Neutral Citation: [2016] IEHC 575

THE HIGH COURT

[Record No: 2014/ 9083P]

IN THE MATTER OF J.B.

AND IN THE MATTER OF THE INHERENT JURISDICTION OF THE HIGH COURT

BETWEEN:

HEALTH SERVICE EXECUTIVE

PLAINTIFF

AND

J.B. (A PERSON OF UNSOUND MIND NOT SO FOUND REPRESENTED BY HIS SOLICITOR PATRICK DALY) (NO. 2)

DEFENDANT

AND

W.B. (MOTHER)

NOTICE PARTY

JUDGMENT of Ms. Justice Bronagh O'Hanlon delivered on the 6th day of October, 2016

1. J.B., the subject matter of these proceedings, has resided in St. Andrew's Hospital in Northampton by order under the inherent jurisdiction of the Irish High Court since 4th October, 2011. This case has been subject to continuous review by the Irish High Court. The English Court of Protection recognised the orders of the Irish High Court and declared them enforceable in the jurisdiction of England and Wales. This gave St. Andrew's the legal authority to detain J.B.

2. The procedure under Article 56 of the Council Regulation (EC) No. 2201/2003 of 27th November, 2003 Concerning Jurisdiction and the Recognition of Judgments in Matrimonial Matters and the Matters of Parental Responsibility states as follows:-

> "Article 56 Placement of a child in another member State
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> 1. Where a court having jurisdiction under Articles 8 to 15 contemplates the placement of a child in institutional care or with a foster family and where such placement is to take place in another Member State, it shall first consult the central authority or other authority having jurisdiction in the latter State where public authority intervention in that Member State is required for domestic cases of child placement.
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> 2. The judgment on placement referred to in paragraph 1 may be made in the requesting State only if the competent authority of the requested State has consented to the placement.
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> 3. The procedures for consultation or consent referred to in paragraphs 1 and 2 shall be governed by the national law of the requested State."

3. Since J. became an adult, EC Regulation 2201/2003 has no longer been applicable. Therefore, on foot of orders from the Irish High Court, the plaintiff, its servants or agents, then made an application to the Court of Protection in England pursuant to the provisions at Part 4 of Schedule 3 of the English Mental Capacity Act 2005 seeking an order for the enforcement and recognition of the Irish High Court orders. This procedure was accepted by Baker J. of the English Court of Protection in this case which was joined with two other similar cases and was referred to as *Health Service Executive of Ireland v. P.A. & ors* [2015] EWCOP 38. Baker J. recognised and enforced orders of the Irish High Court noting the procedural safeguards which were in place where a regular review of the treatment and circumstances of the detained individual was conducted by the Irish High Court in order to prevent the orders from being "manifestly contrary to public policy".

4. J.B. was detained under the inherent jurisdiction of the Irish High Court while he was a minor. The position was reviewed upon the occasion of J.B. attaining his majority on 24th October, 2014. Those proceedings came before this Court by way of Notice of Motion issued by the Health Service Executive dated 23rd October, 2014.

5. On 5th March, 2015, this Court delivered a judgment in this case. The issue before this Court at that point was whether J.B. had capacity to make material decisions as to his residence, care arrangements and his medical treatment. That judgment summarised medical evidence heard from Dr. Martin Lawlor, Consultant Psychiatrist who was of the view that J.B. lacked the capacity to weigh and balance the overall pros and cons of care in the UK as opposed to receiving treatment in Ireland and should therefore remain in St. Andrew's. Dr. Ciarán O'Malley, Consultant Psychiatrist provided evidence to this Court after carrying out an independent assessment of J.B. as requested by J.B.'s guardian *ad litem* at the time. Dr. O'Malley was of the view when he gave evidence prior to March, 2015 that it was reasonable to conclude that J.B. was not capable of properly protecting his own interests as he did not have the understanding or the ability to weigh the pros and cons and think rationally about the decisions he was making. That judgment also records Dr. Margaret Kelleher's concern that the appropriate facilities are not available in Ireland and that, upon return, J.B. could become very dangerous.

6. Dr. Stephen Attard, Consultant Psychiatrist in St. Andrew's Hospital, Northampton, who was J.B.'s treating psychiatrist at the time of the judgment also gave evidence during the previous hearing. He expressed a view that J.B. needed to do additional work including an anger management course that was indicated would take eighteen weeks. Dr. Attard is recorded in this Court's previous judgment as stating that J.B. should remain in St. Andrew's for a further twelve to eighteen months although it could be longer. This time has now passed. The judgment of 5th March, 2015 records Dr. Attard as confirming that J.B. does have capacity to decide where he lives.

7. The judgment of this Court on 5th March, 2015 also records J.B.'s then guardian *ad litem* as stating that J.B. has the ability to instruct a solicitor and no longer required the assistance of a guardian *ad litem*. The guardian thus left the proceedings and J.B. has since been represented directly by his own legal team.

8. In this Court's judgment, dated 5th March, 2015, it was determined that J.B. lacks capacity in terms of making material decisions in regards his medical treatment and therapy. This Court concluded that J.B. should continue to be detained for the purposes of overseeing an orderly transition from St. Andrew's to an appropriate placement in Ireland. This Court recommended the formation of a committee of doctors to oversee J.B.'s transition to Ireland and come to a consensus as to when and how such a transition was to be affected.

9. J.B. has been diagnosed with bi-polar affective disorder which is currently in remission as he is receiving medication in respect of same. He has also been diagnosed with a personality disorder. There is some conflict between the medical professionals in relation to his diagnoses which will be set out below. It is accepted by all parties that J.B. is not currently detainable under the Irish Mental Health Act 2001. He would be detainable under the English Mental Health Act 2005 on the basis of his personality disorder.

10. The legal representatives for J.B. renewed their position that J.B. is an adult who has capacity and, therefore, cannot be detained under the inherent jurisdiction of the High Court. This is the issue which is now before this Court.

Expert Evidence

11. As per the directions of this Court, a committee of three doctors, Professor Casey, Dr. Kelleher and Dr. Lawlor, was established for the purpose of overseeing J.B.'s transition to Ireland. There were three reports before the Court from the three doctors, along with a report from St. Andrew's Hospital by way of update. The Court indicated at the hearing of the expert evidence on 3rd December, 2015 that the core question for the committee of doctors was how J.B.'s transition to Ireland could be achieved. The committee of doctors was generally of the opinion that J.B. could not return to Ireland immediately. However, it was accepted by counsel for the HSE that J.B. cannot be indefinitely detained in the UK.

12. Dr. Martin Lawlor, Consultant Psychiatrist gave evidence on 3rd December, 2015. He provided an extensive report dated 27th November, 2015 which he adopted into his evidence.

13. Dr. Lawlor stated that he believes that J.B. has a diagnosis of bipolar effective disorder which is currently largely in remission although some evidence of mood fluctuation is still present. He agreed with Professor Casey that J.B. also presents with a personality disorder. Where he differed is that he believed J. presents with a mixed picture of anti-social traits and emotionally unstable (impulsive type) traits. Dr. Lawlor further stated that there is also evidence of historical substance misuse. Dr. Lawlor stated that the severe version of bipolar disorder has not been seen but that J.B. did present with a depressed mood in April and May of 2015. He explained that bipolar disorder is defined as a combination of manic symptoms and depressive symptoms.

14. Dr. Lawlor stated that it was his opinion that the therapy required is driven by J.B.'s needs assessment and by his diagnosis. He stated that he believes that J.B. needs access to appropriate psychological interventions for his personality disorder, he needs support in managing his anger, and he needs structure. It was the opinion of Dr. Lawlor that J.B. exceeds the capacity to be safely cared for in any low secure setting. He believed J. needs medium secure care in order to manage the significant risks that he presents, largely to other people although he recognises that there was some history of vulnerability. It should be noted that J. was moved by this Court from the inappropriate solitary setting to the medium secure unit in order for him to be able to access amenities, services and anger management therapy.

15. Dr. Lawlor was of the opinion that it was possible to put in place therapies that would give J.B. a chance to overcome the anti-social and emotionally unstable personality disorder. Dr. Lawlor stated that these therapies could be provided to J.B. in St. Andrew's Hospital. Dr. Lawlor indicated that any treatment plan has to be driven by J.B.'s diagnosis and needs assessment. It was his view that J.B. needed to be treated in St. Andrew's as a first stage in ensuring that he received treatment.

16. Counsel for the HSE focused Dr. Lawlor on the question of how and when J.B. could be returned to Ireland. Dr. Lawlor stated that the how element of the question had to be based on safety. J.B. would need the structures to be put in place. Dr. Lawlor was of the opinion that J.B. needs the appropriate level of physical support which would include a locked ward. He also needs appropriate relational security which would involve creating positive relationships with staff.

17. Dr. Lawlor stated that J.B. cannot be moved safely to a unit that does not meet his needs and he exceeds the capacity to be safety cared for within the services available in Ireland. His scores on the internationally accepted risk assessment tools are at the maximum. Dr. Lawlor further stated that it was the view of himself and J.B.'s current treating team that J.B. needs medium secure care. Dr. Lawlor supported the view of the Court that J.B. was not appropriately placed in December, 2015 in his ward in St. Andrew's. The purpose of the proposed move to the medium secure unit, referred to as the Pritchard Ward, would be that he would have access to a garden, he would have a higher level of nursing support and he would have access to education.

18. Dr. Lawlor was asked whether the move to a medium secure unit from his then location in the low secure unit would be a step backwards in J.B.'s progression. Dr. Lawlor stated that what had happened was a case of positive risk taking and J.B. had been tested by moving him to the low secure unit to try him out in the least restrictive environment but that it had not worked out and that J.B. was at that time living in a segregated area on the low secure unit.

19. Dr. Lawlor stated that it would take 12 to 18 months to answer the questions around engagement and treatability and that J.B. could not be transitioned to Ireland before then. Dr. Lawlor stated that J.B. would exceed the security capacity of any unit in Ireland as none of them were designed to meet the level of care required by J.B. Dr. Lawlor indicated that there were plans in place to establish regional secure units across Ireland but this had not happened and Dr. Lawlor emphasised that that was a decision for the HSE.

20. Dr. Lawlor disagreed with Professor Casey on the issue of treatability. He stated that he would not base his opinion solely on the programme from the UK that Professor Casey outlined as the problems in that study were not in the treatability but in the implementation of the programme in a prison setting. Dr. Lawlor further emphasised that anti social personality disorder is a spectrum and that at the worst end people would have marked psychopathic traits. However, J.B. has shown a responsiveness to his environment that would not be indicative of such psychopathy. Treatment has moved on and there is now a "whole person" approach. J. has to be supported in accessing education, his peers and his motivation and engagement needs to be built upon. The study referred to in Professor Casey's report incorporated the worst end of the spectrum. Dr. Lawlor indicated that it was still early on in J.B.'s development to diagnose him specifically with a personality disorder and his treating team in St. Andrew's have classified him as having an emerging personality disorder. Dr. Lawlor identified that he has impulsive traits that are separate to his anti social personality disorder. The marked difference is that J.B.'s impulsive traits are definitely treatable according to Dr. Lawlor.

21. Dr. Lawlor identified a belief that J.B. did want to get better. Dr. Lawlor discussed treatment with his treating consultants in St. Andrew's. Stability is essential for J.B. in terms of physical structure and a humane environment. His setting was definitely

inappropriate as of December, 2015. The doctor indicated that it would be very difficult to consistently engage J. if he was not in a stable environment. Dr. Lawlor identified Dialectic Behaviour Therapy as one of the most effective treatments. Dr. Lawlor identified the evident humanity of the Court in its approach to J.B. However, he believes if J.B. was to be moved it would deny him an opportunity to stay in the appropriate setting and get the treatment which he requires.

22. Dr. Lawlor accepted that J.B. does need access to the gardens and access to his peers. However, he stated that, unfortunately, because of the disimprovement in J.B.'s behaviour the positive risk taking of putting him in the low secure setting was not successful. It was in J.B.'s interests to go into the Pritchard Ward and access the correct services. Dr. Lawlor stated that, if he got this period of stability then he had a much greater chance of successfully being stepped down.

23. Counsel for J.B. asked about the distinction between the emotionally unstable personality disorder and the anti-social personality disorder. Dr. Lawlor stated that most personality disorders are best defined as a difficulty regulating relationships. The nurse manager who worked with J.B. on a day to day basis identified that J.B. could improve with treatment and that he did not just have an anti social personality disorder. J.B. has also shown warmth and engaged with some staff members. The inability to regulate anger is slightly different from impulsivity. Impulsivity was described as the inability to understand and predict consequences. J.B. does not present with an entirely clear picture, it is a mixed picture. A lot depends on the severity of the personality disorder. In most instances J.B.'s violence is mostly reactive and not planned. Dr. Lawlor stated that he would be reluctant to diagnose psychopathy as it holds a certain stigma and consequences. Dr. Lawlor further emphasised that he was of the opinion that J.B. reaches the threshold for emotionally unstable personality disorder as classified by the international standards. Dr. Lawlor accepted that J.'s bipolar disorder is in remission.

24. Counsel for J.B. put to Dr. Lawlor that he had considered J.B.'s anger, impulsivity and violent outbursts in his assessment of J.B.'s capacity and he suggested to Dr. Lawlor that he is using the attributes of J.B.'s personality disorder in order to make a finding of a lack of capacity. Dr. Lawlor stated that the assessment of capacity is a legal test but as a clinician he was undertaking a mental state examination to look at J.'s ability to understand and retain and to weigh up information. Dr. Lawlor confirmed that he is not saying that a personality disorder equals a lack of capacity. He stated that he is saying that there are certain features which affect J.B.'s ability to weigh up information.

25. Dr. Lawlor stated that they had previously estimated a return time based on J.B. engaging with therapy but he has not done so. Because of J.B.'s risk profile he was placed in the "enhanced care suite" and that has curtailed J.B.'s ability to access treatment and other facilities and has prevented his engagement.

26. Dr. Lawlor also noted that J.B. perceives restrictions on him as being unjustified. All treatment is being done in a therapeutic manner and is being appropriately supervised with a strong clinical framework. Dr. Lawlor did not accept that it was punishment. Dr. Lawlor accepted that one can sometimes end up in a vicious circle where because of J.B.'s risk level he was put in the "enhanced care suite" and that J.B. then cannot see what he is working towards and refuses to engage. J.B. was slowly now starting to engage again because of the new flexible approach of his treating psychiatrist, Dr. Roychowdhury.

27. Dr. Lawlor stated that J.B. cannot be detained in Ireland and would have to be treated on an outpatient basis. Dr. Lawlor believed that J.B. would not take his medication outside of a structured setting so he would be at high risk of a manic episode. He would not advocate such an approach as it would expose J.B. to suffering and would put the public at risk. Dr. Lawlor pointed out that they required a six person team to get J.B. under control when he was experiencing a manic episode previously in St. Andrew's in 2014.

28. Counsel for J.B. asked what could be done in terms of treatment in secure care in St. Andrew's over the proposed period of 12 to 18 months that had not been done up to that point in December, 2015. Dr. Lawlor believed the evidence supported the approach being taken by J.B.'s treating team. J.B. needed that period of stability and structure.

29. Dr. Margaret Kelleher, Executive Clinical Director of J.B.'s local Mental Health Services gave evidence on 3rd December, 2015 that she was part of the committee of doctors and that they met regularly and that they did have it in their minds that this was an exercise to figure out how J.B. could be brought back to Ireland.

30. Dr. Kelleher indicated that one of the problems faced by the committee was that J.B.'s behaviour deteriorated and he had to go into the segregated "enhanced care suite" within the low secure ward. They were concerned that it was an anti-therapeutic setting although they understood that he was placed there on the basis of his level of risk. J.B. was not able to avail of the therapeutic treatment that would have helped him to progress. Dr. Kelleher stated that there was nowhere in Ireland that would be appropriate for J.B. She stated that for J.B. to come back to Ireland there would have to be work done on his mental state so that he would not pose such a risk.

31. Dr. Kelleher also stated that it would be a period of 12 to 18 months before J.B. could return to Ireland and that J.B. would really have to engage and focus on the therapeutic work during that period and that it would be most suitable for him to be in the Pritchard Ward which is a medium secure unit. It would be hoped that J.B. could progress to not requiring that level of security.

32. Dr. Kelleher stated that at that stage there may be options available in Ireland such as the acute psychiatric hospital in his local area. However, he would need to be detained under the mental health legislation for him to be held in any of the secure units in Ireland. Dr. Kelleher believes that this raises a problem as his bipolar disorder is in remission so he would not be detainable under the Mental Health Act 2001. Dr. Kelleher stated that she believed that J.B. deserves a chance. She noted that the process had gone from three months to three months and that had been unsettling for J.B. She identified that J.B. had a good opportunity to work in St. Andrew's.

33. Professor Patricia Casey, Independent Consultant Psychiatrist who was invited to assess J.B. on behalf of J.B. himself also gave evidence on 3rd December, 2015. She further agreed that J.B. is not detainable in Ireland for his personality disorder. His level of aggression exceeds what the units in Ireland could cope with.

34. She agreed that J. has an anti-social personality disorder. However, she disagreed with her colleagues in so far as she does not believe J.B. has an emotionally unstable personality disorder but rather that those traits are a symptom of his anti-social personality disorder. Professor Casey believed that the anti-social personality disorder could not be treated. She pointed to the fact that there is no consensus among practitioners that it is treatable. She cited a case study from the UK in which no improvement was shown through treatment of individuals with anti-social personality disorder. This was in the context of the preventative detention regime in the UK which has since been disbanded.

35. Professor Casey stated that J.B. is not detainable in Ireland because his bipolar disorder is contained and he is not detainable for

the personality disorder. The best that could be done for J.B. would be to link in with the outpatient forensic services provided by the Central Mental Hospital. It was noted that if he went off his medication and if his bipolar disorder were to return that then J.B. would be detainable under the Irish Mental Health Act 2001. He would probably end up in the Central Mental Hospital because of his level of violence when he is manic.

36. Professor Casey stated that if J.B. is not treatable he should not be kept where he is as there may be no improvement. Although she stated that there is a possibility that he would mature and develop and this would show a natural improvement, she would be unsure that this would decrease his level of violence by a significant amount. She was highly sceptical about his treatability. Professor Casey identified that J.B. may well end up being dealt with through the criminal justice system. Professor Casey stated that any continued stay in St. Andrew's would have to be balanced against the likelihood or, as the case may be, unlikelihood of a therapeutic benefit.

37. Professor Casey pointed out that J.B. has been institutionalised for a prolonged period of time (5 years) and some work needed to be done to reintegrate him into society. He had had no interaction with his peers for the past 6 months as of December, 2015. He would need a step down placement. He himself had expressed an interest in anger management. Professor Casey saw no therapeutic benefit for J. to remain in St. Andrew's and therefore believed that he should only remain there for a period of a few months in order to engage in preparations for departure.

38. Professor Casey stated that there was some merit in J.B. going to the medium secure unit for a period of time as there are many more facilities available there than in the segregated area of the low secure unit. In terms of the practicality of moving him towards reintegration medium secure would be more desirable as he can engage in various activities there. J.B. himself felt that he would be very stigmatised by going to the medium secure unit.

39. Professor Casey identified that she had met J.B. twice and had also reviewed his file for the purpose of writing her report. She noted that J.B.'s diagnosis had changed over time. The possibility of ADHD (Attention Deficit Hyperactive Disorder) was raised at one point. They also queried an Autistic Spectrum Disorder. One of the reasons J.B. did not accept the diagnosis of bipolar disorder is because his diagnosis has changed several times. He also indicated to her that things seemed to have gotten worse for him rather than better since his diagnosis and the supposed treatment of the bipolar disorder. Professor Casey noted that J.B. was able to process the information. The bipolar disorder is in remission. His concerning behaviour is caused by an anti-social personality disorder. She believes he falls into the more extreme end of the spectrum of that disorder. All the troubling traits that J.B. presents with are attributable to his personality disorder in Professor Casey's opinion.

40. Professor Casey stated that she believed that J. has capacity. She explained that J. understands information given to him and that he is able to process it. He may come up with incorrect conclusions but he is able to consider and process the information. She was of the view that he is also able to weigh up options and he is able to identify what therapy he believes will be beneficial to him. Just because he refuses certain treatment does not mean he lacks capacity.

41. Professor Casey also referred to the cultural factor that the travelling community are very reluctant to consider mental illness and this may also be why J. does not accept his diagnosis. J.B. did not say it to Professor Casey in those terms but he questions the diagnostic process. Professor Casey had concerns with regard to the ethics of preventative detention. The way she saw it J.B. was being detained because there was a risk that he would commit violence in the future. Professor Casey believed that J.B.'s personality disorder was not treatable. She stated that there were not any studies that show a benefit of treatment to a person with an extreme anti social personality disorder. Professor Casey further stated that if the Court disagreed with her and accepted that J.B. is treatable then it would take a number of years to treat him and he would have to be detained for that period. She feared that the Court may return to the issue in 18 months and be in the same position with regard the risk of violence. Professor Casey forecast exactly what happened that the Court remains in the same position as J.B. continues to be at a high risk of committing a violent act and no treatment has been effective.

42. When one looks objectively at J.B.'s situation, it appeared to Professor Casey that J.B. had not improved as a result of treatment over the past period in St. Andrew's and he was, as of December, 2015, effectively in a "cage". However, Professor Casey accepted that the new, more flexible treatment approach is better for J.B. Professor Casey explained that they were using a reward system with J.B. where he was allowed out if he goes 12 hours without an incident. She accepted that when someone is moved to a more secure area as a result of violence they will perceive it as a punishment. Professor Casey stated that it was not surprising that J.B. considered himself as being punished.

43. Professor Casey pointed to the risk assessment evidence and that J.B.'s risk level has not changed so they cannot say that he has improved significantly. Professor Casey agreed that J.B. does lack insight. Professor Casey stated that he does maintain capacity as a person can still have capacity while not having insight in coming to the correct answer. She stated that J.B. does recognise he has an issue with anger. Professor Casey believed that the other clinicians were being very over optimistic about J.B.'s treatability.

44. Professor Casey confirmed that she is concerned that the detention in St. Andrew's is preventative detention as J.B. has capacity, is over 18 years old and is not treatable. Professor Casey believed J.B. has actually deteriorated during his time in St. Andrew's. If J.B. returned to Ireland, Professor Casey has stated that there is nowhere for him to go and because of this J.B. is likely to stop taking his medication, suffer a relapse of his bipolar disorder and become detainable under the Mental Health Act 2001 and/or commit a violent offence, end up being dealt with by the criminal justice system and eventually be detained in the Central Mental Hospital. Professor Casey accepted that moving him to the medium secure unit with access to the various facilities was worth trying for a few months. She was concerned that this would end up being another protracted process that would result in no improvement.

45. At that point in the evidence this Court proposed that J.B. could move temporarily to the medium secure unit within St. Andrew's. It was expected that J.B. would be provided with a tailor made programme including anger management and access to the facilities in the medium secure unit. J.B. agreed to this as he believed that anything would be better than the segregated area where he was at that point.

46. Dr. Ashimesh Roychowdhury, Consultant Forensic Psychiatrist in St. Andrew's supplied a report to the Court. He stated that J.B. is able to understand but he is not able to weigh the pros and cons of different treatment options. J.B. also lacks insight into the difficulties he may face living in the community. Therefore, Dr. Roychowdhury believed that he should remain detained in St. Andrew's and should move to the medium secure Pritchard Ward. Given that J.B. had been there before so he could gain access to the facilities in Pritchard Ward after a few days and not months as previously believed. This was predicated on J.B. "buying in". The committee of doctors was in agreement to a certain extent that a period of months in Pritchard Ward would be beneficial to J.B.

47. Counsel for the HSE highlighted that Dr. Roychowdhury felt that Professor Casey's assessment of the anti-social personality

disorder as being untreatable was fundamentally incorrect and that the study she referred to only dealt with convicted criminals. Counsel for the HSE assured the Court that there was a therapeutic benefit to J.B. remaining in St. Andrew's.

48. Dr. Roychowdhury gave evidence on 17th December, 2015 by video link. He prepared a report dated 27th November, 2015. Dr. Roychowdhury identified that J.B. is not cognitively impaired but that the issue was whether he could weigh the pros and cons of different treatment options. Dr. Roychowdhury identified that J.B. did not accept the diagnosis of bipolar disorder and that he has stated he would not take his medication as he does not see the benefit of it. It remains Dr. Roychowdhury's view that J. lacks capacity.

49. The plan at the end of December, 2015 was to move J.B. to the Robinson Ward because there was another patient in the Pritchard Ward that may cause him some problems. Dr. Attard, who J.B. knew previously, would be his treating clinician on the Robinson Ward. He was assessed by Dr. Iles from the Pritchard Ward who was concerned about the mix of patients on the Pritchard Ward and refused J.B. a place there. Both Pritchard and Robinson are medium secure adult mental health wards. Dr. Attard was going to be asked to assess J.B. for going to the Robinson Ward.

50. Counsel for the HSE pointed out to Dr. Roychowdhury that the HSE want to facilitate a return to Ireland in three to six months from December, 2015. Dr. Roychowdhury identified that J.B. needed to engage in the treatment programme and he would make quicker progress in the Robinson Ward. Dr. Roychowdhury stated that they were very limited in what they could do with J.B. in the environment he was in. Dr. Roychowdhury identified the facilities within the building of the Robinson Ward as including an education unit, gym, café, etc. He noted that decisions about J.B.'s care would now be up to Dr. Attard.

51. Counsel for the HSE asked if J.B. could buy into this treatment programme and whether he could appreciate the urgency to return to Ireland. Dr. Roychowdhury stated that J.B. believed that the HSE just wanted to keep him locked up. J.B. could engage but it was difficult to know if he actually would. Dr. Roychowdhury further stated that he did not see a clinical benefit in having a set discharge date. Clinically, it was not just about the length of time spent in St. Andrew's but also how J.B. engaged and how he was at the end of certain programmes.

52. Counsel for J.B. put it to the doctor that the treatment programme might work better if it was for a limited period. Dr. Roychowdhury stated that it made sense that it would not be open ended. Counsel for J.B. suggested that J.B.'s move to the Robinson Ward should really be part of a discharge plan in effect. Dr. Roychowdhury accepted that J.B. had spent a prolonged time in St. Andrew's, however, he also stated that J.B. had acknowledged some progress and improvement although J.B. attributed that to natural maturation and not to his treatment. Dr. Roychowdhury stated that he could see improvements in J.B. Dr. Roychowdhury accepted that detaining somebody on a never ending basis is not appropriate. J.B. is still at an age where his problems are not set in stone and he is capable of improving and this is why Dr. Roychowdhury would favour keeping him for a limited period in medium secure care.

53. Counsel for J.B. put it to the doctor that different doctors seem to have different views as to capacity. Dr. Roychowdhury accepted that there would be different views on capacity in J.'s case because it was not clear cut. Dr. Roychowdhury noted Professor Casey's report and stated that he believed that she placed a lot of emphasis on the processing ability element of the capacity test. He agreed that J.B. had the cognitive ability to process information. However, Dr. Roychowdhury would emphasise the balancing element of the capacity test. If a person claimed their mental illness did not exist then, almost always, Dr. Roychowdhury would think that they did not have the capacity to consent to medication and treatment.

54. Counsel for J.B. also put it to Dr. Roychowdhury that the issue was further complicated by the fact that the legal position as to capacity in Ireland is also not very clear. Dr. Roychowdhury agreed with this and further stated that because in England the capacity issue is not a necessary element under their mental health legislation the English professionals are unfamiliar with the process of making such assessments.

55. Dr. Roychowdhury accepted that the period of time in the medium secure unit would be decided by the Court and he would adapt to the time scale set by the Court. He noted that significant clinical change was not likely within 6 months, although J.B. could receive a type of relevant therapy. Dr. Roychowdhury further emphasised that the treatment would be much more successful if J.B. bought into it and cooperated. Dr. Roychowdhury stated that he would recommend giving medium secure care a 12 month time period in which they could work with J.B. It would be dependent on actual therapeutic change and a set time period is not necessarily helpful. Dr. Roychowdhury had a concern that J.B. might just think he could wait the time out and not engage in the programme. He was of the view that, rather than fixation on the number of months, they should rely on the view of the clinical team.

56. J.B. gave further evidence on 17th December, 2015. He agreed to cooperate with an anger management programme and a move to the medium secure unit for a short period of time. He believed that St. Andrew's is not the place for him as his mental health issues are under control. J.B. believed that the treatment should be made available to him in a community setting.

57. Ms. Louise Shannon, social worker in J.B.'s home area also gave evidence on 17th December, 2015. She identified that she had spoken with J.B.'s mother about the possible plans. The mother has been to the medium secure unit and thought it was a good idea as there were more facilities and it would be an improvement on where he was. Ms. Shannon noted that she was very conscious of the discharge plan and the fact that the family may need some support as they would be J.B.'s biggest asset in the community. The mother was open to educational sessions. She was happy to have repeat visits home although it was not an option for J.B. to stay in the family home as he has younger siblings. J.B. would need an independent living unit.

58. As the case progressed it became necessary to involve the local County Council in the onward planning for J.B. in order to find accommodation for him. The Director of Housing for that County Council gave evidence to this Court on 11th May, 2016. He stated that a housing application form had been submitted on behalf of J.B. but that they required further information. Counsel for the HSE emphasised that they would assist in this process as much as possible. The Director gave further evidence on 2nd June, 2016 after receiving the completed application form. He stated that there would be a decision in relation to the application within two to three weeks. If J.B. was eligible he would be put on the housing waiting list. Mr. Breen stated that there were, on 2nd June, 2016, 1,349 people seeking single occupancy accommodation on the list and that there were 289 people with a disability that would put them on the priority list for single occupancy accommodation. Mr. Breen stated that this meant that it may take a number of years before J.B. would be allocated accommodation. These procedures are regulated by the Housing (Miscellaneous Provisions) Act 2009. Mr. Breen committed to meeting with the HSE in relation to J.B.'s case in an effort to find a creative solution as he agreed that J.B. should certainly not end up homeless.

59. Nua Healthcare were also asked to assess J.B. to see if he was suitable for a placement in one of their facilities in Ireland. Dr. Séan Ó Domhnaill, Consultant Psychiatrist with a special interest in Neurodevelopmental Disorders who works for Nua Healthcare, gave

evidence on 13th July, 2016 after having travelled to St. Andrew's on 30th June, 2016. The doctor identified that J. has a mixed diagnosis of ASD, ADHD and his anxiety is developing into a paranoid personality disorder. He noted that J. has a low level of empathy and is at a high risk of committing violence. Dr. Ó Domhnaill stated that J. would need a stand alone unit if he was to go to Nua Healthcare and that they are not in a position to provide him with such a facility at that point in time.

60. Dr. Ó Domhnaill was of the view that J.'s risk level could be reduced through the effective treatment of his anxiety that is linked to the ADHD. It was Dr. Ó Domhnaill's view that the key to addressing J.'s difficulties is to treat his anxiety and the paranoia that has developed from it. Dr. Ó Domhnaill described J. as having alexithymia which means that he has no way to describe his emotions. Dr. Ó Domhnaill stated that J. was at a very high risk of slipping into a paranoid psychosis. He further noted that J. had failed to make meaningful progress in the secure setting of St. Andrew's and that his placement there was likely to no longer be therapeutic but one of mere containment. Dr. Ó Domhnaill was of the view that J. might actually be getting worse rather than better in St. Andrew's. Dr. Ó Domhnaill recommended that J. should be trialled on Atomoxetine to treat his ADHD. Dr. Ó Domhnaill accepted that an unsupported community setting would be ill advised for J. However, the doctor identified a level of urgency in changing J.'s situation in St. Andrew's as his risk of falling into a psychosis was described by Dr. Ó Domhnaill as imminent, ongoing and unpredictable. Dr. Ó Domhnaill went so far as to state that J.B.'s detention in St. Andrew's may be counter therapeutic.

61. Dr. Ó Domhnaill gave further evidence on 25th July, 2016 after having specifically interviewed J. on 22nd July, 2016. Dr. Ó Domhnaill identified that it would be extremely risky to place J. with his family. He noted that J.'s level of aggression was heightened by a lack of empathy. Dr. Ó Domhnaill reiterated his view that J. could significantly benefit from the use of Atomoxetine and that results could be seen within four to six weeks of commencing that medication. If J.'s high level of impulsivity was appropriately treated then the doctor believed that his prognosis would be significantly improved. Dr. Ó Domhnaill also pointed to the fact that J. had little to no experience of integration within the community because of his prolonged detention.

62. When asked about J.'s capacity to consent to treatment, Dr. Ó Domhnaill stated that he had capacity as he met the criteria in terms of understanding the questions put to him and the positive and negative consequences when explained to him. However, the doctor noted that J.'s intense desire to return to Ireland had limited his ability to see the risks involved. J. also had some difficulty with verbal comprehension. Dr. Ó Domhnaill reiterated that J. had capacity to make decisions about his treatment although he noted the proviso that J. did not seem to care or give weight to any potential negative outcomes of a return to Ireland. The doctor noted that a later assessment of an appropriately treated J. might show a more clear capacity. Dr. Ó Domhnaill clarified that J. had the ability to weigh up pros and cons but the quality of this weighing exercise was poor because J. was so set in his desire to return to Ireland.

63. As of Dr. Ó Domhnaill's assessment of J.B., on 22nd July, 2016, the doctor was of the view that J.B. could not live with others and that he would require a high level of staffing in any onward placement. According to Dr. Ó Domhnaill, J. appeared to be open to the idea of his proposal for treatment although J. currently lacks confidence in the psychiatric process.

64. Under cross examination, Dr. Ó Domhnaill stated that J. had been on medication for depression which he would not have recommended as he believed that J. should be treated for his anxiety and the hyperactivity linked to the ADHD. The doctor stated that there was no evidence that J.'s medication was making him any better and therefore it was difficult to see any therapeutic benefit. Dr. Ó Domhnaill noted that it would be best if J. was trialled on the Atomoxatine while residing in the secure setting of St. Andrew's. Dr. Ó Domhnaill accepted that St. Andrew's had provided containment for J. and very little in terms of therapy, especially in recent times since J. himself had disengaged. However, the doctor believed that the detention may have been justified because he was of the view that J. might not still be alive were it not for the detention in St. Andrew's. Dr. Ó Domhnaill stated that there were no guarantees that the medication would work but that it would be obvious whether or not the medication had worked within eight weeks of the commencement of the trial.

65. Dr. Ó Domhnaill emphasised that J. deserved to be appropriately treated and that the wider society also deserved for him to be appropriately treated. The doctor further stated that he believed it was within the power of the HSE to facilitate this.

66. Upon hearing the evidence of Dr. Ó Domhnaill, this Court was highly concerned about the long term impact on J.'s mental health of his continued detention without the treatment as recommended by the doctor. On 13th July, 2016, this Court requested that communication occur immediately between Dr. Ó Domhnaill and Dr. Attard, J.'s treating psychiatrist in St. Andrew's, and it was hoped that J. would commence treatment as recommended by Dr. Ó Domhnaill. The Court was notified by letter dated 9th August, 2016 that Dr. Attard agreed to commence J. on a trial of Atomoxetine and that the benefits may start to be seen within a matter of weeks.

67. Dr. Ó Domhnaill provided the Court with a further detailed report dated 24th July, 2016. He set out that J.B.'s diagnosis has posed a very real challenge to the professionals involved. He has been diagnosed with Bipolar Affective Disorder and Autism Spectrum Disorder. Dr. Ó Domhnaill noted that his history is suggestive of a Pervasive Developmental Disorder. Dr. Ó Domhnaill is of the view that he also has a Hyperkinetic Disorder which he says is closely associated genetically with Bipolar Affective Disorder. Dr. Ó Domhnaill noted that there may have been a misdiagnosis due to alexithymia as J. finds it difficult to experience, express or describe his emotional states. Dr. Ó Domhnaill identified that the ADHD is the only readily treatable element of J.'s diagnosis.

68. Dr. Ó Domhnaill expressed surprise that Atomoxetine which is the only licensed medication for the treatment of impulsivity in adults had not been trialled for J.B. especially considering that it had been prescribed for other patients in St. Andrew's. The advantage of Atomoxetine identified by Dr. Ó Domhnaill is that it prevents impulsive acts making the lack of empathy and remorse less dangerous. Dr. Ó Domhnaill warned that the use of this medication does not necessarily mean that J.'s use of violence will necessarily end but it makes the anxiety that feeds his frustration and paranoia more likely to remain at a low base line level. Dr. Ó Domhnaill stated in his report that there has been no discernable improvement in J.'s behavioural condition over the past five years in St. Andrew's. Dr. Ó Domhnaill further stated that there is a very high risk related to any potential return to living with his family. He further noted in his report that J. is unlikely to adhere to a medication and therapeutic plan in a community setting.

69. Dr. Ó Domhnaill stated that J. has the capacity to understand and retain the treatment information identified by his treating professionals. J. simply disagrees with what the professionals are telling him and he displays a reckless disregard for the risks. Dr. Ó Domhnaill identified that J. was able to discuss the pros and cons relating to staying in St. Andrew's although he is unwilling to seriously consider any option other than an immediate return to Ireland. Dr. Ó Domhnaill stated that it is unlikely that J. will be able to protect his interests without substantial support from social services as he has been in detention for so long. He emphasised that any inability to protect his interests is not a result of impaired faculties but rather the absence from community living over the past years.

70. Dr. Ó Domhnaill recommended that J. commence Atomoxetine while remaining in St. Andrew's for a short period of time and then that he be transferred to a facility provided by Nua Healthcare.

71. J.B. himself gave further evidence on 28th July, 2016. He indicated to the Court that things were not going well for him in St. Andrew's as he had recently been assaulted by another patient, his psychiatrist, Dr. Attard, was on annual leave and he disliked the uncertainty as he had expected to be home in Ireland before this date and this was a cause of frustration for him. J. stated that he was willing to take the medication recommended by Dr. Ó Domhnaill.

72. Dr. Stephen Attard supplied the Court with a report dated 30th August, 2016. This report set out the behavioural issues which have occurred over a period in St. Andrew's from May 2016 including various altercations with peers. Dr. Attard stated that anger management therapy had been discontinued. Dr. Attard stated that J.B. displayed limited insight into the nature of his mental disorder and the need for treatment. Dr. Attard outlined that J. had access to regular open psychotherapeutic groups and J. attended to a limited number of these and his engagement when he did attend was also limited.

73. Dr. Attard stated that he is of the opinion that J.B. meets the diagnostic criteria for an emerging personality disorder with prominent dissocial features. He identified the risks around this as being poor interpersonal relationships, anxiety, depression and progression into an adult antisocial personality disorder. Dr. Attard noted that the bipolar affective disorder is currently in remission. Dr. Attard disagrees with Dr. Ó Domhnaill's diagnosis of autistic spectrum disorder and ADHD although he accepts that there is an element of impulsivity and has agreed to commence a trial of Atomoxetine and a baseline assessment has been completed. Dr. Attard identified that there is a significant risk of violence if J.B. is released into the community and would not recommend his release.

74. At the request of the Court Professor Casey provided a further report dated 20th September, 2016. She set out her belief that J.B. has capacity. She stated that he has a very clear understanding of the treatment and he has a particular interest in attending anger management. He believes that he will be able to reintegrate into the community with the assistance of the social worker and his family. He wishes to enrol with Open University. JB understands that medication will be part of the plan. He believes the Atomoxetine is helping by reducing his tension and he will continue to take it. He will not continue to take Olanzapine as he does not believe he has Bipolar Disorder. JB indicated that if he does have Bipolar Disorder and it returns upon him ceasing Olanzapine his brother and mother will notice that he is unwell and he will act on their advice. He understands that he will be offered support in relation to budgeting. He also believes that he could be assisted with family therapy sessions. JB accepts that he should not take alcohol while on Atomoxetine. He hopes to live at home for a few weeks and then obtain an apartment in Tralee and live independently which he has been preparing for by taking cooking classes and he will be supported by his social worker and his family.

75. Professor Casey felt that it was very clear that JB was able to retain information about his treatment plan. She stated that, not only did he have the ability to retain information, he also suggested a new and potentially helpful measure in family therapy. She also indicated that he asked her what her decision in relation to his capacity was and what her reasons for that decision were.

76. Professor Casey indicated that JB does have the ability to use and weigh information. He understands that if he fails to adhere to his treatment plan he might become aggressive and that aggressive behaviour would bring him to the attention of the Gardaí. Professor Casey is of the view that JB should be more cautious in dismissing the diagnosis of Bipolar Disorder although she believes it is positive that he is willing to listen to his family members and be guided by them if they see Bipolar Disorder symptoms. JB was also able to evaluate the dangers of consuming alcohol. Professor Casey stated that JB is clearly able to communicate his decisions and does not require a third party.

77. Professor Casey stated that she is of the view that JB has capacity to make decisions for himself. However, she did note that he is impulsive and volatile which stems from his personality disorder which she believes is anti-social type. Professor Casey accepted that JB's engagement with therapeutic process has been limited to date. Professor Casey further accepted that JB poses a significant risk to himself and to other people because of his Personality Disorder Antisocial Type which is arguably untreatable. Professor Casey noted that JB has had extensive treatment in a specialised unit in Britain for more than five years with minimal impact on his behaviour. She stated that JB is not detainable in Ireland for his personality disorder and would only be detainable for the Bipolar Disorder if it destabilised. Professor Casey stated that it is unlikely that JB will benefit from any further intervention in St. Andrew's Hospital.

78. Professor Casey gave further evidence to the Court on 29th September, 2016 in which she adopted the above outlined report into her evidence. She stated in no uncertain terms that she believes that J.B. has capacity. Professor Casey stated that J.B. is very rational and engaged with her around the issue of capacity. She noted that J.B. is likely to make decisions that the professionals may consider to be wrong but that does not mean that he is incapable of making decisions.

79. She also stated that St. Andrew's has not provided him with any appreciable benefit in the five years that he has been detained there. She noted that when she visited him on 16th September, 2016 J.B. was in a much better environment than when she had last seen him. She described his accommodation as deeply regressive and that he was being kept in a "cage". Professor Casey stated that she believes there is no option but to release J.B. from detention in the UK. She confirmed that J.B. does not have a mental illness as defined within the Mental Health Act 2001 and is therefore not detainable in Ireland. Professor Casey stated that if J.B. had his current presentation in Ireland today they could not detain him and he never would have been detained.

80. She stated that the ideal transition would be to an institution type setting in Ireland with much less security such as a Nua Healthcare facility. Professor Casey stated that J.B. would have to go there voluntarily. She noted that J.B. has formed a therapeutic bond with Dr. Ó Domhnaill and he trusts him so it would be positive for him to continue to see him regularly although J.B. cannot be forced to do so. She noted that it is a disgrace that the State does not have the appropriate facilities and that J.B. was detained in the UK in the first place. Professor Casey stated that it is her view that the State has an obligation to facilitate a safe and orderly transition for J.B. to return to Ireland.

81. Professor Casey accepted that J.B. remains extremely impulsive and there is a very high risk that he will injure himself and others. Professor Casey was adamant that psychiatry should not be used in order to detain dangerous individuals.

82. Professor Casey was asked about the risk if J.B. stops taking the Olanzapine as he has said he will and she responded that this was the treatment for Bipolar Disorder and she was not convinced that he has Bipolar Disorder. She stated that if he does have it and comes off his medication he is likely to have a manic episode which would somewhat simplify the situation as it would make him detainable in Ireland and he would be brought to the Central Mental Hospital. However, she also stated that stopping Olanzapine may have no effect.

83. Professor Casey stated that any further delay in returning J.B. to Ireland could make him much worse as he already has significant trust issues. She stated that the best solution would be with Nua Healthcare although J.B. must be returned to Ireland and the only option may be to go to his family although the State must provide a high level of support in such a situation.

84. Dr. Ó Domhnaill also gave further evidence on 29th September, 2016. He stated that he agrees with Professor Casey that J.B. has capacity. Dr. Ó Domhnaill is of the view that the Atomoxetine which he recommended will have a positive effect on J.B. and his impulsivity and therefore his risk levels will reduce. He stated that Nua Healthcare are currently unable to offer J.B. a place as they are of the view that he requires a single occupancy facility and such a facility would not be available for 6 to 9 months. Dr. Ó Domhnaill is of the view that J.B. could live in a mixed unit. Dr. Ó Domhnaill volunteered to have regular contact with J.B. upon his return to Ireland and stated that this would ameliorate some of the risks associated with his return.

85. Dr. Ó Domhnaill stated that the prudent professional opinion may be to keep him in St. Andrew's. He was asked what the therapeutic rationale was for continuing to detain J.B. in St. Andrew's and he stated that change is stressful for J.B. and that there is the "therapeutic use of security". Dr. Ó Domhnaill accepted that J.B. could deteriorate significantly and swiftly if he remains in St. Andrew's.

Applicable Law and Legal Submissions
86. The High Court has an inherent jurisdiction which allows it to make orders depriving a person of their liberty when it is necessary in order to vindicate the conflicting constitutional rights of that individual. This inherent jurisdiction stems from Article 40 of the Constitution:-

> "40.3.1 The State guarantees to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen."

87. In the case of *D.G. v. Eastern Health Board* [1997] 3 I.R. 511 the Supreme Court recognised that it may be lawful in certain circumstances for a court to order the detention of a child with a view to protecting his or her constitutional rights. This inherent jurisdiction has been analysed by the High Court on several subsequent occasions, in particular in the case of *S.S. (A Minor) v. HSE* [2008] 1 I.R. 594.

88. By analogy, Birmingham J. extended this jurisdiction to vulnerable adults in the case of *HSE v. J.O'B.* [2011] IEHC 73. Consideration was given by Birmingham J. to Article 5 of the European Convention of Human Rights which provides:-

> "1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure described by law;
>
> (e) The lawful detention of persons for the prevention of the spreading of infectious diseases of person of unsound mind, alcoholics or drug addicts or vagrants."

Birmingham J. further analysed the case law of the European Court of Human Rights in relation to the detention of individuals of "unsound mind" and found that certain minimum requirements must be met:

> - the individual must reliably be shown to be of unsound mind
>
> - the mental disorder must be of a kind or degree warranting compulsory confinement
>
> - the validity of continued confinement depends upon the persistence of such a disorder.

After further discussion of the cases in the English jurisdiction, in particular *Re S.A. (Vulnerable Adult with Capacity Marriage)* [2006] F.L.R. 867, Birmingham J. held:-

> "where an adult lacks capacity and where there is a legislative lacuna so that the adult's best interests cannot be served without intervention by the Court, I am satisfied that the Court has jurisdiction, by analogy with cases like D.G. and the several High Court decisions from different judges of the High Court there referred to, to intervene."

Therefore, Birmingham J. ordered the detention of Mr. O'B. in the Central Mental Hospital subject to the regular review of the Court.

89. It is within the inherent jurisdiction of this Court to detain an individual who is a minor or who is an adult who lacks capacity in order to vindicate their constitutional rights. In order to decide whether it is within the inherent jurisdiction to detain J.B. this Court must decide whether J.B. has capacity. Although the law on capacity has been set out elsewhere and in previous judgments of this Court it may still be of assistance to reiterate same at this point.

90. In *Fitzpatrick v. F.K.* [2009] 2 I.R. 7, Laffoy J. set out the principles which this Court must consider in determining whether an individual has capacity (para.84):-

> "(1) There is a presumption that an adult patient has the capacity, that is to say, the cognitive ability, to make a decision to refuse medical treatment, but that presumption can be rebutted.
>
> (2) In determining whether a patient is deprived of capacity to make a decision to refuse medical treatment whether-
>
> (a) by reason of permanent cognitive impairment, or
>
> (b) temporary factors, for example, factors of the type referred to by Lord Donaldson in *In re R (Adult: refusal of medical treatment)* [1993] Fam. 95
>
> the test is whether the patient's cognitive ability has been impaired to the extent that he or she does not sufficiently understand the nature, purpose and effect of the proffered treatment and the consequences of accepting or rejecting it in the context of the choices available (including any alternative treatment) at the time the decision is made.
>
> (3) The three stage approach to the patient's decision making process adopted in *In re C (Adult: refusal of medical treatment)* [1994] 1 WLR 290 is a helpful tool in applying that test. The patient's cognitive ability will have been impaired to the extent that he or she is incapable of making the decision to refuse the proffered treatment if the patient-

(a) has not comprehended and retained the treatment information and, in particular, has not assimilated the information as to the consequences likely to ensue from not accepting the treatment,

(b) has not believed the treatment information and, in particular, if it is the case that not accepting the treatment is likely to result in the patient's death, has not believed that outcome is likely, and

(c) has not weighed the treatment information, in particular, the alternative choices and the likely outcomes, in the balance in arriving at the decision.

(4) The treatment information by reference to which the patient's capacity is to be assessed is the information which the clinician is under a duty to impart information as to what is the appropriate treatment, that is to say, what treatment is medically indicated, at the time of the decision and the risk and consequences likely to flow from the choices available to the patient in making the decision.

(5) In assessing capacity it is necessary to distinguish between misunderstanding or misperception of the treatment information in the decision making process (which may sometimes be referred to colloquially as irrationality), on the one hand, and an irrational decision or a decision made for irrational reasons, on the other. The former may be evidence of a lack of capacity. the later is irrelevant to the assessment.

(6) In assessing capacity, whether at the bedside in a high dependency unit or in court, the assessment must have regard to the gravity of the decision, in terms of the consequences which are likely to ensue from the acceptance or rejection of proffered treatment. In the private law context this means that, in applying the civil law standard of proof, the weight to be attached to the evidence should have regard to the gravity of the decision, whether that is characterised as the necessity for "clear and convincing proof" or an enjoinder that the court "should not draw its conclusions lightly."

91. It is the view of this Court that the presumption of capacity can only be rebutted if the person is unable to:

1) understand the treatment information

2) retain said information long enough to make a decision as to their treatment

3) weigh alternative treatment options

4) communicate their decision.

This Court wishes to emphasise that capacity does not require that the individual makes the decision that the professionals deem to be the correct decision but that they come to a reasoned conclusion.

92. The inherent jurisdiction only applies where there is an absence of a statutory scheme for the detention of the individual involved. The Mental Health Act 2001 regulates the circumstances and manner of detention, psychiatric assessment and medical treatment of persons with a mental disorder. However, in circumstances where a person suffers from a mental impairment which does not come within the scope of the Mental Health Act 2001 for the purposes of involuntary admission, there is, at present, no statutory scheme in force that regulates the circumstances and manner in which therapeutic intervention can be imposed. Section 8 of the Mental Health Act 2001 deals with the involuntary admission of persons to approved mental health centres and provides as follows:-

"(1) A person may be involuntarily admitted to an approved centre pursuant to an application under section 9 or 12 and detained there on the grounds that he or she is suffering from a mental disorder.

(2) Nothing in subsection (1) shall be construed as authorising the involuntary admission of a person to an approved centre by reason of the fact that the person –

(a) is suffering from a personality disorder,

(b) is socially deviant, or

(c) is addicted to drugs or intoxicants."

93. J.B. has been diagnosed with a personality disorder and his bi-polar disorder is currently in remission and he is, therefore, not detainable under the 2001 Act. The Court cannot use the inherent jurisdiction of the High Court to circumvent the express provisions of the Oireachtas that a person cannot be detained for a personality disorder. To do so would constitute a violation of the doctrine of the separation of powers.

94. Counsel for J.B. made oral legal submissions to the Court without prejudice to his position on capacity. He noted the practical reality that J.B. has been in St. Andrew's for more than four years and that even if it had done him some good there was a limit to what else can be achieved. Counsel further submitted that the chances of cooperation were much less if there was no set period of time for his return to Ireland. Counsel submitted that both on the legalities and the practicalities there was much to be said for saying that there would be a set period of time. Counsel noted that the English doctors see it in terms of their legislation, however, they need to accept that J.B. has been there for four years and that we are now in the end faze. Counsel submitted that there needed to be some element of freedom now. It was further submitted that a plan needed to be put in place in the community in Ireland to give J.B. the best chance possible.

95. Counsel for the HSE indicated in December, 2015 that parallel planning had begun in order to sustain J. financially and organise housing for him in Ireland. He agreed that a time line was a good idea. Counsel also accepted that this situation could not go into a sixth year in St. Andrew's in fairness to the man's fundamental rights. Counsel requested that the orders be put in place for the transfer to the Robinson Ward so that it could happen as quickly as possible.

96. However, counsel for J.B. identified the need for a report from Dr. Attard saying that the Robinson Ward would be appropriate for

J.B. as of December, 2015. It would not be appropriate for the Court to make any order without such a report. He further noted that, logically, the Court should hear from Dr. Attard in January, 2016 and the Court should set the time period then. Counsel for J.B. urged the Court to set a date for the return of J.B. Dr. Attard would then know that he had that period to get J.B. as well as possible before his discharge. Counsel further noted that if J.B. is going to have a chance when he gets out he needs to have some gradual freedom in order to learn to cope.

97. On 17th December, 2015, this Court requested that a plan for J.B.'s step down arrangement be put in place.

98. As time went by and progress towards a transition was very slow, counsel for J.B. continued to submit that he should be returned to Ireland. On 5th July, 2016, it was submitted that J. wanted to return to Ireland immediately and that he was prepared to engage with Nua Healthcare so long as that involved a speedy return to Ireland. It was further set out by counsel for J.B. that, in the long term, he wanted his own accommodation but he was willing to continue to engage with services while living in the community. On 25th July, 2016, counsel outlined that J.B. had been detained in St. Andrew's with little to no therapeutic benefit. By 28th July, 2016, counsel for J.B. was firmly questioning the lawfulness of J.'s continued detention as the evidence before the Court was that there was no therapeutic benefit without the trial of Atomoxetine which it was proving difficult to commence in St. Andrew's due to an apparent lack of communication. Counsel for J.B. emphasised that it had become a question of legality and he submitted that J.'s detention would be illegal if he was not given the appropriate treatment. On 29th July, 2016, counsel for J.B. indicated that they had been patient up until that point but that it may be necessary to make an application to have the orders detaining J.B. in St. Andrew's quashed.

99. Counsel for J.B. stated on 29th September, 2016 that the law is clear that a person with capacity cannot be detained under the inherent jurisdiction. He stated that there is no legal basis to detain J.B. as both Professor Casey and Dr. Ó Domhnaill were clear that he has capacity. Further to this, the detention is providing no therapeutic benefit and is potentially making J.B. worse rather than better. Counsel for J.B. further stated that the State has an obligation to J.B. to put the appropriate supports in place and facilitate his return to Ireland.

100. Counsel for the HSE stated on 29th September, 2016 that money was not the issue in this case and that the problem was in finding suitable accommodation in which J.B. could reside in Ireland.

Conclusions

101. This Court gave judgment in March 2015 that J.B. should commence a transition period from St. Andrew's to an appropriate placement in Ireland. Extensive evidence was heard in December 2015 when it became clear to the Court that it was imperative for J.B. to be transferred to Ireland.

102. This Court noted on 28th July, 2016 that J.B. cannot continue to be detained in St. Andrew's indefinitely simply because there is no place for him to live being made available to him in Ireland. A solution is required considering the fact that his family cannot safely take him to live with them, the County Council also appear unable to provide housing for J.B. within a short time frame and Nua Healthcare are of the opinion that they do not have a suitable facility for him immediately, but hope to have same in some months' time.

103. This Court has to make a decision as to which clinical view is more persuasive with regard to capacity and whether J.B. could legally continue to be detained in St. Andrew's in England.

104. In summary, both Dr. Lawlor and Dr. Kelleher are of the view that J. lacks capacity and that he is treatable and can gain a therapeutic benefit from his detention in St. Andrew's. They accepted that J.B. is not detainable under the Irish Mental Health Act 2001. They both emphasised that there was no suitable placement for J. in Ireland and that there is a high level of risk if he returns to live in the community. It is of particular note that Dr. Kelleher stated that J.B. was in an anti-therapeutic setting in December, 2015. They both recommended, as of December 2015 that J.B. should remain in St. Andrew's for a further period of 12 to 18 months. Much of this time period has now passed.

105. Professor Casey disagreed with Dr. Kelleher and Dr. Lawlor, she believed that J. may have capacity but, more importantly, that J. is not treatable and therefore could not be detained as there is no therapeutic benefit. She warned the Court in December, 2015 that these proceedings may return in several months and the situation would be the same. This has turned out to be the case. Professor Casey reiterated in September 2016 that J.B. has capacity and cannot be detained. This Court accepts the evidence of Professor Casey in her reports and in her oral evidence and the evidence adduced under cross examination.

106. Dr. Roychowdhury and Dr. Attard set out their view that J.B. lacks capacity and that he is treatable such that there is a therapeutic benefit to his detention in St. Andrew's. However, Dr. Roychowdhury noted that capacity is not clear cut.

107. Dr. Ó Domhnaill identified that J. has limited capacity although he could gain full capacity with the correct treatment. He later clarified that J.B. does have the capacity to understand and retain treatment information and that he simply disagrees with the assessment of his treating professionals. He also noted that St. Andrew's could have been seen as a counter therapeutic environment for J.B. and that there was a risk that J.B. could fall into a psychosis if not appropriately treated. This Court considers that this is a grave risk to the wellbeing of J.B.

108. It has been continuously stated by various professionals that J.B. requires what is referred to as a singleton unit as a step down until he can, in the long term, live on his own in the community after being provided housing by the local county council. It is the view of this Court that it is not feasible for J. to live with his family at this time.

109. It is accepted by all of the Irish medical professionals that J.B. is not detainable under the Mental Health Act 2001. However, upon his return to Ireland, if he develops a mental disorder within the definition of the 2001 Act, this Court is certain that the relevant authorities will take the appropriate steps to ensure treatment for him.

110. In the context of a careful step-down of J.B. mental health providers like all other medical professionals have a duty of care to their patients. There is a difficult balancing act between the patient's right to freedom and right to be treated. It is clear from the Supreme Court decision of *DPP v. McMahon* [2011] IECCA 94 where O'Donnell J. found that there was no jurisdiction to impose an open-ended preventative detention on the grounds of anticipated future risk of harm. It was held that the Mental Health Act 2001 provides the only mechanism for the detention of someone considered a danger to the public or themselves.

111. J. has constitutional rights, in particular pursuant to Article 40.4.1 of the Constitution which provides that "no citizen shall be deprived of his personal liberty save in accordance with law". It has been accepted within the inherent jurisdiction case law that a

person who is either a child or a person lacking capacity can be detained in order to protect their right to life and their welfare. The inherent jurisdiction exists in this context to enable the Court to vindicate the rights of vulnerable persons.

112. With respect of the obligations of the Child and Family Agency pursuant to s. 45 of the Childcare Act, 1991, as amended:

> "45.—(1) (a) Where a child leaves the care of the Child and Family Agency, the Agency may, in accordance with subsection (2), assist him for so long as the Agency is satisfied as to his need for assistance and, subject to paragraph (b), he has not attained the age of 21 years.
>
> (b) Where the Child and Family Agency is assisting a person in accordance with subsection (2) (b), and that person attains the age of 21 years, the Agency may continue to provide such assistance until the completion of the course of education in which he is engaged.
>
> (2) The Child and Family Agency may assist a person under this section in one or more of the following ways—
>
> (a) by causing him to be visited or assisted;
>
> (b) by arranging for the completion of his education and by contributing towards his maintenance while he is completing his education;
>
> (c) by placing him in a suitable trade, calling or business and paying such fee or sum as may be requisite for that purpose;
>
> (d) by arranging hostel or other forms of accommodation for him;
>
> (e) by co-operating with housing authorities in planning accommodation for children leaving care on reaching the age of 18 years."

Although the language of this section is discretionary, it should also be noted that, and this Court takes judicial notice, that the vast majority of care leavers are supported in some way by the Child and Family Agency and their own figures suggested that in March, 2015 they were providing aftercare services to 1,720 young people between the ages of 18 and 22 years. The Child and Family Agency have provided a document in this case dated 29th June, 2016 which addresses aftercare but does not clearly set out what supports, in particular in accessing further education, will be put in place for J.B. upon his return.

113. A person with a mental illness or mental health issues, while not detainable under the Mental Health Act, 2001, may still have significant needs and may be considered to have a disability within the meaning of the Disability Act, 2005. "Disability" is defined in s. 2 of the 2005 Act in relation to a person as meaning "a substantial restriction in the capacity of the person to carry on a profession, business or occupation in the State or to participate in social or cultural life in the State by reason of an enduring physical, sensory, mental health or intellectual impairment". Such a person can apply for an assessment which shall be carried out under s. 8 of the Disability Act, 2005 to determine what disability the person has and what health and educational services are required to meet the needs of the person with the disability. A "service statement" shall then be prepared setting out the health and educational services which shall be provided to the individual by the HSE and/or other bodies consistent with the resources available.

114. It is the strong view of this Court that it is not appropriate given that J. has been in a psychiatric institution for a long number of years and has been in secure care before that, to suddenly expect him to transition immediately back into the community without a suite of supports. Given the difficulties he does have which are described by Professor Casey as untreatable, even though in her view, he has capacity and is therefore not detainable under the mental health legislation in Ireland, it is nonetheless apparent that he has a reasonable legitimate expectation to have his rights vindicated in the provision of a safe place of abode for him given his difficulties. The evidence this Court has heard is that the local county council will not be able to provide accommodation for him for a number of years and in the meantime it seems to this Court to be appropriate that the HSE provide secure and settled accommodation for him in the interim period. This Court sees this as the responsibility of the HSE to seek to provide immediate accommodation for him pending his being given long-term accommodation by the local county council. It seems to this Court that the duty of care owed by the HSE to J. is much higher than the normal duty of care they owe to a person leaving secure care given the severity of his enduring difficulties over many years and given that he has been in a psychiatric facility abroad for a very lengthy period of time.

115. The State has a Constitutional obligation to vindicate the rights of J.B. The HSE is under a statutory obligation to provide services to a person with a disability such as J.B. under the Disability Act 2005, should he be formally assessed as a disabled person. The Child and Family Agency may also assist in the provision of services to J. under the aftercare provisions of the Child Care Act 1991, as amended. The HSE have detained J.B. in the UK for many years at a high cost to the Irish tax payer and they have a continuing duty to him.

116. As already is set out in this judgment this Court deems that the idea of J. being released into the care of his family would not be a suitable interim solution. This is because he has expressed himself as having issues which he would like to explore with his family in therapy and it does not seem appropriate to this Court that at this point that would work. In fact this Court takes the view that that would be a recipe for disaster.

117. A temporary arrangement is now available with a bed in C.M. Hospital where J.B. may choose to go as a voluntary patient pending provision of the promised place with Nua Healthcare. Professor Casey has agreed to remain involved and provide joint clinical care for J.B. with Dr. Ó Domhnaill and the committee already appointed. It is in his best interests that he would be monitored weekly in that area to ensure that he is compliant with his medication. Dr. Lawlor is clinical director of the C.M. unit and naturally would remain on the committee of doctors set up to advise the Court in this case.

118. J. has given evidence that he will look after his own living arrangements but in the view of this Court that would not be an acceptable step down situation. The HSE has set out as an ongoing obligation to him as have the Child and Family Agency.

119. J. has an ongoing desire for education. While in isolation his education was not provided for. He has a desire to gain a qualification and it is the view of the Court, given the particular circumstances of the case, that the HSE and the Child and Family Agency should support J.B. in his application for and participation in onward training and education, as soon as this is practicable in accordance with his wish.

120. This Court holds, on the basis of the clear and current evidence of Professor Casey and Dr. Ó Domhnaill that J.B. has capacity. The fact that J.B. is an adult with capacity and is not presently detainable under the Irish Mental Health Act 2001 renders any further

detention illegal.