HUMAN RIGHTS IN AMHP PRACTICE

This is not just any chimpanzee. This is Cecilia. She is 20 years old and confined to the Mendoza Zoo in Argentina. Staff did not have the financial means to provide better conditions for her. An unannounced inspection found her in the corner of the enclosure, where the sun was, her food trough was empty, and she had little in the way entertainment. Drawings of trees and shrubs on the cemented walls of her cage tried awkwardly to imitate her natural habitat.

What is unusual about Cecilia is that a writ of habeas corpus was brought on her behalf to secure her release and transfer to the Great Ape Project's sanctuary in Brazil. Chimpanzees can reach the intellectual capacity of a 4-year-old child. Human beings share between 94 and 99% of their DNA with chimpanzees who possess characteristics analogous to us. In perhaps the first case of its kind, Judge María Alejandra Mauricio held that Cecilia was a sentient being and a subject with "non-human rights". She was held to have legal capacity to exercise rights at law:

"*Great apes are subjects of rights and are holders of those that are inherent in the quality of being sentient.*"

So, at least in Argentina, the ape is no longer an involuntary actor in the theatre of human rights. Cecilia had the non-human right to live in an environment and in the conditions of her species and is being moved to the Brazilian sanctuary.

This decision made me reflect upon the living conditions of the human species. Earlier this year was a case involving a 35-year-old man with autism, cerebral palsy, learning disability, visual and hearing impairment, who had always been unable to weight bear. The corridors of his one-bedroom 24/7-staffed flat were too narrow to move his wheelchair around the lounge and kitchen. He had no option but to crawl on his bottom using his hands and knees. This caused painful bursitis in both knees and calluses to his knees and ankles.

At first instance, the judge held that she could not endorse a care regime which risked breaching this man's right to liberty. She refused to continue to authorise his continued deprivation of liberty: [2015] EWCOP 64. After years of not being able to find more alternative accommodation, one

was found within four weeks. But the appeal judge said the decision was wrong. He held that the "*deprivation of liberty of a person who lacks capacity in his own home, under a care plan delivered by qualified care providers, is most unlikely to breach his Article 5 rights*". And "*all that is required is that the conditions are appropriate, not that they are the most appropriate for the detained person*". Indeed, it was considered "*inflammatory*" and "*unhelpful*" for me to raise the concern that such living conditions were degrading or inhuman: [2016] EWCOP 5.

I want to focus on the underlying inherent dignity that we should afford to others in our day to day practice as an AMHP. Specific judicial decisions on human rights violations provide examples, but it is the underlying interaction of the actors involved that we must focus on. The ways in which such interaction impact upon the inherent qualities of being human.

Human rights are inherent entitlements. They come from being human. As such, they began long before the Human Rights Act 1998 and will continue long after if/when the Act is repealed. Examples of their written encapsulation include of course the Magna Carta (1215) and the English Bill of Rights (1689). But these are legal pronouncements of inherent qualities of what it means to be human. Those pronouncements, like the European Convention on Human Rights, seek to protect these qualities. But it is not just law that does so.

Professional standards protect human rights. Ethical values do so. Social work principles similarly. All too often human rights law is seen as a self-contained discipline; its own book, worthy of study. When in fact human rights are a language permeating all books in the library of life and professional conscience. But forgive me, I am no linguist so must confine myself to legal examples that use the language of human rights.

AMHPS ARE UNIQUE

They are described by Rob Brown as "*mini-courts on legs*". AMHPs, like BIAs, are a bulwark between the State and the citizen. You ultimately decide whether a hospital application to detain your fellow being "*ought*" to be made. Objective medical expertise on that issue is not decisive. It is your independent judgment that counts. A judgment which provides checks and balances; which protects human rights and the interaction between the State and its citizen. And, of course, as public bodies you must not act incompatibly with the ECHR.

Whilst you may be mini-courts, your judgment is not the judgment of a court. Different public bodies are entrusted by Parliament with different functions. We cannot, of course therefore, interpret the MHA/MCA as we see fit. We must follow the legislation. And we must follow the Codes of Practice, except where there is a cogent – and documented – reason for not doing so.

All too often, and all to easily, hospital is seen as the easy option; a place of safety where care arrangements break down. Removing me from my society simply moves the risks to somewhere else. But whether I need to be in hospital depends upon what is available to me outside it. At present, the lack of available resources poses a direct threat to basic human rights. Only last week, the UN Committee on Rights of Persons with Disabilities found that the UK to have committed grave violations of such rights-holders with regard to social welfare reforms. The clear and present danger is that less money means less liberty for those dependent upon others. And my anecdotal sense is that there is a danger of mental health care moving back towards larger-scale care regimes as social and health authorities look to make savings.

ARTICLE 2

There is no general obligation in this country to be a good Samaritan. You – at least when not at work! – can walk past someone attempting suicide. You might be morally criticised. But would not be legally liable. The law requires intervention only if a duty of care is owed. And harm being foreseeable, without more, does not trigger a duty.

It is not for me to say whether the inherent qualities of being human should include a dignified end of life, in addition to its preservation. If animals have non-human rights, it seems that such rights include a dignified death. Human rights – Article 2 – at present protects the right to life but not a right to death. Although decisions about death fall within Article 8. And the right to life is of course particularly relevant to AMHPs.

A number of cases – *Savage, Rabone* – have identified that in certain circumstances, where a public body knows or ought to know of a real and immediate risk to another's life, they must take reasonable precautions to minimise it. So this is a positive obligation to be a good Samaritan. But protecting us from ourselves is no easy task when the short term benefits of escaping life outweigh the perceived long term agony of having to endure it.

I am not aware of any successful Article 2 claim brought against an AMHP for failing to apply to detain a suicidal patient. The crucial issue for AMHPs is what are those "certain circumstances"? Risks presenting in the community are more difficult to identify and minimise than those presenting in a more secure setting. Documenting the reasons for not making an application are just as important as those for making one.

ARTICLE 3

We rarely use torture in mental health; although understanding the complexity of the DoLS legislation can at times be tortuous. Winterbourne View is one exception where patients were tortured. But inhuman or degrading treatment can and does occur. And where it does occur, it cannot be justified, even on the basis of a lack of resources. In *Dybeku v Albania* [2009] 1 MHLR 1 the European Court of Human Rights held that, "… *a lack of resources cannot in principle justify detention conditions which are so poor as to reach the threshold of severity for Art 3 to apply*."

In *MS v UK* (*Application no. 24527/08,* 3 May 2012), ECtHR, a MHA s.136 took place at 4.20am and MS was taken to a police station. He was assessed as requiring hospital detention and was severely unwell. On day 1, he was clapping loudly, shouting, banging on the door, lowering his trousers and "waving" his testicles about, licking the wall of his cell, and repeatedly hit his head against the wall. On day 2, he removed all of his clothing and drank water from the bowl of the toilet in his cell. On day 3, he was still naked, rocking to and fro on a bench, talking to himself, banging his chest and ranting. He also smeared his naked body with food and faeces. He remained in detention beyond the maximum 72 hours and, on day 4, was finally transferred to a medium secure unit and diagnosed as experiencing a manic episode with psychotic features.

The ECtHR recognised the difficulties of co-ordination when confronted with urgent mental health case. There was a systemic bed failure. But it was held:

> "39… the mentally ill are in a position of particular vulnerability, and clear issues of respect for their fundamental human dignity arise whenever such persons are detained by the authorities."
> "44. [T]he applicant was in a state of great vulnerability throughout the entire time at the police station, as manifested by the abject condition to which he quickly descended inside his cell. He was in dire need of appropriate psychiatric treatment, as each of the medical professionals who examined him indicated. The Court considers that this situation, which persisted until he was at last transferred to Reaside early on the fourth day, diminished excessively his fundamental human dignity…It is of some significance that the applicant's

> situation failed to respect both best medical practice in England as well as the maximum time-limit set by Parliament in the relevant legislation. Throughout the relevant time, the applicant was entirely under the authority and control of the State. The authorities were therefore under an obligation to safeguard his dignity, and are responsible under the Convention for the treatment he experienced.
> 45. Even though there was no intention to humiliate or debase him, the Court finds that the conditions which the applicant was required to endure were an affront to human dignity and reached the threshold of degrading treatment for the purposes of Article 3."

A lack of hospital beds is of course a real problem. But what is being done about it? What can, what should, we as AMHPs do about it? Having nowhere to admit someone who is in dire need of psychiatric care is surely a serious safeguarding issue. But rarely have I heard of an AMHP raising a safeguarding alert. These may be systemic problems. They may be economic problems. But things are unlikely to change if the principal safeguard of the AMHP does not report their safeguarding concerns.

There was a suggestion – nothing more than that – that an AMHP might have to do a reconnaissance of the hospital before admitting them. But the claim in *DD v Durham*[1] was discontinued. And rightly so. It is of course wrong to confine someone to a wholly inappropriate ward. After all, at least for longer term detention, appropriate medical treatment must be available. But it is not the AMHP's responsibility to assess the quality of the hospital. That is a matter for others. But if you do have major concerns, then of course report them.

ARTICLE 5

The right not to be arbitrarily deprived of liberty is of course where the interaction between the person and the State has changed considerably since *Cheshire West*. Normalism has been replaced with legal formalism. Reinterpreting the meaning of being deprived of liberty in the context of the Mental Capacity Act 2005 has driven a coach and horses through the Mental Health Act 1983. For AMHPs in particular, it impacts upon admission to hospital and discharge from hospital.

If the State is to detain you, it is only right to require the legal procedure to be followed. Breaching the procedure should be a serious matter. There must be dignity in the process. We may well be justified in doing what we are doing, but it must be done in the proper, lawful way. And those that fail to follow the legal detention procedure should be held to account. But at the moment, it feels

[1] [2012] EWHC 1053 (QB); [2013] EWCA Civ 96.

entirely unrealistic, at least under the MCA, because the number of people requiring safeguards is entirely disproportionate to the availability of those safeguards.

Accountability under the MHA however seems more realistic. In *R (GP) v Derby City Council* [2012] EWHC 1451, the AMHP made an unlawful s.3 application because they did not drive 30-minutes to the nearest relative's house when there was 7 ½ hours remaining on a s.2. In *TTM v Hackney* [2011] EWCA Civ 4, the s.3 was unlawful because the AMHP had wrongly thought that the nearest relative was no longer objecting when in fact he was. And in *TW v Enfield LBC* [2014] EWCA Civ 362, the legality of the detention was brought in to question because the AMHP decided not to consult the nearest relative without sufficient consideration given to the patient's Article 5 rights.

But legal formalism or proceduralism is not just impacting upon hospital admissions. The *Cheshire West* effect is being felt at the point of discharge, for example in relation to conditional discharge, CTOs and guardianship.

ARTICLE 6

Financial resources, or lack thereof, of course has an impact upon the care options available. And whether someone needs to be in hospital depends upon what less restrictive options are outside it. Not only relevant to AMHPs but also to hospital managers hearings, tribunals, and the Court of Protection. The extent to which a person, or a best interests decision-maker on their behalf, is able to interact and negotiate with public bodies with regard to the options will be considered next month by the Supreme Court in *MN*.

ARTICLE 8

AMHPs make a detention decision. But your practice is very much within the realms of Article 8. You cannot be an AMHP without interfering with Article 8. Going into people's homes. Determining that someone lacks capacity. Determining that it is even necessary to assess whether someone lacks capacity. Removing someone to hospital. Consulting with families and carers. Applying to receive someone into guardianship. Approving a CTO. All these things interfere with people's right to respect for their home, private life, family life and correspondence.

We must therefore always acknowledge the interference, check whether it is necessary, ask why are we doing it, and question whether there is a less restrictive way of doing it. Is abstinence from alcohol really a necessary CTO condition? Is a CTO condition the most effective means of

achieving the aim? After all, discretionary conditions have no teeth and cannot be compelled. Indeed, query whether a CTO is even appropriate in the first place, given the OCTET research.

The *Cheshire West* effect and legal formalism is also impacting upon people's Article 8 rights. For example, an incapacitated 16-year-old requires Article 5 safeguards even though their parents agree. A day before their 16th birthday, however, the parents can consent on their behalf. There is tension between parental responsibility – Article 8 – and the child or young person's right to liberty under Article 5.

THE INHERENT QUALITIES OF BEING HUMAN

In my opinion, following the principles in the Code of Practice, and considering the dilemmas they give rise to, are a good place to start when it comes to human rights:

Respect and dignity
Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

Empowerment and involvement
Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

Purpose and effectiveness
Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

Efficiency and equity
Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

Least restrictive option and maximising independence
Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

Ask questions of others

Human rights are about not being afraid to ask questions. Neighbours give you a key to enter the house. Did the person envisage an AMHP entering? Should we get a warrant? Human rights is about knowing the number of a good locksmith. It is about knocking on the door or ringing the bell before needing a locksmith. It is about recognising that this person will have to come back here after being removed from society. If I must go to hospital, please take me when the neighbours are at work.

Understanding the person and the science

Human rights are about understanding the reason for the person's behaviour. They are about looking at why people behave in the way they do. We often see: "Refusing to engage"; "not taking medication"; "refusing access"; "failed to attend". But what were the person's reasons? They may be perfectly valid. It is about listening, not just hearing. It is about considering what is important to them.

Human rights are about appreciating the uncertainty behind the science of psychiatry. It is not an exact science, said Lady Hale. Diagnosis is not easy or clear cut. Human rights are about looking at the longer term when dealing with the crisis here and now. Thinking about recovery and the future return to the community.

Small places

Human rights are about the little things; little things that can make a huge difference. Human rights are found in small places. Perhaps, put simply, they are about treating others how you would want to be treated in their situation.

Gandhi once said, "*The greatness of a nation and its moral progress can be judged by the way its animals are treated.*" Argentina has recognised the non-human rights of Cecilia, the chimpanzee. Perhaps by following the principles of the Code of Practice we will be better judged for respecting the human rights of those with mental ill health. Thank you.

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