent on the persistence of the illness.²⁴ Excessive delay in the conduct of periodic review will be in breach of Article 5 (4). In *E v Norway*, a delay of eight weeks was held to be excessive.²⁵

Recall of Patients Conditionally Discharged

The Secretary of State has the power under Article 48 of the MHO to recall a person who has been discharged subject to a restriction order. There is no requirement for a further medical assessment prior to the exercise of this power. Clayton & Tomlinson note, in relation to the English legislation, that “it is difficult to see how this power is compatible with the Convention.”²⁶ Where a restricted patient is re-admitted for assessment or treatment, there is no mechanism for application to the Mental Health Review Tribunal unless the formal power under Article 48 (3) has been used. This anomaly is also likely to be in breach of Article 5 (4).

²⁴ *Megyeri v Germany* [1992] 15 EHRR 584

²⁵ *E v Norway* [1990] 17 EHRR 30

²⁶ Clayton & Tomlinson. *Law of Human Rights*. Oxford University Press. 10.184

Minors and Detention: Article 5 (1) (d)

The ECHR envisages that detention of a minor will be lawful where it is done for the purposes of educational supervision. There is a clear tension between the terms of Article 5 (1) (d) and the use of accommodation orders under the Children (Secure Accommodation) Regulations 1995.²⁷

The European Court has taken a relatively broad view of the term “educational supervision”. In *Koniarska v United Kingdom*, it found that “the words ‘educational supervision’ must not be equated rigidly with notions of classroom teaching. In particular, in the present context of a young person in local authority care, education supervision must embrace many aspects of the exercise, by the local authority, of parental rights for the benefit and protection of the person concerned.”²⁸

In *DG v Ireland*, the Court found that education supervision could apply beyond the statutory school leaving age. The applicant was a 17 year old who displayed indications of a serious personality disorder. There was no secure unit available for his assessment in the jurisdiction and he was consequently detained in a penal facility. The Court found that the absence of any instruction, education or recreational facilities at the penal institution constituted a breach of Article 5 (1) (d).²⁹

It would appear that detention in inappropriate facilities can constitute a breach of Article 5. Given the absence of appropriate facilities for mentally disordered young people in this jurisdiction, this is likely to be a continuing problem in relation to the detention and treatment of minors in Northern Ireland.

POINTS FOR DISCUSSION

1. The various factors relevant to the question of involuntary detention. In particular, what are the prevalent human rights issues?

²⁷ see Children’s Law Centre submissions to the Mental Health Review

²⁸ *Koniarska v United Kingdom* [2000] (unreported decision 33670/96)

²⁹ *DG v Ireland* [2002] (unreported decision May 16th 2002)

2. The definition of unsound mind: how broad should the definition be? Should the present definitions contained in the Mental Health Order be retained or amended?
3. The criteria facilitating and limiting compulsory detention: is the present statutory formula (which is based on likelihood of harm to self/others) appropriate?
4. Should the nearest relative be part of the formal admission process?
5. What particular safeguards or alternative provision is necessary to secure the interests and/or protect the rights of children and young people?
6. Should prospective legislation make specific provision for non-voluntary detention (ie the Bournewood scenario)?
7. How quickly should compulsory detentions be subject to independent review: (a) by a legal tribunal or court; (b) by an “independent” psychiatrist?
8. Given that many detained persons have reduced mental capacity by reason of their respective mental conditions, should the holding of regular Review Tribunals be mandatory?
9. What new or enhanced safeguards could assist in providing greater protection for the rights of compulsorily detained persons?

DETENTION OF A CHILD IN THE CONTEXT OF MENTAL ILL-HEALTH LEGISLATIVE REQUIREMENTS

The “Best Interests” principle **must** be clearly incorporated within mental health legislation pertaining to children, thus aligning it with the Children (NI) Order 1995 (the paramount consideration is always the child’s best interests – Article 3 checklist), acknowledging and promoting existing obligations under international and domestic law (particularly the UNCRC (Articles 19, 23, 25, 37(b), concluding observations of the UN Committee on the Rights of the Child (October 2002) and recognising the well established ECHR jurisprudence on the “best interests” principle).⁶⁷

Address the relative invisibility and consequent injustice suffered by children affected by mental illness by mainstreaming children’s rights to care, treatment and appropriate services within mental health law **and** policy.

Legal mandate for equal, effective enjoyment of all human rights (substantive and procedural) without discrimination to the maximum extent possible by children with mental disability (incl. Section 75 of the Northern Ireland Act 1998; Article 2 in the context of UNCRC rights; Article 14, Protocol 1; Article 2 in the context of ECHR).

Principles of equality and non-discrimination do not apply differently in the context of the child with mental or intellectual disability. A human rights framework of reference must include a child falling within disability discrimination agenda (incl. the DDA; EU Disability Directive; Section 75 of the Northern Ireland Act 1998 and see <http://www.sre.gob.mx/discapacidad/paper> and acknowledge the duty to comply with other equality categories).

Principled statement restricting use of control and restraint in line with the UNCRC framework (Articles 37, 19 (a)); the White Paper in 2000, ‘The Involuntary Placement and Treatment of Minors’; and the European Committee for the Prevention of Torture (ECPT) guidelines.

Clear provision for participation of the child within the legal and policy framework for compulsory assessment and treatment, including age-appropriate review regime and a mechanism to provide for the choice of ‘nominated person/nearest relative (*JT v United Kingdom*). Incorporation of Article 12 UNCRC within overall mental health framework requires appropriate and accessible information.

Acknowledgement (a) that a child should be treated in separate accommodation from adults (units need to meet certain standards and specific protocols relating to the admission of young people); and (b) of the competent child’s right to consent to treatment and confidentiality (already existing in England and Wales, UK Care Standards Act). Also, (c) incapacitated but compliant child included under the legislative safeguards (*R v Bournemouth Community and Mental Health Trust 1998 and HL v United Kingdom*).

A mechanism to provide for separate legal representation of children detained under mental health law. This recognises the need to provide a safeguard for the child with mental ill-health acknowledging him or her as highly vulnerable subjects in the civil commitment field.

In certain circumstances, for example, the looked - after child detained on the basis of mental ill-health, consider use of the existing model of tandem representation for children that is specified in relation to public law proceedings under the Children Order.

Specific remit for the Mental Health Commission (or substitute body) with regard to notification and fast-track review of children admitted to an adult unit under the Mental Health Order (in line with existing policy in England and Wales).

In the context of Article 5 (1) (d) ECHR, framing of an individualised education plan within the care plan (*Bouamar v Belgium* 11EHRR 1; *Koniarska v United Kingdom*).

Restriction of a child’s liberty **outside of** mental health legislation where a severe mental disorder/impairment is suspected or acknowledged must trigger (i) fast-track referral to specialist CAMHS **or** (ii) a court order to mandate specialist mental health assessment. Lack

⁶⁷ *L v Finland* (2002) 2FLR 118; *Scott v UK* appl no. 34745/97 and *Yousef v the Netherlands* appl no. 33711/96. para 66. If there is any clash of A8 rights between a child and its father, the interests of the child should always prevail. Para 73 In judicial decisions where the rights of parent and those of the child are at stake, the child’s rights must be the paramount consideration

of appropriate facilities and treatment for such children may constitute a breach of Art 5 (1) (e).⁶⁸

Recognition that the loss of citizenship rights in adulthood as a consequence of childhood detention under mental health legislation is inherently discriminatory. Penalties with respect to future adult citizenship rights and accompanying stigmatisation by labelling, conflicts with international laws on the rights of the child and should be removed.

⁶⁸ *Aerts v Belgium* [1998] 29 EHRR 50; *Johnson v UK* [199] 27 EHRR 296; *DG v Ireland*, 2002; and cf 'Secure Care: An inspection of secure accommodation at Shamrock House and Linden House' Report by SSI & ETI June 2002

REPRESENTATION AT MENTAL HEALTH REVIEW TRIBUNALS

INTRODUCTION

One important human rights issue is the extent to which the law currently safeguards a patient's right to have his or her case properly aired before a Tribunal, a crucial dimension of a person's access to justice. In cases before courts and tribunals, parties commonly retain lawyers and provide them with instructions as to their situation. On the basis of these instructions, the lawyer will then present the client's case to the court or tribunal.

Persons with mental health difficulties or a learning disability potentially may be disadvantaged by reason of any reduced ability to make appropriate decisions in relation to representation, and/or by any reduced ability to provide coherent, rational and comprehensible instructions. In such circumstances what provision:

- (a) does the law make to alleviate/prevent disadvantage and prejudice to the person concerned?
- (b) should the law make to alleviate/prevent disadvantage and prejudice to the person concerned?

THE LEGAL BACKDROP

In the case of *Megyeri v Germany* (1993) 15 EHRR 584, Mr Megyeri was convicted of a number of criminal offences. The court ordered that he be detained in a psychiatric hospital. Although his detention was reviewed periodically, in two sets of review proceedings he did not ask for representation and the review body did not appoint a lawyer to assist him. He claimed that this failure to appoint a lawyer contravened Article 5 (4) of the European Convention.

The European Court found that the absence of representation in his case constituted a breach of Article 5 (4): that the national authorities should have ensured that he was legally represented at all hearings. The Court recalled the jurisprudence of the European Court in relation to this issue in the following terms:

"(a) A person of unsound mind who is compulsorily confined in a psychiatric institution for an indefinite or lengthy period is in principle entitled, at any rate where there is no automatic periodic review of a judicial character, to take proceedings at reasonable intervals before a court to put in issue the lawfulness – within the meaning of the Convention – of his detention.

(b) Article 5 (4) requires that the procedure followed has a judicial character and gives to the individual concerned guarantees appropriate to the kind of deprivation of liberty in question; in order to determine whether a proceeding provides adequate guarantees, regard must be had to the particular nature of the circumstances in which such proceeding takes place.

(c) The judicial proceedings referred to in Article 5 (4) need not always be attended by the same guarantees as those required under Article 6 (1) for civil or criminal litigation.

Nonetheless, it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation. Special procedural safeguards may prove called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves. [emphasis added]

(d) Article 5 (4) does not require that persons committed to care under the head of 'unsound mind' should themselves take the initiative in obtaining legal representation before having recourse to a court." (Paragraph 22)

The Court went on to add its contribution to European Convention jurisprudence, stating:

"...where a person is confined in a psychiatric institution on the ground of the commission of acts which constituted criminal offences but for which he could not be held responsible on account of mental illness, he should - unless there are special circumstances - receive legal assistance in subsequent proceedings relating to the continuation, suspension, or termination of his detention. The importance of what is at stake for him - personal liberty - taken together with the very nature of the affliction - diminished mental capacity - compels this conclusion." (Paragraph 23)

European Convention Law does not appear to guarantee a right to legal representation in every case. However, the import of the *Megyeri* decision appears to be that:

"even if a right to representation funded by the State is not (yet) a general right, a court which reviews detention must always consider whether a particular person is capable of acting for himself, for example, whether he is able to marshal arguments and points in his favour, and understand any legal issues arising. If not, then legal representation must be

provided and must be paid for the State.” (Commentary on the *Megyeri* decision taken from the Mental Disability Advocacy Centre Website - www.mdac.info/resources/echr_cases.htm)

In Northern Ireland, the Mental Health Review Tribunal (NI) Rules 1986 do not guarantee a patient legal representation. Rule 10 (1) permits a patient to authorise any person to act for him or her as long as the nominee is not "*a person liable to be detained or subject to guardianship under the Order or a person receiving treatment for mental disorder at the same hospital as the patient*".

Where the patient does not want to conduct his or her own case and has not authorised a representative to act for him, the Tribunal may appoint a representative to act for him/her (Rule 10 (3)). This apparently was originally intended by the legislator to be a discretionary power. Notwithstanding, pursuant to the Human Rights Act 1998, the Mental Health Review Tribunal should interpret and apply the Mental Health Review Tribunal (NI) Rules 1986 in light of the *Megyeri* decision (Sections 2, 3 and 6 of the Human Rights Act).

PREVALENT CONCERNS

A number of concerns in relation to compulsorily detained mentally ill patients and their access to justice (and, in particular, liberty) can be identified. In particular, how many such patients are able to organise their thoughts sufficiently coherently to enable them to "marshal arguments and points in [their] favour and understand any legal issues arising"? More specifically, how many patients are able to make considered decisions in relation to representational issues, such as:

- the arguments they want to put forward;
- whether they ought to appear in person or obtain representation; and
- whether it is in their interests to obtain legal representation?

POTENTIAL PROBLEMS IN RELATION TO PATIENT REPRESENTATION

Mental Health Review Tribunal hearings focus on a patient's "right" to liberty and, in particular, the statutory criteria governing compulsory detention. The subject matter of these hearings ranks high in legal terms given the importance attached by the law to individual liberty. Such hearings are often contentious by reason of the conflicting views of the Health

and Social Services Trust and the patient. Moreover, the focus is largely on the medical evidence led by the Trust, which itself can be controversial. (Normally the Consultant Psychiatrist in charge of the patient is opposing the discharge of the patient, which can place a strain on the Doctor/Patient relationship.) It is fundamental to both a patient's health and welfare and his or her human rights that he/she is properly represented at these Tribunals.

From a patient perspective, there are arguably a number of shortcomings in the current system of representation at Mental Health Review Tribunals, creating obstacles which can serve to abrogate their human rights (eg. their right to liberty and/or a fair hearing) including:

- No automatic access to legal advice and assistance. Often decisions in relation to representation are left in the hands of the patient. Patients are not always fully capable of acting in their best interests, by reason of, inter alia, their medical condition and/or medication. Moreover, a patient may have little or no knowledge of how to go about obtaining appropriate legal assistance.
- Some patients seek legal assistance and obtain non-expert assistance; eg. junior barristers and junior and/or generalist solicitors are often involved in representation notwithstanding their lack of requisite knowledge, skill, experience and/or expertise. One reason is the low rate of payment by legal aid for such representation. As a result, patients do not always enjoy adequate legal representation: eg. independent psychiatric reports are not always obtained, where appropriate.
- Some patients refuse legal assistance and represent themselves or obtain non-legal representation. This can detrimentally affect their prospects of having their arguments and submissions properly presented and fully aired.

Such factors undermine a patient's right to have his or her case properly presented to a Tribunal, which, in turn, can abrogate a patient's human rights, including the important right to liberty.

COMPETING RIGHTS, INTERESTS AND OBLIGATIONS

All of the above issues concern the interplay between a patient's interests, a patient's rights and the responsibility of the State. Two of the main underlying ethical issues are:

- in what circumstances should a patient's rights outweigh his or her perceived best interests? (e.g. if the patient refuses to nominate a representative or instruct a representative who has been appointed to act on his behalf, should the patient be entitled to dispense with representation and, if so, when?)
- what policies, procedures and practices should the State put into place to ensure a patient's access to justice and the patient's right to have his or her case properly aired? (e.g. should the State ensure that every patient receives legal representation, or that legal representation is always provided in specified circumstances?)

ISSUES FOR CONSIDERATION

Representation

- When should the patient have the autonomous right to decide whether and how his case is represented to the Tribunal: i.e. by him or herself, by a representative or by a legal representative?
- To what extent should the right to make such an autonomous decision be subject to the patient's mental condition, and circumscribed thereby?
- In what circumstances should the state ensure that a patient is represented, irrespective of the patient's wishes?
- Should special provision be made in relation to children and young persons?

Legal Representation

- Should a patient be represented by a lawyer in every case?
- In what circumstances should the State ensure that a patient is legally represented?
- Should a patient have the right to refuse representation and/or legal representation, and if so in what circumstances?

- Should special provision be made in relation to children and young persons?

ADVOCACY

INTRODUCTION

People with mental ill-health and learning disability are particularly vulnerable to human rights violation. Their rights and interests must be identified specifically under the legislation and within regional policy mandates. For human rights to be a reality, however, they must be accompanied by accessible and effective enforcement mechanisms. Yet for many people with mental ill-health and learning disability, current processes are largely inaccessible and/or insensitive to their needs. Children and young people, older people, people from diverse ethnic communities and individuals with profound and multiple disabilities are likely to need additional, specific support to address their needs.

This paper covers:

- defining the need for advocacy;
- human rights principles involved;
- models of advocacy;
- advocacy in other jurisdictions;
- specialist mental health advocacy;
- advocacy support for people with a learning disability; and
- advocacy for children and young people.

This paper recommends the need for:

- a **statutory right** to advocacy support.
- the development of a **coherent, co-ordinated regional strategic framework** to provide for access to advocacy support for people with mental ill-health and learning disability. This advocacy support should be available both in hospital and in community settings, and should extend to those undergoing assessment and treatment voluntarily and involuntarily;
- the setting of deadlines and targets for the implementation of this strategy.

- the development of **a diverse range of advocacy models** in Northern Ireland.
- the development of **advocacy models that are sensitive to the needs of different groups** and to specific circumstances and tasks. Account will also have to be taken of the needs of groups identified under Section 75 of the Northern Ireland Act 1998.
- the development of **agreed quality standards and consistent monitoring** of advocacy support.

DEFINING THE NEED FOR ADVOCACY

The ECHR is intended to guarantee **not** rights that are theoretical and illusory **but** rights that are practical and effective.¹ Article 6 guarantees everyone the right to a fair hearing. Article 5 guarantees everyone the right to liberty and security of person and Article 8 guarantees everyone the right to family and private life. Articles 1 and 14 provide a duty to guarantee effective rights to everyone without discrimination.²

Strasbourg jurisprudence has been highly influential in the development of both the substantive and the procedural aspects of the rights of those subject to compulsion. The Court's emphasis on procedural aspects of ECHR rights has extended its scope and is of great practical significance in the field of compulsion under mental health law. In the case of children and young people it acknowledges the requirement for special consideration for children and young people in detention and supports the need to have the lawfulness of detention reviewed in compliance with Article 37 (b) of the UNCRC.

Most of the provisions of the ECHR were incorporated into UK domestic law in October 2000 by the Human Rights Act 1998 and are now enforceable in this jurisdiction.³ The Act requires public authorities, including the courts, to exercise their authority in a way that is compatible with the ECHR. Courts are required to take into account the decisions of the European Court, but are not obliged to follow them in all cases.⁴ The standards applied by

¹ Markx v Belgium 1979 2EHRR 330 at paragraph 31

² Article 14 of the ECHR is not free standing and must be argued in conjunction with other ECHR rights

³ Articles 1 and 13 have not been incorporated

⁴ s3, s6(2)

Strasbourg provide a minimum standard – a floor, which should be met and applied in all circumstances. Mere compliance, particularly in matters concerning children and other vulnerable groups, leads only to increasingly complex proportionality exercises and although in some circumstances this may be the only appropriate solution, in others, it may impede the advancement of basic human rights standards.⁵

Central to the concept of the development of advocacy support is the right of individuals to express their views and to be heard. Although professionals *may* advocate on behalf of the individuals they are working with, because of possible conflicts of interests, independence from the statutory sector and, where possible, from direct service provision is considered to be a core element of advocacy. Moreover, it has been widely observed that traditional professional practices have been seen as misrepresenting disabled people's interests and removing power and control away from them (*Morris, 1993, French, 1994, Dunning 2001*).

Advocacy seeks to redress an imbalance of power between the individual and professionals. It is concerned with empowerment, autonomy and self-determination, the safeguarding of citizenship rights and the inclusion of otherwise marginalised people.

For many people with mental ill-health or learning disability, their access to justice is not so much frustrated by the imposition of an unwanted representative, but rather by the absence of support or assistance. Recognising that many disabled people must, to a greater or lesser degree, rely upon third parties to “represent their claims” is to acknowledge that procedural barriers exist for the disabled person in accessing justice. The Strasbourg authorities have stated that a restrictive or technical approach in this area should be avoided.

Whilst for people with mental ill-health and learning disability, capacity building towards self advocacy is the ideal, a wider availability of advocacy services is necessary for many and this appears to be an inevitable response to the Human Rights Act. An advocate aims to help the person speak up and express their views on his/her treatment and care.

⁵ The abolition of corporal punishment in the independent school sector under s 131 of the Schools Standards & Framework Act 1998 and the legal sanctioning of adoption irrespective of sexual orientation under the Adoption & Children Act 2003, clearly exceed the requirement under the ECHR

It should be acknowledged, however, that there is long-standing resentment about disabled people having to deal with a range of systems so complex and unresponsive to their needs that their only chance of success is to rely on an advocate to act as an intermediary.

In considering, in particular, the process of assessment and civil detention of people with mental ill-health and acknowledging the inherent potential for interfering with human rights, particularly those enshrined within Article 5 (2), it is essential that there is optimal access to information and representation.

*“Advocacy services are services of support and representation made available for the purpose of enabling the person to have as much control of, or capacity to influence [their own] care and welfare as is, in the circumstances, appropriate.”*⁶

Access to high quality advocacy support is a key component in combating the discrimination faced by disadvantaged groups and individuals and must acknowledge both the growing diversity of the population in Northern Ireland and the diversity of advocacy provision required to meet that need in operationalising a comprehensive regional advocacy service.

HUMAN RIGHTS PRINCIPLES INVOLVED⁷

An underpinning theme of the Review is to ensure progress in aligning mental health legislation, policy and practice with national and international human rights standards. This requires, amongst other things, the introduction of a new legal framework, setting out how,

⁶ Section 259 (4) Part 17 Ch 2, MH (Scotland) Act 2003

⁷ The main rights affected by a regime for compulsion for the purposes of assessment and treatment are:

- The right to liberty (article 5 ECHR)
- The right to freedom from inhuman or degrading treatment (Article 3 ECHR)
- The right to dignity in detention (Article 3 ECHR)
- The right to respect for family and private life (Article 8 ECHR)
- The right to participate in decision-making process (Article 6 ECHR and Article 12 UNCRC)
- The right to periodic review of treatment and placement (Article 5 ECHR)

International standards include:

- Article 5 (2) ECHR includes the requirement that detained patients should be informed of their rights under the law, of the reasons for their detention and of their right to challenge this. Failure to do may violate Article 5 (2) c.f. *Van der Leer v Netherlands* (1990)
- Principle 12.1, MI Principles states that ‘a patient.... Shall be informed [of his/her rights] as soon as possible after admission in [an understandable] form and a language [including] an explanation of these rights and how to exercise them’
- Article 12 UNCRC the participatory rights of the child, including language and format used

Domestic Law: Although Article 27 of the Mental Health (NI) Order necessitates steps to ensure that the patient understands the rationale for their detention, there is at present no right to representation or advocacy. The lack of access to independent advocacy services for patients with mental ill-health in NI impairs the person’s ability to make informed decisions

when and where, including in the community, treatment for mental illness may be provided on a compulsory basis in accordance with the rights and best interests of the patient, whilst simultaneously preventing serious harm to themselves and others.

The rights particularly at risk are outlined:

1. In domestic law: by virtue of Section 6 of the Human Rights Act, ECHR rights incorporated by the Act are binding on all public authorities.
2. Effective protection under the ECHR: Article 1 guarantees Convention rights to everyone and is the platform from which effective protection can be developed. The Court has consistently found that Article 1 imposes a positive obligation on States to ensure the equal application of the Convention to all those within their jurisdictions. This approach is particularly important where specific reference to the individual's (especially the child's) need for protection is identified. The provision of ECHR rights for the individual with mental illness, learning disability or for other vulnerable individuals may require obligations of a positive nature to be read into other provisions and the rights (eg. under Articles 5 and 8) clearly facilitate such an interpretation, one response to which is the appointment of an independent specialist advocate.

In addition to explicit procedural rights contained in Article 6, the development of procedural protection as an implicit part of certain substantive provisions (Articles 2, 5 and 8) permits the development of safeguards which are specific to the rights guaranteed and go beyond the scope of the fair trial provision. This applies to administrative as well as judicial decisions where the rights of the individual and, where this is a child, to the parents to be consulted and informed about the decision-making process may be decisive as to whether, for example, their Articles 8 and 5 rights have been respected.

Thus, implicit procedural safeguards were formulated under Articles 5 and 8 where the Court has found respect for the right to liberty and the right to family life respectively to include the right of the individual and their family to be involved in the decision-making process to a degree sufficient to provide them with adequate protection of their interests. In light of the procedural element implicit in Articles 5 and 8, it is likely that the Court will find consultation with children and young people, including those with mental illness and learning disability, to be essential for the effective protection of their rights.

The UK is also bound under international law to observe :

1. Rights under the International Covenant on Civil and Political Rights (ICCPR); and
2. Rights under the UNCRC in the case of those under 18 years of age.

Additional national and international standards have been developed which, whilst not binding, do provide a framework of evidence, values and ethics that have been widely endorsed.

However, even the most elaborate and comprehensive system for conferring and protecting the rights of the individual is unlikely to be fully effective unless, as a last resort, the individual has access to practical means of exercising and, if necessary, enforcing those rights.

Consequently, explicit safeguards are required to ensure protection for the rights and interests of the individual in the particular context of defining the criteria and procedures for compulsion in assessing and treating people with mental illness and learning disability. The introduction of a protective statutory regime of mental health advocates to advise and assist patients and their nominated persons is considered a fundamental element in such a system of protection.

MODELS OF ADVOCACY

A spectrum of advocacy models has developed in response to different advocacy needs and each has a particular role in addressing the needs of the individuals it serves. The provision of a legal aid scheme and the introduction of independent specialist mental health advocates are only two of several possible responses to the disadvantage experienced by people who find it difficult to self-advocate.

Different types of advocacy will be needed by different people at different times of their lives and to respond to different circumstances. In practice, advocacy is likely to mean:

- independent information and advice about rights and services;
- a way for people to come together to have a greater say and bring about change; and

- a way of identifying someone to represent the interests of an individual or to support them to represent themselves.

Different forms of advocacy are continuing to develop. The main types of advocacy are:

- Self advocacy: whereby individuals speak up for themselves. All forms of advocacy would aim to promote self advocacy.
- Individual Advocacy: whereby individuals are supported by others to secure and assert their rights. This includes Citizen Advocacy, Peer Advocacy, Professional Advocacy or paid advocacy, Legal Advocacy (See Appendix 1 for more information about each model).
- Group Advocacy: whereby individuals come together on particular issues or concerns.

Advocacy support can be provided at a crisis, on a short-term or one-off basis; or may involve a long-term relationship that builds over a period of time.

Underpinning each model of advocacy are the principles of independence, inclusion and empowerment (Dunning 2001). All models of advocacy are important and necessary to safeguard the interests of vulnerable and disadvantaged people. It is important, too, that different, new models of advocacy are encouraged to develop to respond to, and be inclusive of, the needs and circumstances of individuals and groups, such as people with more severe or profound learning disability, who may have difficulty in accessing some models of advocacy support.

ADVOCACY IN OTHER JURISDICTIONS

Models of advocacy exist in the Republic of Ireland, the USA, Canada, New Zealand and Australia⁸ and models of specialist mental health advocacy already exist in a number of other jurisdictions including Austria, Belgium, Denmark.

⁸ The Australia Guardianship Tribunals have argued that the advocacy can sometimes avoid the demand for guardianship, particularly in cases where the reason for the application is for access to social resources that have been previously denied. Appointing a guardian is, in principle, an inappropriate way of achieving a resolution of problems about access to services, since it involves the transfer of rights

Specialist mental health advocacy is also an integral component of the national mental health strategy. The White Paper, Reforming the Mental Health Act 2000, proposed that individuals subject to the powers of a new Mental Health Act in England and Wales should have access to independent specialist advocacy services. The draft Mental Health Bill provides for specialist independent mental health advocacy services to anyone being treated in accordance with the Bill.

The Health and Social Care Act (Section 12) provides for the development of advocacy services for NHS patients in England.

Pursuant to the role envisaged by the White Paper, the Department of Health commissioned the Durham Report (www.doh.gov.uk/mentalhealth/advocacy 2001) to consider the most appropriate model of advocacy. The Durham Report proposed:

- a definition for specialist advocacy: “independent professional advocacy for individuals who are subject to the powers of mental health legislation in England and Wales”;
- that its purpose was to safeguard users’ rights, empower service users, support and represent their views, protect the particularly vulnerable and provide feedback;
- individual rather than group advocacy, with support limited to issues relevant to care and treatment for mental illness, time limited for specific issues, reactive and proactive but not an out of hours emergency service. This service would be for service users exclusively. It has been suggested that advocates should have a duty to make contact with service users within 3 working days of the time at which the service user became subject to compulsory powers;
- the professional model of advocacy provided by trained paid staff, although the value of volunteers is recognised and considered an additional part of the service;
- independence from health care providers as being of utmost importance, with the suggestion that, over time, provision should move away from health and social care sources;

- a range of advocacy services, although the report does not indicate how the provision of non-specialist mental health advocacy models are to be safeguarded; and
- the monitoring of service provision by the newly-created Health Care Inspectorate, so that complaints against advocacy services would be investigated by the Health Care Inspectorate.

The Mental Health (Care and Treatment) (Scotland) Act 2003

This Act enshrines the right of access of a patient to advocacy. It places a duty on each Local Authority and Health Board to ensure the provision of independent advocacy services to *any* person with mental disorder within their area. Under the Scottish Act, therefore, Local Authorities and Health Boards are required to ensure that all people with a mental disorder can access independent advocacy services. An advocate is someone who enables the patient to “find their voice” and to express their views, for example at a Tribunal hearing. Unlike a named person, the advocate cannot act independently of the patient, but rather helps the patient to represent their own wishes and feelings. The right to advocacy and the duties on Local Authorities and Health Boards may be found in Part 17, Chapter 2, part 7.

The Draft Mental Health Bill, England & Wales

The provision of specialist independent advocacy services for the individual relates *only* to those involuntarily detained under the law.⁹

The proposal in the draft Mental Health Bill requires the preliminary examination to be completed within 5 days, followed by the 28 day, second stage formal assessment and initial treatment. It is unclear from the Durham Report when access to a specialist advocate kicks in. The advantages of specifying time limits include strengthening the definition of access and any enforceable rights, add certainty to an otherwise very confusing and difficult time, thus acting as a more effective safeguard of patients rights and interests, and also sets standard with which to measure service delivery. The disadvantages include the fact that more advocates are required and each advocate will be under more pressure to comply, which has implications for the quality of service delivery.

⁹ Durham Report 2001 www.doh.gov.uk/mentalhealth/advocacy

The Durham Report does not identify what the relationship should be between the specialist advocate and the “nominated person”, nor suggest that the specialist advocate has any role in respect of carers or other relatives.

GROUPS WITH PARTICULAR NEEDS

- those subject to compulsory powers under mental health legislation;
- people with a learning disability;
- children and young people;
- older people;
- people subject to compulsory powers under the law following a court order;
- those on community treatment orders; and
- people who may be classified as “*Bournewood*” patients.

THE ROLE OF THE SPECIALIST MENTAL HEALTH ADVOCATE

The rationale for proposing the introduction of a legal mandate under new mental health legislation, which will provide for the appointment of an individual, independent specialist mental health advocate to all persons with mental illness subject to compulsion under the law is 3-fold:

- a. such persons constitute a particularly vulnerable group within society and their dignity, autonomy and related human rights, including their liberty and integrity, are specifically threatened by a regime of compulsion (this includes compulsory assessment, treatment and detention);
- b. compared with most other members of society, such persons are less likely to be able to take action to protect their own rights, accordingly;
- c. they depend heavily on other people to provide adequate safeguards and on legislation to ensure that those safeguards are in place.

Moreover, any such measure must be provided on an equitable basis, subject to equality impact assessment, giving due recognition to the need to promote equality across all the Section 75 categories.

Specialist Mental Health Advocates (SMHAs) would also form part of a scheme of safeguards to patients and their families where patients not capable of consenting or withholding consent to treatment, but who are compliant with directions from professionals, receive statutory protection under a system for appointing nominated persons to represent their interests and mental health advocates to advise and assist them.

Procedural safeguards

Compulsory detention constitutes a radical interference with Articles 5 and 8 rights. Consequently, the procedure must carefully balance the interests of those persons if a violation of Articles 5 and 8 is to be avoided. The compulsion process thus demands explicit and implicit procedural safeguards applicable to both administrative and judicial decisions to safeguard Convention standards.¹⁰

It is well-established by Strasbourg case law that there are inherent in Article 8 certain procedural requirements entitling individuals to be involved in any decision-making process concerning the deprivation of their liberty, family and private life to a degree sufficient to provide them with the requisite protection of their interests.¹¹

Whilst acknowledging the difficult task facing Mental Health Tribunals, and according them a due measure of discretion:

- (i) the decision-making process is fundamental in safeguarding the interests protected by Articles 5 and 8; and thus
- (ii) the necessity for explicit procedural requirements to protect against arbitrary interference is imperative. If the authority's decisions interfere with the applicant's

¹⁰ In the case of children, only the most pressing grounds can be sufficient in a democratic society to justify the disruption of existing family ties. In *Johansen v Norway*, the Court held that the state's actions in placing the child outside the family should be justified by an over-riding requirement pertaining the child's best interests. In depriving the applicant of her parental rights and access, the competent national authorities [are] required by Article 6(1) to act with exceptional diligence in ensuring the progress of the proceedings'. [para 88]

¹¹ This approach has its basis in *W v UK* where the Court extended its interpretation by deciding that the lengthy duration of the proceedings therein resulted in a decision which could not be regarded as necessary in a democratic society within the meaning of Article 8. Many Article 8 rights are 'civil rights' in the context of Article 6 and decisions concerning them must be taken by a procedure which satisfies that article. [Eg *Airey v Ireland* A 32 [1979] re access to legal procedure for terminating obligations part of family life; *Olsson v Sweden* (No 1) A 130 [1988] re conditions of foster-care of children taken from natural parents; *W v UK*; *L v Finland*]. If the right protected by Article 8(1) is a 'civil right' within the terms of Article 6(1) and if the act of interference by the state has determined the applicant's civil right then the procedural protection which he is due is that established by Article 6(1) a fairly rigid standard with little room for flexible interpretation. Some aspects of Article 6 may however be interpreted in ways related to the Article 8 character of the right eg the need for special haste in child-care cases. The procedural failure under Article 6(1) may also be a substantive failure under Article 8

right to respect for his family life and in the event of a catalogue of exclusion and delay which may characterise this, Article 8 may be violated.

In making decisions in relation to compulsory detention, Convention jurisprudence stipulates that:

- public authorities are required to follow fair procedures which ensure involvement of the individual in the overall decision-making process to an extent sufficient to protect their interests;
- the decision-making process must ensure that their views and interests are made known and duly taken into account, and that they are able to exercise as necessary, any remedies available to them;
- decisions should be driven by considerations of the individual's best interests, not by administrative factors, which further inclined the Court to finding a violation.

ADVOCACY SUPPORT FOR PEOPLE WITH A LEARNING DISABILITY

The UN Declaration of the Rights of Mentally Retarded Persons (1971) outlined rights to personal advocacy, protection from exploitation, abuse and proper legal safeguards where rights were to be restricted or denied. This has given rise to advocacy projects in the United States, Canada and Australia.

The White Paper for England: Valuing People: A New Strategy for Learning Disability in the 21st Century (2001) and the follow-up guidance (LAC; 2001) outlined the government's commitment to advocacy for people with a learning disability. The White Paper recognised the uneven development of both citizen advocacy and self advocacy and need to develop a range of independent advocacy services in each area so that people with a learning disability could choose the one that best met their needs. A number of advocacy projects have been funded as part of Valuing People.

Other Government initiatives which refer to the need for advocacy include Making it Work (2001), a Social Services Inspectorate Report about welfare to work provision for disabled people; Building Capacity and Partnership in Care (2001), concerning the agreement between the statutory and independent social care, health care and housing sectors;

Domiciliary Care Standards consultation (2001), regarding the drafting of minimum standards for domiciliary care and a partial regulatory impact assessment; National Minimum Standards for Care Homes for Younger Adults (2001), which is the Government's statement of national standards for residential care for young adults with a disability; Families Matter (2001) which calls for more investment in independent advocacy for people with a learning disability and their family carers.

Advocacy services for people with a learning disability are unevenly and poorly developed in Northern Ireland. Equal Lives, the report of the Review's Learning Disability Committee, states that "the range and volume of advocacy services for people with a learning disability is low. There are examples of good practice throughout Northern Ireland, but these are sporadic and often groups are relying on unpredictable funding and volunteer support to keep them going". The report recommended that there should be an independent advocacy service in place.¹²

People with a learning disability will need access to a diverse range of advocacy models, including the development of group advocacy, citizen advocacy and self advocacy. Particular attention, however, must be taken to ensure that advocacy models are developed to take account of the:

- historical treatment of people with a learning disability by society and the need to build the capacity and skills of individuals and groups to speak out;
- limited personal development and risk taking opportunities available, for example, to young people with a learning disability, which also limits their opportunity to develop and express personal views, to make new choices and to move in new directions in their life;
- specific needs of children and young people with a learning disability;
- need for specialist technical advocacy support required for people with a learning disability involved in formal and legal procedures including parents with a learning

¹² Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland 2005

disability involved in child court procedures, or individuals involved in procedures associated with mental health legislation; and

- needs of people with more severe or profound learning disability and the consideration of principles and procedures associated with “best interest” or “substituted decision-making”.

Alternative methods of gathering views and providing support through, for example, circles of support should also be considered.

INDEPENDENT ADVOCACY FOR CHILDREN AND YOUNG PEOPLE IN THE CONTEXT OF THE MENTAL HEALTH & LEARNING DISABILITY REVIEW

Central to any debate on advocacy for children and young people is the need to ensure that there is a clear legislative basis within the mental health framework to ensure that they can participate in and understand both the proceedings in which they are involved and the administrative/medical decisions which are taken in relation to their ongoing care and treatment.¹³ This is one of the key issues which the Review has to address if it is to give effect to children’s rights as protected by the UNCRC and the ECHR, as incorporated by the Human Rights Act 1998. Legislative mandates notwithstanding, the right to “have a say” is related to perceptions of justice, and it is well recognised that being treated fairly increases not only perceived justice but also enhances treatment efficacy.¹⁴

The need for advocacy for children and young people has been endorsed at the highest levels. In 1999, the Royal College of Psychiatrists¹⁵ highlighted the particularly vulnerable position of children and young people in contact with mental health and learning disability services and emphasised the need for strong structures and independent advocacy to safeguard their interests and protect them from abuse.

¹³ See *T & V v UK*, judgement of European Court of Human Rights, 1999 – in order for children to be deemed to have a fair hearing, they must be able to participate in and understand proceedings in which they are involved

¹⁴ National Standards for the provision of Children’s Advocacy Services, Dept of Health, Nov 2002

¹⁵ Royal College of Psychiatrists Council report, CR74, London, Feb 1999

In 2004, under the auspices of the Quality Protects programme, the Government made a long-term commitment to the continued development and growth of advocacy and children's rights services. They outlined a comprehensive framework to plan, develop and review advocacy practice at all levels, and additionally, acknowledged the particular vulnerability of looked after children and young people, seeing advocacy services as one mechanism to ensure that these young people would receive levels of support comparable to that of their peers.

Nevertheless, despite the emerging evidence for the benefits to children and young people under this programme, Northern Ireland continues to await its introduction. The ongoing lack of policy or legislative mandate thwarts local efforts to establish and extend a robust advocacy network to support vulnerable children and young people across the province yet, driven by the need for advocacy services, patchy evidence of good practice is already emerging.¹⁶

Towards a Children's Rights Framework

In relation to children and young people, all legislation, policy and practice should be in accordance with the UNCRC, which has been ratified by every country in the world, except Somalia and the USA.¹⁷

The UNCRC states at Article 12:

“State parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.”

¹⁶ eg Young People's Involvement in Evaluating and Developing Adolescent Inpatient Mental Health Services, a presentation to the Regional CAMHS Review Subgroup, June 2004. Undertaken by young people supported by a voluntary/statutory partnership between VOYPIC and the Young People's Centre, S&E Belfast Trust.

¹⁷ See Annex 6. It should be noted that the importance of adhering to international children's rights standards is outlined in the Joint Committee on Human Rights Report on the Draft Mental Health Bill; HL Paper 181, HC 1294.

For this purpose, the child shall in particular be provided with the opportunity to be heard in any judicial or administrative proceedings affecting the child, either directly or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law."

Article 25 states:

"State parties recognise the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement."

The UN Committee on the Rights of the Child recommended in October 2002 that the UK Government should take further steps to consistently reflect the obligations imposed by Article 12, by ensuring that all legislation governing procedure in courts and administrative proceedings allowed children and young people who were capable of forming their own views the right to express those views and that those views were given due weight.¹⁸

The relevant rights under the ECHR, as incorporated by the Human Rights Act in the context of a discussion of procedural rights for children and young people, are Article 1 (which requires states to ensure equal application of Convention rights to those in its jurisdiction), Article 5 (the right to liberty and security), Article 6 (the right to a fair hearing) and Article 8 (the right to family and private life).

It is clearly established that for children and young people to have a fair hearing in criminal cases they must be able to participate in and understand the proceedings in which they are involved.¹⁹ In the case of *T & V v United Kingdom*, the lawyers for the child defendants successfully argued that the mode of trial breached their Article 6 rights. What is perhaps not so well known is that it was also argued that a breach of Article 3 (inhuman and degrading treatment had occurred because of the conditions pertaining to the Crown Court trial and adverse publicity – this point was lost by a narrow majority).

¹⁸ See Annex 6. It should be noted that the importance of adhering to international children's rights standards is outlined in the Joint Committee on Human Rights Report on the Draft Mental Health Bill; HL Paper 181, HC 1294

¹⁹ See Annex 6. It should be noted that the importance of adhering to international children's rights standards is outlined in the Joint Committee on Human Rights Report on the Draft Mental Health Bill; HL Paper 181, HC 1294

It is suggested from a review of recent case law from the European Court that the twin concepts of understanding and participation as essential factors in the guarantee of a fair hearing for children should be read across into all judicial and administrative proceedings relating to children and young people. In addition to explicit procedural rights to a fair hearing contained in Article 6, the development of procedural protection as an implicit part of certain substantive provisions of the ECHR, namely Articles 2, 5 and 8, permits the developments of safeguards which are specific to the rights guaranteed. In the context of Article 8, the right to family life, this is perhaps most striking in relation to the inherent right to fair procedure, which has developed in relation to family and care proceedings under Article 8²⁰ and the right to liberty and security under Article 5.²¹

Mr Justice Munby, in an article published recently in the Family Law Journal entitled “Making Sure the Child is Heard,” specifically recognises and emphasises the importance of advocacy services for children in administrative as well as judicial decision making processes and cites a number of areas where this is essential including mental health. To quote:

“But administrative decision makers should be under no illusions. Article 8 imposes procedural safeguards that impose on administrative decision makers whose decisions impinge on private and family life burdens significantly greater than I suspect many of them really appreciate. And the burden may extend in some instances to an obligation not merely to permit the representation but even to ensure that parents, and particularly children are properly represented when decisions fundamental to the children’s welfare are being taken.”

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Shortly after publication of this article, judgment was given by the European Court in the case of *S.C v United Kingdom*.²³ In this case, an 11 year old boy had been assessed as having a significant degree of learning delay with a verbal IQ and performance IQ falling at or below the first percentile. He was reported as having the level of vocabulary of approximately a six year old. He was tried for attempted robbery in the Crown Court, which put in place measures such as no wigs and gowns, not requiring him to sit in the dock, frequent breaks etc. as per

²⁰ See eg *W v UK*, 1992, *Sahin v Germany*, July 2003, judgement of Grand Chamber, *Kutzner v Germany*, Application No 46544/99, 26 Feb 2002, P, C and S v UK, 16 July 2002

²¹ *Re C (Secure Accommodation Order; Representation)* (2001) EWCA Civ 458, 2001 FLR

²² May [2004] Fam Law

²³ *Op Cit* footnote 9

the Practice Direction which had been issued by the Lord Chancellor after the case of *T & V v United Kingdom*. The Court found a breach of Article 6 (1) and stated:

“The Court considers that when the decision is taken to deal with a child who risks not being able to participate effectively because of his young age and limited intellectual capacity, by way of criminal proceedings rather than some other form of disposal directed primarily at determining the child’s best interest and those of the community, it is essential that he be tried in a specialist tribunal which is able to give full consideration and proper allowance to him.”

The wider effects of this case are yet to be determined.

In light of the procedural safeguards implicit in Articles 5 and 8, it is submitted that it is likely that the European Court will find consultation with and representation of children and young people, including those with mental illness and learning disability to be essential for the effective protection of their rights. It is also submitted that we must be imaginative in the advocacy services and judicial and administrative forums and structures which we introduce to deal with children’s cases, ensuring that they meet the needs of the children and young people that are set up to serve.

A Regional Strategy

In terms of an overarching strategic children’s rights framework in which to place advocacy services, it is our view that it must underpin the development of the Strategy for Children and Young People which has been published for consultation by the Children and Young People’s Unit of the Office of the First Minister and Deputy First Minister and also the DHSSPS Strategy for Children In Need. In formulating proposals for advocacy services for children and young people, the Sub Group needs to have particular regard to the introduction of advocacy services for children and young people in England on a statutory footing,²⁴ the

²⁴ See article 119 Adoption and Children Act 2002

relevant provisions of the Mental Health (Care & Treatment) (Scotland) Act 2003²⁵ and the draft Mental Health Bill in England and Wales.²⁶

Members must also have regard to the relevant provisions of the Commissioner for Children and Young People (NI) Order 2003 which established the first office of the Commissioner for Children and Young People in Northern Ireland (NICCY); to the strategic priorities set by NICCY; and to any recommendations made on foot of the current research being conducted by NICCY into children's rights in Northern Ireland, which has considered the provision of advocacy services for children and young people throughout all sectors including education, youth justice, family, care and mental health.

Models of Advocacy for Children and Young People

The current position in relation to advocacy services for children and young people with mental health problems or a learning disability is uneven. There is certainly no mechanism for ascertaining the views and opinions of children and young people, for example, as required under Section 75 of the Northern Ireland Act 1998 in respect of legislation and policy which is likely to affect them, and there is no legislative basis for individual advocacy services to be provided for children and young people with mental health and/or learning disabilities (note, however, that legal aid is currently available under the Advice by Way of Representation (ABWOR) scheme for representation at Mental Health Tribunals by solicitors and children and young people need to be made aware of this).

NICCY was set up in October 2003. The Commissioner is required to keep under review the adequacy and effectiveness of services provided for children and young persons by relevant authorities²⁷ and is empowered to review advocacy arrangements of relevant authorities in certain circumstances.²⁸ Assistance may be provided in relation to legal proceedings in relation to proceedings involving law or practice concerning the rights or welfare of children or young persons which a child or young person has commenced, or wishes to commence or

²⁵ The Mental Health (Care & Treatment) (Scotland) Act 2003 enshrines the right of access to independent advocacy services to any person with a mental disorder

²⁶ The Department of Health commissioned the Durham Report ([www.doh.gov.uk/mental health/advocacy](http://www.doh.gov.uk/mental_health/advocacy) 2001) to consider the most appropriate model of advocacy which proposed an independent professional advocacy service for individuals who are subject to the powers of the mental health legislation in England and Wales. The provision of these services to the individual relates only to those involuntarily detained under the law

²⁷ Article 7 of the Commissioner for Children & Young People (NI) Order 2003

²⁸ *ibid*, Article 9

proceedings in the course of which a child or young person relies or wishes to rely on such law or practice.

It is useful to compare advocacy for children and young people in the mental health and learning disability fields with advocacy in other areas involving children's rights. Children who are subject to specified public law proceedings under the Children Order are provided with a Guardian ad Litem to represent their best interests and an accredited solicitor (so called tandem representation). Details on tandem representation are at Appendix 4.

For children involved in family disputes, their wishes and feelings are generally brought before the family proceedings courts by a social services report or a court welfare officer and in the Family Care Centre and High Court in exceptional cases the Official Solicitor can be appointed to represent their best interests. There is currently no legislative basis for the provision of separate representation by either a Guardian ad Litem or solicitor in private family law proceedings in the family proceedings courts or divorce proceedings and the Children Order Advisory Committee have established a sub group to explore the separate representation of children in private family law proceedings.²⁹

Children in care can access voluntary organisations such as Voice of Young People in Care (VOYPIC) and the Children's Law Centre. Advocacy services for children in care have recently been put on a statutory footing in England and Wales and reviewing officers have been introduced to review care plans.

The Official Solicitor³⁰ will, in the absence of any other willing and suitable person, act as Next Friend or Guardian Ad Litem of a minor or child who is a party to family proceedings, but whose own welfare is not the subject of those proceedings and also in certain non-specified private law proceedings under the Children Order in the Family Care Centre and High Court.³¹ Helpful examples of cases in which the Official Solicitor is likely to become involved are provided in Section 11 of the Children Order Advisory Committee Best Practice Guidance. The Official Solicitor can also act for children in certain adoption, litigation, medical treatment and criminal injury cases on behalf of children and young people.

²⁹ Children Order Advisory Committee, Fourth Report, January 2004

³⁰ Articles 118 & 1991 of the Adoption & Children Act 2002

³¹ Family Proceedings Rules (NI) 1996

There is currently no legislative framework for the provision of advocacy services for children and young people and their families who are seeking health and social services provision or medical treatment. In education cases, there is no legal aid for representation of children and young people at education tribunals and very few organisations providing advocacy in this specialist area, apart from the Special Educational Needs Advice Centre (SENAC) and Children's Law Centre. It is suggested that particular regard should be paid by this review to the need for advocate to represent the rights and best interests of children and young people with special educational needs in relation to decisions made under the Code of Practice and statementing process, including representation at tribunal.³²

All voluntary agencies such as the Children's Law Centre, VOYPIC and SENAC mentioned above have limited resources.

There is, therefore, a patchwork of different models which vary greatly. Each of these models should be studied in further detail before this Review makes any recommendations in respect of an advocacy model for children and young people.

What Young People Want

Various studies have found that in a source of advice young people seek trustworthiness, friendliness, the ability to maintain confidentiality, a non-judgmental attitude, patience and good listening skills. The research has suggested that the level of young people's needs for legal or rights based advice may be significantly higher than that experienced by other age groups and that where they exist young people will access youth specific advice and advocacy services.³³ It has also been shown that lack of access to reliable legal advice can be a factor in social exclusion.³⁴

It is, therefore, important that the Review considers how best to consult with children and young people about the development of an advocacy service which will best meet their needs.

³² See Read & Right, A Human Rights Audit of Education Law & Policy in Northern Ireland Kathryn Stevenson, Children's Law Centre, 2004 forthcoming. See also Response by the Children's Law Centre to the proposals contained within the Special Educational Needs and Disability Bill Consultation Document, 2004 www.childrenslawcentre.org

³³ Rights to Access; Meeting Young People's Needs for Advice, Childright, September 2002

Paths to Justice; What people do and think about going to law, H Genn with National Centre for Social Research, 1999

³⁴ Legal and Advice Services: A Pathway out of Social Exclusion; Nov 2001, Law Centres Federation

Standards of Provision

The Department of Health (London) published National Standards for the Provision of Child Advocacy Services in November 2002 pursuant to Section 7 (1) of the Local Authority Social Services Act 1970:

“Advocacy is about speaking up for children and young people. Advocacy is about empowering children and young people to make sure that their rights are respected and their views and wishes heard at all times. Advocacy is about representing the views, wishes and needs of children and young people to decision makers, and helping them to navigate the system.”

Children and young people actively contributed to the development of the standards and to the following core principles:

- Advocates should work for children and young people and no one else;
- Advocates should value and respect children and young people as individuals and challenge all types of unlawful discrimination;
- Advocates should work to make sure that children and young people can understand what is happening to them, can make their views known and, where possible, exercise choice when decisions about them are being made; and
- Advocates should help children and young people to raise issues and concerns about things about which they are unhappy.

The key standards are:

1. advocacy is led by the views and wishes of children and young people;
2. advocacy champions the rights and needs of children and young people;
3. all advocacy services have clear policies to promote equalities issues and monitor services to ensure that no young person is discriminated against due to age, gender, race, culture, religion, language, disability or sexual orientation;
4. advocacy is well-publicised, accessible and easy to use;
5. advocacy gives help and advice quickly when they are requested;
6. advocacy works exclusively for children and young people;

7. the advocacy service operates to a high level of confidentiality and ensures that children, young people and other agencies are aware of its confidentiality policies – this standard deals with confidentiality, child protection and disclosure;
8. advocacy listens to the views and ideas of children and young people in order to improve the service provided;
9. the advocacy service has an effective and easy to use complaints procedure;
10. advocacy is well-managed and gives value for money.

Key Elements of a Successful Model for Child Advocates in the Field of Mental Health and Learning Disability

We consider that the key elements of a successful model for child advocates in the field of mental health and learning disability are:

1. independence;
2. grounded in legislation as the right of the child and in the Strategy for Children and Young People and the Strategy for Children in Need;
3. compliant with the children’s rights principles enshrined in the UNCRC and ECHR;
4. informed advocates who are trained in relation to mental health and learning disability, children’s rights, the legislative framework and communication techniques;
5. confidentiality and child protection – there should be clear confidentiality and child protection guidance in place;
6. flexible – able to provide a spectrum of advocacy services for children and young people depending on the situation;
7. responsive to children’s rights and best interests;
8. properly resourced;
9. accessible and developed in consultation with children and young people; and
10. subject to specific standards for the provision of advocacy services to children and young people.

ISSUES TO BE ADDRESSED

In order to comply with human rights and equality principles, recommendations made by the Sub Group on advocacy must address the following issues:

- the current lack of an enforceable statutory right to access advocacy support;
- the current law does not ensure for independent information or independent;
- advocacy support for individuals liable to detention and compulsory treatment;
- the uneven development and provision of advocacy;
- the current lack of investment and under funding of advocacy provision;
- the lack of agreed quality standards and consistent monitoring of services;
- the absence of a funded, co-ordinated advocacy strategy for Northern Ireland;
- the need to support and maintain a diversity of advocacy provision; and
- the need for an advocacy support framework to provide support, advice and guidance and training to specific advocacy projects.

This appendix is not meant to be an exhaustive list of the different models of advocacy that exist.

Models of Advocacy

Advocacy is most commonly associated with the legal profession in the context of pleading in a court of law. However, there is a wider concept of an advocate as “one who pleads for another” (*Oxford English Dictionary*) and different approaches to advocacy have emerged over the years from the experiences and practices of those involved in providing advocacy across a range of health and social care settings (*in ‘Health Advocacy of Minority Ethnic Londoners’ King’s Fund and NHS Executive, London, 2000*).

1 Self Advocacy

The key elements of this form of advocacy are that the person acts on their behalf, puts their own case and tries to regain control over their life. Self advocacy is often the starting point or the ultimate goal of other types of advocacy.

2 Citizen Advocacy

The citizen advocate’s role is to:

- enable their partner to be heard and respected;
- uphold and represent the interests of the partner as if they were their own;
- respect their partner’s right to privacy and confidentiality;
- act as an authorised representative; and
- ensure that their partner has his/her place in society as a valued citizen.

Two major facets of citizen advocacy are instrumental advocacy and expressive advocacy. Instrumental advocacy is essentially task-centred and problem solving, for example helping a partner to gain access to benefits, services, health care, move to a new home job/service, dealing with abuse or complaints. Expressive advocacy is primarily forming a friendship, for

example offering support, sharing leisure, family/friends' time, becoming involved in the life and social networks of the local community etc.

Both the expressive and instrumental roles should have equal weight. In practice an advocate may devote much more time to the expressive role, particularly at the beginning of a partnership when the partners are getting to know each other and understand each other's communication systems etc. However, time must always be spent on the instrumental role to ensure that their partner's rights are upheld and that they receive whatever help and support they need. It is also important that the advocate provides information or ensures that he or she has access to information in order that choices made are informed. The advocate should also strive to ensure that their partner has opportunities to experience a range of settings that will help to both widen their network and to help in choice making.

3 Peer Advocacy

Peer advocacy refers to the help and support offered by people with a similar background or experience to that of the individual concerned. Peer advocates may also be part of a user-run advocacy group or a project providing independent advocacy services, as in a mental health unit or in the community in general.

4 Professional/Paid Advocacy

Professional advocacy usually refers to projects run by voluntary groups, which are rarely user-led. The managers and advocates in these projects are often paid for their work. They normally combine various approaches to meet client's needs, based on specialist knowledge, such as prioritising options. They often act for both carers and service users and are often managed by major voluntary service providers.

5 Legal Advocacy

This is the term used to describe the range of methods and activities by which lawyers and other legally trained individuals assist individuals to exercise and/or defend their rights.

Legal advocates act in their professional capacity using specialist knowledge and expertise on behalf of people with disabilities or those who are disadvantaged. Their role can require casework, negotiation, assessment of service requirements, scrutiny of legislation and regulations, representation before administrative tribunals and agencies (including civil and criminal courts) and monitoring compliance with laws and regulations which pertain to the rights of those they represent.

Legal advocates do not usually work long-term with an individual. Quite often they work intensively for short periods on behalf of one or more person on a specific issue that requires their specialist input.

6 Collective or Group Advocacy

This refers to a group of people working together to speak up for what they want. It is self advocacy by a group or organisation offering mutual support, skill development and a collective voice, usually to improve services.

Advocacy Charter

(Source: Advocacy Across London)

The following points are made in the Charter:

- clarity of purpose, with clear aims and objectives, scope of the scheme;
- independence, structurally independent from statutory organisations, and preferably from all service provider agencies;
- putting people first, ensuring that the wishes and interests of the people they advocate for direct advocates' work;
- empowerment, people who use the scheme should have a say in the level of involvement and style of advocacy support they want;
- equal opportunity, a written policy that recognises the need to be proactive in tackling all forms of inequality, discrimination, and social exclusion;
- accountability, have in place effective systems to monitor and evaluate its work;
- accessibility, the service will be provided free of charge, and ensure that its service is accessible to the whole community;
- supporting advocates, ensure that advocates are prepared, trained and supported in their role;
- confidentiality, have a policy in place; and
- complaints, have a written policy.

The principles upon which mental health law, policy and practice are founded must include the following:

- The protection of human rights in relation to compulsory assessment and treatment;
- This in turn requires the explicit safeguarding of patients autonomy, dignity and physical and moral integrity;
- The prevention of discrimination and promotion of equality in respect of persons with mental disability;
- The participation of patients in the decision-making process to the maximum extent possible;
- A fair and open decision-making process: including the incorporation of sufficient procedural protection for the human rights of patients within the decision-making process; and
- When providing treatment, interference or restrictions imposed upon patients must be the minimum necessary to protect the health and safety of themselves and others.

The Tandem Model of Representation under the Children (NI) Order 1995.

This is a model which gives effect to the requirements of Article 12 UNCRC.

Article 3 of the Children (NI) Order 1995 states:

- (1) *“Where the court determines any question with respect to -
 - (a) the upbringing of a child; or
 - (b) the administration of a child’s property or the application of any income arising from it;the child’s welfare shall be the court’s paramount consideration.*
- (2) *In any proceedings in which any question with respect to the upbringing of a child arises, the court shall have regard to the general principle that any delay in determining the question is likely to prejudice the welfare of the child.*
- (3) *In the circumstances mentioned in paragraph (4), a court shall have regard in particular to -
 - (a) the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding);
 - (b) his physical, emotional and educational needs;
 - (c) the likely effect on him of any change in circumstances;
 - (d) his age, sex, background and any characteristics of his which the court considers relevant;
 - (e) any harm which he has suffered or is at risk of suffering;
 - (f) how capable of meeting his needs is each of his parents and any other person to whom the court considers the question to be relevant;
 - (g) the range of powers available to the court under this Order in the proceedings in question”.*

The statutory basis for the representation of children is Article 60 of the Children Order. This Article provides for the appointment of a Guardian ad Litem for a child who is the subject of specified proceedings, which are defined and listed in Article 60 (6) as follows:

- "(a) on an application for a care or supervision order;*
- (b) in which the court has given a direction under Article 56 (1) and has made, or is considering whether to make, an interim care order;*
- (c) on an application for the discharge of a care order or the variation or discharge of a supervision order;*
- (d) an application under Article 58 (4);*
- (e) in which the court is considering whether to make a residence order with respect to a child who is the subject of a care order;*
- (f) with respect to contact between a child who is the subject of a care order and any other person;*
- (g) under Part VI;*
- (h) on an appeal against –*
 - (i) the making of, or refusal to make, a care order, supervision order or any other order under Article 53;*
 - (ii) the making of, or refusal to make, a residence order with respect to a child who is the subject of a care order; or*
 - (iii) the variation or discharge, or refusal of an application to vary or discharge, an order of a kind mentioned in head (i) or (ii);*
 - (iv) the refusal of an application under Article 58 (4); or*
 - (v) the making of, or refusal to make, an order under Part VI; or*
- (i) which are specified, for the purposes of this Article, by rules of court”.*

If a child is the subject of any of the above proceedings the court has the power to appoint a Guardian ad Litem who will also appoint an accredited solicitor to represent the child in court.³⁵

³⁵ Magistrate's Courts (Children NI Order 1995) Rules (NI) 1996, rule 11 (1) provides that the court must appoint a guardian ad litem as soon as practicable after the commencement of proceedings unless the court thinks that it is not necessary to safeguard the interests of the child. Under rule 12 (2) the guardian as litem must appoint a solicitor for the child unless one has already been appointed

The Role of the Guardian Ad Litem

The paramountcy of the best interests of the child and the requirement that the voice of the child should be heard when decisions are being made about his or her future are central principles of the Children Order. The role of the Guardian ad Litem is to safeguard the interests of the child³⁶ and to report to the court on what he/she considers to be in the best interests of the child and to ensure that the child's wishes and feelings are made clear to the court. Guardians Ad Litem are qualified social workers with considerable experience in childcare matters and a sound understating of family law. They are independent and are all appointed by the Northern Ireland Guardian Ad Litem Agency (NIGALA).³⁷

The Role of the Accredited Solicitor

The Guardian ad Litem instructs an accredited solicitor to act in specified proceedings. Accredited solicitors are accredited to the Children Order Panel in Northern Ireland and receive specialised training in relation to Children Order proceedings.³⁸ The solicitor and Guardian ad Litem work together combining their different backgrounds, training and experience to provide the child with “tandem representation”. The Guardian ad Litem conducts an independent investigation into the child's circumstances and forms a view about what is in the child's best interests. The solicitor ensures that the child's legal rights are protected, and advises the Guardian ad Litem on the law and the range of legal options available.

Conflict between Instructions of Competent Child and Best Interest of the Child

One of the most interesting features of the tandem model of representation is its recognition of the importance of representing the views of the competent child, even when this conflict with what the Guardian ad Litem has stated in their report as being in the child's best interests. If there is a conflict between the instructions of a **competent** child and the views of the Guardian ad Litem, the solicitor is obliged to continue to act for the child and not the Guardian ad Litem.

³⁶ Art 60 (2) b) of the Children (NI) Order 1995.

³⁷ The role and functions of NIGALA are set out in The Northern Ireland Guardian Ad Litem Agency (Establishment and Constitution) Order (NI) 1995 and The Guardian Ad Litem Panel Regulations (NI) 1996.

³⁸ The Solicitors' Children Order (Panel) Regulations 1996 and accompanying procedures

In these circumstances, the solicitor will continue to act on the child's instructions and the solicitor's role is to ensure that the child's views and opinions are made known to the court. The Guardian ad Litem submits the report to court indicating the course of action which is in the child's best interests and the solicitor represents the child's instructions.

Assessing Legal Competency

This is a very skilled task. King and Young in their book *Child as Client*³⁹ provide a useful framework for assessing whether a child has "sufficient understanding". The child should understand (and it is the duty of the solicitor to explain) the following:

1. the solicitor's role;
2. the nature of the proceedings in respect of which the child is subject;
3. the reason for the proceedings;
4. what takes place in court;
5. what other professionals think is best for the child;
6. what the child's parents and other parties to the proceedings think is best for the child;
7. the views of the Guardian ad Litem;
8. the law which affect the proceedings; and
9. the threshold criteria.

The competent child should be able to outline their wishes and feelings regarding the past and future, have some perception of the events leading up to the proceedings and of his/her stay to date in care and be able to give an indication of what type of arrangements/court order they think would be most suitable. There is no specific age at which a child becomes competent and an individual assessment should be carried out in each case. The Guardian ad Litem and solicitor often work together in the assessment of competence – the Guardian ad Litem will have an understanding of the child's emotional and psychological state, cognitive and intellectual capacity and his or her age and stage of development. Ultimately, however, the solicitor must advise the court on a child's competence.

³⁹ Family Law, 1992

Discharge of Solicitor and Guardian Ad Litem from Case

The Guardian ad Litem and solicitor are discharged from the case as soon as a final order is made by the court. No monitoring role remains for the Guardian ad Litem. The child can however contact their solicitor if further matters arise in future, but this will depend on their age and competency to do so. In England, the Children Act 1989 has been amended by the Adoption and Children Act 2002 to introduce reviewing officers who can monitor a child's placement and refer the matter back to court, if necessary.

ADVOCACY SEMINAR, 25 SEPTEMBER 2004
SUMMARY OF POINTS FROM IN THE DISCUSSION FORUM

Accessing advocacy was seen to be very difficult. There was little or no clear information within the health service on types of advocacy, its availability etc. There was a need for much greater clarity and openness in advocacy services and a need to publicise the services in accessible formats.

It was also pointed out that advocacy couldn't be done piecemeal. Users expect any valid advocacy services to be:

- a) independent; and
- b) financially viable in the long term.

It was hoped that an overall body could be formed to govern and regulate advocacy services.

It was noted that advocacy was an issue for the whole Review, and that one of the seminar's purposes was to look at the different definitions.

Another concern was that if there was an overarching advocacy regulating or co-ordinating body, then the unique experience and skills of peer advocates might be lost.

There was strong support for a range of advocacy services as, for example, people with a learning disability would need different types, as appropriate. Peer advocacy was seen as very empowering, but not suitable in every circumstance. There was a difficulty with the word, as different types of advocacy were suitable in different circumstances. There was scope for a top-down/bottom-up mix.

Peer advocacy to be sustainable needed direct funding. This is the only way it could retain its independence.

The importance of advocating for a child, and training for carers were important issues. In addition, it was argued there is an existing statutory right to a 'carer's assessment' but this was hardly ever carried out.

The potential tensions between the need for confidentiality and for the sharing of information with carers were raised. Carers and users were asked, however, to understand the context in which doctors offer treatment. Each patient is entitled to have someone with them in a consultation, but there was considerable pressure on professionals to be seen to be taking confidentiality seriously. The goal of any effective advocacy service mustn't be on a "them and us" situation.

It was also seen as important that Agencies and Trusts listen to advocates and that there were standards agreed among them. A shared working relationship between advocates and health professionals would be a key goal, but it was stressed that just because users or carers were genuinely listened to, didn't mean that this would result in any change of treatment.

RECOMMENDATIONS

Access to Rights

1. The Government, the Commissioners for Human Rights, Children and Equality should actively promote and provide information about rights to people with mental health difficulties or learning disability.
2. Public, voluntary and independent sector staff, including front line staff and policy makers, should receive training on human rights and equality issues in relation to people with a mental health problem or learning disability. This requirement should be reflected in contractual arrangements.

Right to Vote, to Found a Family and to Life

3. The continued use of common law in current electoral practice should be reviewed.
4. The new capacity legislation should be based on the presumption of an individual's capacity to make a decision and place responsibility on those challenging or questioning capacity to provide evidence of incapacity.

Education Rights

5. The right of every child and young person with a mental health problem or a learning disability to education should be explicitly recognised and reflected in any new legislative framework.

Capacity, Incapacity and Human Rights

6. Any new legal framework must include appropriate rules and procedures to govern:
 - (a) the determination of capacity or incapacity;

- (b) the circumstances when substitute decision-making can be lawful in relation to someone who is capable;
- (c) how to deal with persons with intermittent capacity; and
- (d) the appropriate mechanisms for dealing with persons who do not have capacity, including putting in place sufficient safeguards to protect such persons.

Involuntary Detention

- 7. The definition of mental disorder should be reviewed.
- 8. The criteria for detention should be broadened to include serious mental or psychological harm, with appropriate safeguards put in place to prevent misuse or abuse of this power.
- 9. The role of the nearest relative as applicant in the compulsory detention of patients should end.
- 10. There should be appropriate safeguards defined in legislation for “Bournewood detentions,” in accordance with the European Court’s ruling.
- 11. Proper safeguards should be put in place to ensure that patient needs are properly accommodated, particularly as regards children and young people, in accordance with the principle of Reciprocity.
- 12. Given the previous under-funding of services for children and young people, there must be adequate resources made available to protect the rights, needs and best interests of compulsorily detained children and young people, including their educational needs and rights.
- 13. Mental health and learning disability services must reflect and be sensitive to the different religious, ethnic, racial and cultural backgrounds of people and groups in

Northern Ireland, and comply with the equality obligations of Section 75 of the Northern Ireland Act 1998.

14. The anti-stigmatisation provisions in the present legislation must be built upon to protect assessed and detained persons from post-detention discrimination.

Representation at Mental Health Review Tribunals

15. A patient, irrespective of his or her income or savings, should have an entitlement to expert legal representation at an independent Tribunal, provided by experienced lawyers with expertise in mental health and compulsory detention.
16. A patient should be able to represent him or herself or appoint a representative of his or her choice for this purpose. Where appropriate, a patient advocate may play a role in assisting the patient.
17. Where the requirements of justice demand it (including the patient's rights to a fair hearing) a suitable lawyer should be appointed to act on the patient's behalf, whether or not the patient consents to such a course.
18. In relation to children, dual or tandem representation should be considered, whereby a lawyer and a Guardian ad Litem would be appointed to act for the child.

Advocacy

19. There should be a statutory right to independent advocacy support, embracing a range of different models.
20. There should be a regional strategy for the development and funding of independent advocacy support in Northern Ireland. This will involve a number of Northern Ireland Departments and should be co-ordinated by the Department of Health, Social Services and Public Safety.

