House of Lords
House of Commons

Joint Committee on Human Rights

Legislative Scrutiny: Seventh Progress Report

Fifteenth Report of Session 2006-07

Drawing special attention to:

Mental Health Bill

HL Paper 112
HC 555

House of Lords
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Report, together with formal minutes and appendices

Ordered by The House of Lords to be printed 21 May 2007
Ordered by The House of Commons to be printed 21 May 2007

HL Paper 112
HC 555
Published on 30 May 2007
by authority of the House of Lords and
the House of Commons London:
The Stationery Office Limited
£0.00

Joint Committee on Human Rights

The Joint Committee on Human Rights is appointed by the House of Lords and the House of Commons to consider matters relating to human rights in the United Kingdom (but excluding consideration of individual cases); proposals for remedial orders, draft remedial orders and remedial orders.

The Joint Committee has a maximum of six Members appointed by each House, of whom the quorum for any formal proceedings is two from each House.

Current Membership

HOUSE OF LORDS	HOUSE OF COMMONS
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Lord Judd	Mr Andrew Dismore MP (Labour, *Hendon*) (Chairman)
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Powers

The Committee has the power to require the submission of written evidence and documents, to examine witnesses, to meet at any time (except when Parliament is prorogued or dissolved), to adjourn from place to place, to appoint specialist advisers, and to make Reports to both Houses. The Lords Committee has power to agree with the Commons in the appointment of a Chairman.

Publications

The Reports and evidence of the Joint Committee are published by The Stationery Office by Order of the two Houses. All publications of the Committee (including press notices) are on the internet at www.parliament.uk/commons/selcom/hrhome.htm.

Current Staff

The current staff of the Committee are: Mark Egan (Commons Clerk), Bill Sinton (Lords Clerk), Murray Hunt (Legal Adviser), Angela Patrick and Joanne Sawyer (Committee Specialists), Jackie Recardo (Committee Assistant), Suzanne Moezzi (Committee Secretary) and Robert Long (Senior Office Clerk).

Contacts

All correspondence should be addressed to The Clerk of the Joint Committee on Human Rights, Committee Office, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general inquiries is: 020 7219 2467; the Committee's e-mail address is jchr@parliament.uk.

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Summary

The Joint Committee on Human Rights examines the human rights implications of all government and private bills, and selected pre- and post-legislative documents, in accordance with the new legislative scrutiny sifting system which it adopted from the start of Session 2006- 07. A full explanation of the Committee's scrutiny procedures is given in the Committee's Twenty-Third Report of Session 2005-06, The Committee's Future Working Practices, HL Paper 239, HC1575.

This is the Committee's Seventh Legislative Scrutiny Progress Report of this Session. It recommends changes in the Mental Health Bill. It also records the Committee's view that the Rating (Empty Properties) Bill does not raise human rights issues of sufficient significance to warrant further scrutiny.

Mental Health Bill

The Committee reported on this Bill at an earlier stage (4th Report of 2006-07). It now reports again in response to the Government reply to the Committee's report and points arising in debate in the Commons. This report should therefore be read alongside the earlier report (paragraphs 1-3).

The Committee remains of the view that the exclusions from the definition of mental disorder should be explicitly stated on the face of the Bill and that Clause 3 should be amended to restore the wording deleted in Committee in the Commons (paragraphs 4-6).

In its original report, the Committee took the view that the opinion justifying detention should come from a medically qualified expert with psychiatric skills. The Committee considers that the Bill should require a report from a doctor justifying renewal of detention where the responsible clinician is not a doctor and that tribunals be required to hear evidence from a doctor or a clinical psychologist in cases where detention is being renewed (paragraphs 7-14).

The Committee recommends that the waiting period before a patient becomes entitled to an independent second opinion in cases of treatment without consent should be reduced to one month (paragraph 15).

The Committee recommends the adoption of an amendment to ensure that young people receive age-appropriate assessment and placement, but which avoids rendering illegal the placement of a child on an adult ward when this is the only way that their needs can be met. It also recommends parental involvement in decisions about community treatment of child patients who lack competence. The Committee shares concerns about the power forcibly to treat children in the community (paragraphs 16-25).

With regard to safeguards in relation to mentally incapacitated patients who are deprived of their liberty, the Committee remains of the view that in order for the Bill to be compatible with the right to liberty in Article 5 ECHR it is necessary to provide a procedure which precedes detention in all cases. It also considers that the position on guardianship is anomalous in terms of the protection of rights under Article 5. The Committee further

recommends the inclusion in the Bill of a provision against charging anyone for accommodation when deprived of liberty (paragraphs 26-33).

Bill drawn to the special attention of both Houses

Government Bill

1 Mental Health Bill

Date introduced to first House	16 November 2006
Date introduced to second House	7 March 2007
Current Bill Number	HC Bill 107
Previous reports	4th of 2006-07

Background

1.1 This is a Government Bill introduced in the House of Lords on 16 November 2006 and brought to the House of Commons on 7 March 2007. The Bill completed its Committee stage in the Commons on 15 May 2007. No date has yet been set for its Report stage.

1.2 We reported on the Bill before its Report Stage in the House of Lords, raising a number of human rights compatibility concerns about certain provisions in the Bill and also regretting that the Bill did not take the opportunity to enhance human rights in certain respects.[1] The Bill was heavily amended during its passage in the House of Lords, although many of those amendments were reversed by the Government in the Commons. We have also received the Government's response to our Report[2] and a letter from the Children's Commissioner for England and the Royal College of Psychiatrists.[3]

1.3 We now report again on certain aspects of the Bill in light of the Government's response to our earlier report and the parliamentary debates to date. We confine our comments to new or additional points arising from that material and do not merely repeat points already made in our earlier report. This report should therefore be read alongside our earlier report. In order to ensure that our views are available before the Bill completes its passage through Parliament, we have not engaged in correspondence with the Government about the further points raised in this report.

(1) The Definition of Mental Disorder and the Exclusions

1.4 In our first Report on the Bill we expressed the view that principles of non-discrimination on grounds of, amongst other things, sexual orientation or sexual identity should be included on the face of the Bill in light of the breadth of the new definition of mental disorder.[4]

[1] Fourth Report of Session 2006-07, *Legislative Scrutiny: Mental Health Bill* Fourth Report of Session 2006-07 HL Paper 40/HC 288, paras 14 and 15.

[2] Appendix 1a.

[3] Appendix 1b.

[4] *Op. cit.* at para. 15.

1.5 Clause 3 of the Bill introduces changes to the statutory exclusions from the definition of mental disorder. The House of Lords amended the Bill to provide that a person should not be considered to have a mental disorder solely on the grounds of, (a) his substance misuse (including dependence on alcohol or drugs); (b) his sexual identity or orientation; (c) his commission or likely commission of illegal or disorderly acts; or (d) his cultural, religious or political beliefs. This amendment was overturned in the Commons Public Bill Committee in favour of a single clause stating that dependence on alcohol or drugs is not considered to be a mental disorder or disability of the mind.

1.6 Obligations under EU law have made it necessary to provide express legal protection against employment discrimination on grounds of sexual orientation or gender reassignment.[5] The European Court of Human Rights has held that sexual identity is protected by virtue of the right to respect for private life under Article 8. Freedom of religion (Article 9), freedom of association and freedom of expression of religious, cultural or political beliefs are protected by Articles 10 and 11 of the Convention. Discrimination in the way rights (including the right to protection against arbitrary detention under Article 5) are protected on grounds of ethnicity, religious, cultural or political beliefs, age or any other status is also proscribed by Article 14 of the Convention. It is hard, therefore, to see the rationale for failing to provide explicit protection against detention or compulsory treatment on those grounds.[6] **We remain of the view that the exclusions from the definition of mental disorder should be explicitly stated on the face of the Bill and that Clause 3 should be amended to restore the wording deleted in Committee in the Commons.**

(2) The Need for Objective Medical Evidence of a True Mental Disorder

1.7 In our original Report[7] we took the view that the requirement in *Winterwerp* v *Netherlands*[8] that there be objective medical evidence of a true mental disorder, coupled with the ruling in *Varbanov* v *Bulgaria*,[9] indicated that the opinion justifying detention should come from a medically qualified expert who has recognised skills in psychiatric diagnosis and treatment. In the Government's view the term 'medical expertise' in *Winterwerp* was 'used in the wider sense and the court was not seeking to lay down which sort of qualifications available in a national system would be acceptable and which would not.'[10] **We hold to the view that the term medical expertise has a minimum content, and that the current case law suggests that this requires that the person be medically qualified.**

1.8 European Union Law recognises certain minimum standards of medical training. For a medical qualification to entitle a person to practise as a doctor in the European Economic Area, Council Directive 93/16/EC expresses the basic requirement in qualitative terms such

[5] Employment Equality (Sexual Orientation) Regulations 2003 (S.I. 2003/1661), Employment Equality (Sexual Orientation) (Amendment) Regulations 2003 (S.I. 2003/2827) and the Sex Discrimination (Gender Reassignment) Regulations 1999 (S.I. 1999/1102).

[6] The Government's view, particularly in regard to sexual identity, is given in Appendix 1a, paras 17 and 18.

[7] *Op. cit.*, para. 26.

[8] (1979) 2 EHRR 387.

[9] Judgment of 5 October 2000.

[10] Appendix 1a, para. 32 and also Fourth Report of Session 2006-07, Appendix 3, para. 32.

as 'suitable clinical experience in hospitals under appropriate supervision', and also in quantitative terms of a minimum course duration.[11] Despite the Government's belief that the precise qualifications for providing medical expertise are a matter for the Member States, there are equally grounds for considering that the requirement of medical expertise has a minimum content in European law and that minimum content is a medical qualification. In relation to the provision of evidence of mental disorder, this suggests that the report should come from a clinical psychologist if the mental disorder is a learning disability, a personality disorder or an illness which calls primarily for psychological intervention.

1.9 The Minister of State for Health Services, Rosie Winterton MP, has made clear that the Government's interpretation of the European case law offers much wider scope for different professions to provide medical expertise. The Minister has asserted that 'there is no requirement in relation to the European Court of Human Rights for doctors to decide about initial detention'. The minister went on to give reasons why, as a matter of policy '[W]e decided to keep doctors as making the decision because at initial detention, some patients are not known to services or have disengaged from services, so a patient's clinical needs may not be known at that point. We felt that it was practical that doctors, with their broad diagnostic skills should decide whether people should be detained. '[12] The Minister recorded the Government's acceptance of 'the case for a medical expert's opinion where someone of unsound mind is to be detained, but we do not agree that it gives authority for the proposition that a psychiatrist must provide the necessary medical expertise in each case.'[13]

1.10 Amendments were carried in the House of Lords imposing the requirement that where the renewal of detention was made by a responsible clinician who is not a doctor there should be a medical report supporting renewal. Government amendments carried in the Commons Public Bill Committee, however, have removed the requirement for medical evidence from a psychiatrist for renewal. The Government considered this to be patronising to non-medical professionals and that the responsible clinician competencies would insist on a high level of skill including the ability to recognise the existence and severity of a mental disorder. The Government is supported by UNISON, the British Psychological Society, the Royal College of Nursing, Amicus, and the British Association and College of Occupational Therapists. These organisations have obtained Counsel's opinion to the effect that there is no necessary incompatibility with the Convention if the objective medical expertise is provided by people who do not necessarily possess a medical qualification but who have another prescribed qualification and who demonstrate the relevant competencies laid down in the Mental Health Act Approved Clinician Directions.

1.11 The professional groups eligible to provide objective medical expertise are set out in Schedule 1 to the draft indicative regulations. The person must be:

a) a registered medical practitioner;

[11] This directive will be replaced by Directive 2005/36/EC on the Recognition of Professional Qualifications which must be implemented by 7 September 2007.

[12] *Public Bill Committee,* Tuesday 1 May (Afternoon), col. 187 Rt Hon Rosie Winterton MP.

[13] *ibid.*, col. 188.

b) a chartered psychologist listed in the British Psychological Society's Register of Chartered Psychologists;

c) a first level nurse, registered in Sub-Part 1 of the Nurses' Part of the Register established and kept by the Nursing and Midwifery Council, with a recordable qualification in mental health or learning disabilities nursing. This means that the nurse must be a specialist practitioner or a nurse prescriber;

d) an occupational therapist, registered with the Health Professions Council; or

e) a social worker, registered with the General Social Care Council.

1.12 The list of competencies is quite extensive and is set out in Schedule 2 to the to the draft indicative competencies for responsible clinicians. There are two principal unanswered questions with regard to these competencies.

1.13 First, it is not specified how people will demonstrate them. The regulations say that the relevant authorities must have regard to references, but there seems to be no requirement for an examination. It would be a concern if the training process was similar to that for approving section 12 doctors under the Act, where attendance at a course is the principal requirement. Section 12 approval is for people who are already qualified doctors, but the competencies under these regulations are competencies to demonstrate skills, many of which are medical skills and where occupational therapists and social workers do not already have baseline qualifications. The evidence submitted to the Commons Public Bill Committee by the groups in favour of broadening the eligibility base for responsible clinician status provides examples of situations where a non-medical responsible clinician may be an appropriate leader of the care team. The examples are provided for psychologists and nurse consultants, but less specific information is provided in support of occupational therapists or social workers.

1.14 Second, the competencies relating to assessment require first an ability to identify the presence or absence of mental disorder and its severity. This may be done by people with little or no professional expertise in providing a more precise diagnosis and therefore a more specifically targeted treatment plan. One competency refers to the ability to undertake a 'broad mental health assessment and formulations (sic) incorporating biological, psychological, cultural and social perspectives.' Frequent use is made of the term 'broad'. The competencies require a 'broad understanding' of different mental health treatment approaches. It is questionable whether 'broad competencies' which may not be subject to a rigorous assessment process meet the intention behind the Convention safeguard of objective medical expertise. The European Court of Human Rights might well uphold a challenge based on *Winterwerp* and *Varbanov* in a specific case where, for example, detention was renewed on the basis of a report from an occupational therapist without evidence from a doctor that the patient continued to suffer from mental disorder of a nature or degree warranting confinement. Similarly advocates in Mental Health Review Tribunals would be likely to ask for medical evidence from a doctor of the continued existence of mental disorder of a nature or degree warranting detention. **We consider that the amendment requiring a report from a doctor justifying renewal where the responsible clinician is not a doctor should be restored to the Bill, and that**

tribunals be required to hear evidence from a doctor or a clinical psychologist in cases where detention is being renewed.

(3) Consent to Treatment

1.15 In our earlier Report we questioned whether the Government's obligation to provide effective supervision and review of treatment without consent would be discharged by the current provisions of section 58 of the Mental Health Act 1983 which impose a delay of three months before a patient becomes entitled to an independent second opinion.[14] The Government has rejected amendments seeking to reduce that waiting period on the grounds that the current three month period provides an opportunity for the treating psychiatrist to reflect on the medications which are to be used on the patient.[15] The Government remains of the view that the 1983 Act has struck the right balance between clinical freedom and safeguards for patients, and that there is no empirical evidence that the 3 month period is too long. In addition, the Government response to the Committee's initial Report states the view that there is no obligation under the Convention to provide a second opinion where treatment is given without consent.[16] **It seems to us that the issue is not how long it takes the medication to take effect or the psychiatrist to arrive at an effective treatment plan, but how long it is reasonable to expect a patient to endure treatment which he or she is resisting without any opportunity to seek review of the need for that treatment. We recommend that the waiting period be reduced to one month in line with the provisions relating to second opinions for treatment in the community.**

(4) Children

(a) Age-appropriate settings

1.16 In ratifying the United Nations Convention on the Rights of the Child, the UK Government has undertaken to respect, protect and promote the rights in the Convention. A number of rights under the Convention deserve mention. Article 3 states that the best interests of the child shall be the primary consideration in all actions concerning children, and article 12 requires consideration of the children's views in deciding issues affecting them, taking into account the age and maturity of the child. Children also have the right under Article 19 to protection from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation including sexual abuse. The Article 19 right reflects the positive obligation on states under Article 3 of the European Convention on Human Rights to protect all citizens against torture or inhuman or degrading treatment.

1.17 There has been considerable debate about the practice of placing children on adult psychiatric wards, and the risks of abuse to which they may thereby be exposed. These have been highlighted in the Children's Commissioner's report *Pushed into the Shadows: Young People's Experience of Adult Mental Health Facilities* which provided evidence from young people's experiences that their health or safety may be seriously compromised by such

[14] *ibid.*, para. 66.

[15] Public Bill Committee Thursday 10 May 2007 (Afternoon) col. 318 Rt Hon Rosie Winterton MP.

[16] Appendix 1a, paras 71 and 72.

placements.[17] The clause which was designed to ensure that care for children was provided in age appropriate settings was deleted in Committee in the Commons,[18] but the Minister has agreed to consider an amendment to require that any child being admitted to hospital must have their needs assessed by a Child and Adolescent Psychiatrist before, or as soon as practicable, after admission, and to make it a duty to provide accommodation suitable to meet those needs as assessed. The Minister has agreed to consider this issue further before report stage.[19] There is clearly the potential for the positive obligation under Article 3 to be engaged by a placement on an adult ward, if a child is not effectively protected from abuse. **We recommend adoption of an amendment to ensure that young people receive age appropriate assessment and placement, but avoids rendering illegal the placement of a child on an adult ward when this is the only way that their needs can be met.**

(b) Child Patients in the Community

1.18 Clause 35 of the Bill governs the treatment of community treatment order patients in the community, without recalling the person to hospital. The basic principle is that a patient with capacity (or competence in the case of a child under 16) may be given treatment in the form of medicine for mental disorder only if they consent and there is a certificate authorising the treatment from a Second Opinion Appointed Doctor. If the patient is capable and refusing treatment, that treatment may only be given without consent by recalling the person to hospital.

1.19 Clause 35 of the Bill[20] authorises 'relevant treatment' to be given to a community patient who has not been recalled to hospital. They set out the circumstances in which medication for mental disorder may be given to a community patient in the community (not necessarily in a hospital or clinic). They apply parts of the decision-making framework of the Mental Capacity Act 2005 to treatment under the Mental Health Act and authorise treatment in the community without the consent of an incapable patient (a) if there is consent from someone authorised under the Mental Capacity Act 2005 to make decisions on the patient's behalf, (b) if the patient lacks capacity (or competence if under 16) and force is not necessary to secure compliance, or (c) if emergency treatment needs to be given, using force if necessary, to a patient who lacks capacity (or competence if under 16).

1.20 We have received a memorandum from the Children's Commissioner for England and the Royal College of Psychiatrists[21] expressing concerns about these provisions and their potential impact on child community patients. The principal broad criticisms advanced are that they provide insufficient safeguards in relation to treatment without consent, that they are complex, cumbersome and confusing, and there is insufficient guidance in the Draft Code of Practice on how the provisions are intended to work. More specifically, a child patient may be given medicine for mental disorder without consent in the community if they lack 'competence.' The same applies to an adult patient if they lack 'capacity.' The Bill specifically provides that decisions about capacity are to be made in accordance with the test in the Mental Capacity Act 2005, but in relation to children, there

[17] The Children's Commissioner for England, January 2007.

[18] Clause 24 of HC Bill 76.

[19] Public Bill Committee Tuesday 8 May Morning col. 239 Rt Hon Rosie Winterton MP.

[20] Adding a new Part IVA to the 1983 Act comprising sections 64A-64K.

[21] Appendix 1b.

is no guidance as to how competence of a child community patient is to be determined, beyond the general guidance from the *Gillick* case that a child is competent if he or she has capacity and is of sufficient maturity and understanding to be capable of making up his or her own mind.[22] The Children's Commissioner argues that, given the significance of competence in the decision to treat, clearer guidance should be provided.

1.21 Child community patients who lack competence may be treated in non-emergencies.[23] Treatment may only be given to an adult,[24] or a child,[25] where either (a) there is no reason to believe that the patient objects or (b) there is reason to believe that the patient objects but it is not necessary to use force against the patient in order to give the treatment. Force is defined in the draft Code of Practice as 'the application of physical force to whatever extent to the patient.'[26] The Mental Capacity Act 2005 uses the more general concept of restraint when speaking of action which is permitted to prevent a mentally incapacitated adult from coming to harm. Restraint means the use or threat of force. The Royal College of Psychiatrists and the Children's Commissioner have raised the issue whether force would include a threat to use the power to recall the patient to hospital.

1.22 Adult patients have greater protection in relation to non-emergency treatment than children since treatment of an adult must not conflict with an advance decision which the person giving the treatment is satisfied is valid and applicable. Equally, for adults, but not for children, the treatment may not be given if it conflicts with a decision of a donee, a deputy or of the Court of Protection. The Children's Commissioner and the Royal College of Psychiatrists argue that this should be addressed by giving those with parental responsibility the right to be consulted over treatment of a child who lacks competence. The European Court of Human rights in *Glass* v *United Kingdom* recognized the rights of the incapacitated child patient's mother as his treatment proxy when he lacked competence. **We recommend that provision should be made for the involvement of those with parental rights in decision making about community treatment of child patients who lack competence and that those with parental rights should have the same rights as donees of lasting powers of attorney or deputies to refuse non-emergency treatment on behalf of an incompetent child patient.**

1.23 The Bill authorises emergency treatment of patients over 16 who are reasonably believed to lack capacity, or children under 16 reasonably believed to lack competence to consent.[27] Again competence is a key issue. Treatment is emergency treatment where it is immediately necessary

a) to save the patient's life; or

b) to prevent a serious deterioration in the patient's condition and is not irreversible; or

c) to prevent serious suffering by the patient and is not irreversible or hazardous; or

[22] *Gillick* v *West Norfolk and Wisbech Health Authority* [1985] 3 All ER 402.

[23] Clause 35, new s. 64F.

[24] Under the proposed section 64D of the Mental Health Act 1983.

[25] Under proposed section 64F.

[26] Para. 16.23e.

[27] Proposed section 64G of the Mental Health Act 1983.

d) to prevent the patient from behaving violently or being a danger to himself or others, as long as the treatment is the minimum interference necessary, and is neither irreversible nor hazardous.[28]

1.24 Irreversible means having unfavourable irreversible physical or psychological consequences, and hazardous means entailing significant physical hazard.[29] The Bill authorises force to be used, but only where emergency treatment needs to be given to prevent harm to the patient and the use of force is proportionate to the likelihood of the patient's suffering harm and to the seriousness of that harm.

1.25 The Children's Commissioner and the Royal College of Psychiatrists have expressed deep concern at the power forcibly to treat children and young people in the community when they may actively resist. They have also insisted that further guidance on the circumstances where emergency treatment and the use of force are authorised should be clarified and that further guidance on this issue is essential. **We share the concerns of the Commissioner and the Royal College of Psychiatrists. Treatment given without consent engages Article 8 ECHR, especially if there is an objection, and in order for such interferences to be in accordance with law, a person's position should be more clearly ascertainable than is currently the case with the lack of specific guidance on competence.**

(5) The Bournewood Safeguards

(a) Procedure

1.26 In our original Report we commented on the complexity of the safeguards introduced in relation to mentally incapacitated adults who are deprived of their liberty.[30] The Government response to our Report expressed confidence that proprietors of residential care homes will be fully conversant with their responsibilities in respect of the deprivation of liberty safeguards in advance of implementation of the safeguards.[31] We also commented on the fact that, following the decision in the case of *JE* v *DE*[32], it may be that the numbers of people deprived of their liberty will be greater than estimated by the Government. Unlike the situation in *HL* v *United Kingdom*, although DE lacked mental capacity to decide where he should live, he had made it abundantly clear that he wished to leave the residential care home where he had been placed by the local authority. Munby J accepted that a deprivation of liberty consisted of both an *objective* element - a person's confinement in a particular restricted space for a not negligible length of time - and a *subjective* element - that the person has not validly consented to the confinement in question.[33]

1.27 As to the subjective element, it was clear that DE was not consenting to placement in the home. The government has maintained the opinion that the operation of a more open care regime may avoid deprivation of liberty. In DE the judge accepted that in relation to

[28] *ibid.*, s 64C(5).

[29] Mental Health Act 1983, s 62(3).

[30] *Op. cit*, para. 90.

[31] Appendix 1a, para. 85.

[32] *JE v DE (by his litigation friend the Official Solicitor), Surrey County Council and EW* [2006] EWHC 3459 (Fam).

[33] *ibid.*, para. [77], following *Storck v Germany* (2005) 43 EHRR 96 at para. [74].

the objective element of deprivation of liberty DE had, within the homes where he was placed, 'a very substantial degree of freedom, .. [and] .. a very substantial degree of contact with the outside world. DE had never been subjected to the same invasive degree of control to which HL was apparently subjected, and had never been subjected to either physical or chemical restraint. Nevertheless, the judge held that the crucial question was not so much whether (and, if so, to what extent) DE's freedom or liberty was or is curtailed *within* the institutional setting. The fundamental issue was 'whether DE was deprived of his liberty to leave the homes where he was placed not in the sense of leaving for the purpose of some trip or outing approved by those managing the institution, but rather 'leaving in the sense of removing himself permanently in order to live where and with whom he chooses.'[34] In this case DE wanted to go home to live with his wife. Munby J held that because he was not free to leave he had been deprived of his liberty.

1.28 In our original Report we also expressed the view that procedures for depriving a person of their liberty should be implemented before the person is detained rather than subsequently. Judicial support for this view is now to be found in the decision of Munby J in *Sunderland City Council* v *PS and CA*[35] where he said that where a court was authorising deprivation of liberty, the following minimum requirements must be satisfied in order to comply with Article 5:

i. The detention must be authorised by the court on application made by the local authority and before the detention commences.

ii. Subject to the exigencies of urgency or emergency the evidence must establish unsoundness of mind of a kind or degree warranting compulsory confinement. In other words, there must be evidence establishing at least a prima facie case that the individual lacks capacity and that confinement of the nature proposed is appropriate.

iii. Any order authorising detention must contain provision for an adequate review at reasonable intervals, in particular with a view to ascertaining whether there still persists unsoundness of mind of a kind or degree warranting compulsory confinement.

1.29 Section 4 of the Mental Health Act 1983 allows emergency admission, but requires that an application supported by one medical recommendation be completed prior to admission. This provides authority for the patient to be taken and conveyed to the relevant hospital. There is no procedure in the Bill for such emergency applications and there is no provision to take and convey someone to a hospital or care home where they urgently need *Bournewood* detention. **We remain of the view that in order for the Bill to be compatible with the right to liberty in Article 5 ECHR it is necessary for the Bill to provide a procedure which precedes detention in all cases.**

(b) Guardianship

1.30 It is generally considered that Mental Health Act guardianship may not be used to authorise a deprivation of liberty. However, a person subject to guardianship may be

[34] *ibid.*, para. [115].

[35] [2007] EWHC 623 (Fam), para. 23.

required to allow access on the part of health and social care professionals, to reside at a specified place, and to attend specified places for the purposes of treatment or training. They may not be given treatment without consent, but they may be brought back to the place where they are required to reside if they abscond, although there is no express power to prevent them from leaving. If the patient does leave they may be taken into custody and returned. The Mental Health Bill contains a provision introducing a power to take and convey a person to their required place of residence under guardianship.[36] **It is possible to envisage circumstances where a guardianship patient might be subject to a degree of control of the requisite degree and intensity to amount to a deprivation of liberty. Admission to guardianship which does not authorise deprivation of liberty is accompanied by a power to take and convey the patient to the place of residence, but a Bournewood authorisation which justifies deprivation of liberty does not. We consider this situation to be anomalous in terms of the protection of rights under Article 5.**

(c) Charging

1.31 In our earlier Report we commented adversely on the proposal, subject to means testing, to charge for deprivation of liberty where a person is detained in a residential care home.[37] A mentally disordered patient who meets the criteria for detention may be deprived of his liberty by detention in hospital under section 3 of the Mental Health Act 1983 and may not be charged for his care in hospital. That same person may subsequently lose capacity and be discharged from detention into a residential care home. He may not be required to pay for his care in the care home, because it must be provided free of charge under section 117 of the Mental Health Act 1983. A person who enters psychiatric hospital as a voluntary patient, but subsequently loses capacity and is placed in the same residential care home under a standard *Bournewood* authorisation, will be subject to a means test and the charging regime. A person who is required to reside in residential care as a condition of guardianship may be required to pay for their accommodation subject to a means test, although not in Northern Ireland where the charging guidance does not allow a patient to be charged for accommodation where they are required to reside as a condition of guardianship under the Mental Health Order 2006.[38] This gives rise to potential issues under Article 14 of the Convention if there are arbitrary bases for charging for deprivations of liberty, such as might arise if a person could be shown to have been charged for residential accommodation primarily on the basis that they lack capacity. The Government does not agree. In their response to our original report they say that to disapply the National Assistance (Assessment of Resources) Regulations 1992 and the Charging for Residential Accommodation Guide and to provide free personal care for all people deprived of liberty in care homes would in fact create new, unacceptable inequities and potential discrimination between those care home residents who are deprived of liberty and those who are not.[39]

1.32 Charging a person for accommodation where they are detained and have no choice about residing raises significant issues of principle. A person who has a mental disorder but retains capacity and who needs detention for treatment in the interests of his own health

[36] Mental Health Bill 2006, Schedule 3 para. 3(5).

[37] *Op. cit.*, para. 91.

[38] Charging for Residential Accommodation Guide Northern Ireland para. 1.005A.

[39] Appendix 1a, para. 92.

may be detained in hospital if he resists. He will not be charged for this detention. However, a person who lacks capacity with the same broad clinical profile and needs may be detained in residential care even if he resists, and may be charged for the detention. Such differences in treatment are likely to prove difficult to justify objectively and raise serious issues under Article 14, since discrimination on grounds of incapacity is likely to amount to discrimination on grounds of any other status under Article 14.

1.33 **We therefore recommend the inclusion in the Bill of a provision to the effect that a person may not be charged in respect of accommodation where they are deprived of their liberty.**

Bill not requiring to be brought to the attention of either House on human rights grounds

Government Bill

2.1 We consider that the Rating (Empty Properties) Bill does not raise human rights issues of sufficient significance to warrant us undertaking further scrutiny of it.

Formal Minutes

Monday 21 May 2007

Members present:

Mr Andrew Dismore MP, in the Chair

Lord Fraser of Carmyllie	Nia Griffith MP
Lord Judd	Dr Evan Harris MP
Lord Lester of Herne Hill	Mark Tami MP
The Earl of Onslow	
Lord Plant of Highfield	
Baroness Stern	

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Draft Report [Legislative Scrutiny: Seventh Progress Report], proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1.1 to 2.1 read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Fifteenth Report of the Committee to each House.

Several papers were ordered to be appended to the Report.

Ordered, That the Chairman make the Report to the House of Commons and that Baroness Stern make the Report to the House of Lords.

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[Adjourned till Monday 4 June at 4pm.

Appendices

Appendix 1a: Letter dated 1 April 2007 from Rt Hon. Rosie Winterton MP, Minister of State, Department of Health, re Mental Health Bill

1 Following the publication of your report on the Mental Health Bill on 4th February 2007, I thought it would be helpful if I provided further explanation of those areas in which the Committee had concerns. We believe that the proposals in the Mental Health Bill ("the Bill") are compatible with Convention Rights guaranteed by the Human Rights Act 1998, and as I have already said, we have taken great care in developing new mental health legislation to make it compliant with the European Convention on Human Rights ("the Convention"). We go through your concerns point by point and hope your Committee will find this further explanation of our approach helpful.

(1) Detention on Grounds of Unsoundness of Mind

1 In order for a non-emergency detention on grounds of unsoundness of mind to conform to the requirements of Article 5(1) (e) ECHR, there must be reliable evidence of a true mental disorder. We are concerned at the possibility that a person with Gender Identity Dysphoria or transvestic fetishism, which are recognised aspects of private life under Article 8, might be detained on grounds of mental disorder without any actual mental disorder such as depression or actual personality disorder. A person with Gender Identify Dysphoria or transvestic fetishism should not be detained unless there is evidence, other than the manifestation of such alternative sexuality or gender identity, that the person suffers from a mental disorder. (Paragraph 14)

2 The Government agrees with the Committee that in order for a non-emergency detention on grounds of unsoundness of mind to conform to the requirements of Article 5(1)(e) of the Convention, there must be reliable evidence of a true mental disorder. It agrees with the Committee's analysis at paragraph 9, in particular with the requirements in *Winterwerp v the Netherlands*[40] (*"Winterwerp"*), which must be met for the lawful detention of persons of unsound mind.

3 For the reasons outlined below, the Government considers that the changes to the definition of the mental disorder and the removal of the sexual deviancy exclusion do not affect compatibility with the requirements of Article 5(1)(e), as interpreted by *Winterwerp*, for lawful detention of persons of unsoundness of mind.

(i) True mental disorder established by objective medical evidence

4 Mental disorder is defined in the Bill as "any disability or disorder of the mind". As the Committee notes at paragraph 8, the Government considers that this definition is consistent with Article 5(1)(e) which uses the term unsoundness of mind, and it refers to previous correspondence on this point.

5 The Committee states that it is "concerned at the possibility that a person with Gender Identify Dysphoria or transvestic fetishism, which are recognised aspects of private

[40] (1979) 2 EHRR 387.

life under Article 8, might be detained on grounds of mental disorder without any actual mental disorder such as depression or actual personality disorder. A person with Gender Identity Dysphoria or transvestic fetishism should not be detained unless there is evidence, other than the manifestation of such alternative sexuality or gender identify, that the person suffers from a mental disorder" (paragraph 14).

6 The Government is unclear from the above passage whether the Committee is suggesting that gender dysphoria and transvestic fetishism, without the presence of another recognised mental disorder such as personality disorder, are not "true mental disorders". If this is the case, the Government questions the basis of this view.

7 Gender dysphoria and transvestic fetishism are very different conditions. The former is a disorder of gender identity, the latter is a matter of sexual preference (see further below). However, as the Committee notes, both appear in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). In addition, both are classified as mental disorders in the World Health Organisation's International Classification of Diseases (ICD-10) – although the ICD-10 refers to them as "transsexualism" and "fetishistic transvestism" respectively. Whilst the ICD-10 is not an authoritative text on what constitutes a mental disorder, its inclusion of these conditions suggests that there is, internationally, a body of clinicians who would regard them as mental disorders.

8 The Government's understanding, therefore, is that gender dysphoria and transvestic fetishism potentially constitute "a disability or disorder of the mind" in the terms of the Mental Health Act 1983 ("the 1983 Act") and a "true mental disorder" for the purposes of Article 5(1)(e) of the Convention, where they reach a sufficient level of clinical significance. The issue has not arisen as far as the Government is aware, and the Government does not think it is possible, in the absence of case-law, to take a definitive view. In the unlikely event that a case were to arise, it would no doubt depend on the particular circumstances. Whilst it is of course accepted that transsexuals have the right to personal development and physical and moral integrity under Article 8, the Court in the case of *Goodwin v United Kingdom*[41] held that transsexualism has wide international recognition as a medical condition for which treatment is provided in order to afford relief. The Government doubts that the fact that transsexuals have the right under Article 8 to have their gender re-assignment recognised is determinative of whether or not gender dysphoria or transvestic fetishism could constitute "unsoundness of mind".

9 As mentioned above, gender dysphoria is a disorder of gender identity, not sexuality. Accordingly, the Government's view is that it has <u>never</u> been excluded from the 1983 Act and the removal of the exclusion for sexual deviancy has not changed the legal position in this regard.

10 It is the Government's understanding that transvestic fetishism, by contrast, would be considered clinically to be an abnormality of sexual preference. The people concerned – almost always men - are not confused about their gender. They simply enjoy wearing the clothes of the opposite sex, and may gain sexual arousal from doing so. Accordingly, the Government thinks that a court might consider transvestic fetishism "sexual deviancy" for

[41] [2002] 2 FCR 577; (2002) 35 EHRR 18 at para. 81. Also see paras 90 and 91.

the purposes of the 1983 Act. In which case, the removal of that exclusion means that this condition would now, in theory, be within the scope of the 1983 Act.

(ii) Mental disorder warrants compulsory confinement or treatment

11 The mere presence of a mental disorder is never sufficient to justify action under the 1983 Act. The relevant criteria must always be met, such as the criteria for admission for treatment in section 3. The criteria ensure, amongst other things, that a person is detained only where it is appropriate that that person receives medical treatment in a hospital for that mental disorder.

12 More practically, the Government can see no reason why the Bill should make it any more likely that anyone will be detained on the basis either of gender dysphoria or transvestic fetishism.

13 As mentioned above, gender dysphoria has never been excluded from the 1983 Act and the removal of the exclusion has not changed the legal position. Yet there is no evidence of people being detained wrongly under the Act as it stands. Indeed, it is hard to imagine the circumstances in which someone suffering from gender dysphoria would meet the criteria for detention under the current or amended Act.

14 In relation to transvestic fetishism, again the Government can see no reason why the amendments in the Bill should lead to people who cross dress being detained. The fact that transvestic fetishism is classified as a mental disorder does not, of itself, mean that it requires treatment, let alone that it would call for treatment in hospital, or that there would be a justification for detaining someone in hospital for such treatment.

15 While very different from one another, gender dysphoria and transvestic fetishism are like very many other mental disorders which are in theory covered by the 1983 Act, but which in practice would not be expected to lead to people being detained. Other examples include mild depression and anxiety, phobia of flying and various forms of sexual dysfunction.

16 On the other hand, if a person did meet the criteria for detention as a result of gender identity or transvestic fetishism (or any other equally unlikely disorder) and needed to be detained for their own sake or to protect others then it is right that mental health legislation should enable appropriate action to be taken. But for that to happen there would have to be wholly exceptional – and very hard to envisage – circumstances.

(iii) Amendments in the House of Lords

17 The Committee may be aware that the House of Lords voted to include in the Bill a number of new exclusions from the definition of mental disorder, against the Government's opposition. The new exclusions (in clause 3) include "sexual orientation and sexual identity."

18 Those terms are not defined, but the Government understands the former to mean sexual attraction towards people of the same, or opposite sex, or both, and the latter to mean the terms (for example "heterosexual", "homosexual" or "bisexual") by which a person thinks of, or describes, their own sexual orientation (regardless of what that orientation is

in objective terms). If that understanding is correct, then the amendment would not affect the position of either gender dysphoria or transvestic fetishism.

(iv) Summary

19 The Government does not share the Committee's view (if that is indeed its view) that gender dysphoria and transvestic fetishism could never be regarded as true mental disorders. Moreover, the mere presence of mental disorders is not enough to justify compulsory confinement; it must be shown that they are of a kind or degree that warrants compulsory confinement. This is provided for by the criteria for detention in the 1983 Act. Accordingly, the Government considers that the amendments do not affect compatibility with Article 5(1)(e) of the Convention.

2 Given the breadth of the new definition of mental disorder, we consider that the argument for principles of non-discrimination to be on the face of the Bill applies to non-discrimination on grounds of sexual orientation and sexual identity. We consider that this is an area where it is desirable to include principles such as non-discrimination and proportionality on the face of the legislation. (Paragraph 15)

20 The Government does not follow the Committee's reasoning in this paragraph. Sexual orientation and identity are not mental disorders. Accordingly, changes in the Bill in relation to the definition of mental disorder have no bearing on the question of whether there should or should not be principles about non-discrimination and proportionality on the face of the legislation.

21 The Committee may, however, wish to note that the Government has amended the Bill so that there is now a statutory requirement on the Secretary of State and Welsh Ministers to provide a statement of Principles in the respective Codes of Practice for England and for Wales. The fundamental issues that the statement must address are listed on the face of the Bill (in clause 10). These include:

a) respect for patients' past and present wishes and feelings,

b) minimising restrictions on liberty,

c) involvement of patients in planning, developing and delivering care and treatment appropriate to them,

d) avoidance of unlawful discrimination,

e) effectiveness of treatment,

f) views of carers and other interested parties,

g) patient well-being and safety, and

h) public safety.

3 We consider that the procedures for ensuring objective medical evidence of a true mental disorder for a lawful psychiatric detention appear broadly to comply with the case law on Article 5(1)(e) of the Convention. (Paragraph 16)

22 The Government welcomes the Committee's conclusion that the procedures in Part 2 of the Act, as they are to be amended by the Bill, for initiating detention are compatible with Article 5(1)(e) of the Convention.

(2) Conditions of Compulsion

4 In our view, in terms of the Convention, there would appear to be no obstacle to replacing 'treatability' with 'availability of appropriate treatment' as a condition of detention. (Paragraph 20)

23 The Government welcomes the Committee's conclusion that there is no obstacle to replacing the so-called treatability test in the criteria for detention for treatment under the Act with a test of whether appropriate treatment is available. Although the House of Lords voted to retain the treatability test – and apply it more widely – the Government continues to believe that it does more harm than good and should be replaced.

(3) Renewal of Detention

5 We do not agree with the Government's definition of objective medical expertise in relation to the establishment of a true mental disorder for renewal of detention. (Paragraph 26)

6 We find the Government's argument, that after mental admission the hospital managers cease to be the detaining authority and responsibility for the patient's case passes to the responsible clinician, unconvincing. (Paragraph 29)

7 Although in some circumstances it might be appropriate for a clinical psychologist to provide the tribunal with the objective medical expertise for renewal of detention, we share the Council on Tribunal's concern that it may be difficult for Responsible Clinicians who may be nurses, social workers or occupational therapists to do so, and that therefore the Mental Health Review Tribunal may be required to seek additional medical evidence to verify that the conditions of detention continue to be met. (Paragraph 29)

24 The Committee relies on the case of *Varbanov v Bulgaria*[42] in support of their view that objective medical expertise involved reports from psychiatrists who are doctors. The opinion of such a person was necessary for a person to be lawfully detained on grounds of unsoundness of mind. The Court in that case held that there would be a breach of Article 5 if a person were detained on the basis that they were of unsound mind without first obtaining the opinion of a medical expert. In that case the patient was detained without first consulting a medical expert even though it was the intention of the detention to obtain such a view. He was then admitted to a psychiatric hospital but there was no evidence that any opinion was sought in hospital as to whether he needed to be detained. The order for his detention for 21 days had already been made without the involvement of a medical expert.

[42] Judgment of 5 October 2000.

25 The Government believes, as did the court in that case, that except in cases of real emergency it is necessary to obtain a medical opinion before detaining a person. However, the Government does not agree that the case requires the necessary medical expertise to be provided every time by a psychiatrist.

26 The Government does not believe there is any case law specifically on what is meant by objective medical expertise. It is clear that different member states have different systems for detention. For example in the Netherlands, the case of *Schuurs v the Netherlands*[43] made various complaints about the detention of the patient on the basis of a certificate by a general practitioner. These were about the fact that the GP did not properly examine her and that she was not allowed to make representations to the District Court that ordered her detention in hospital for 6 months. Her complaints did not however raise any objection to the examination being carried out by a GP rather than a psychiatrist. Yet, a GP may have no particular specialist experience in mental health. The competencies that will be required of responsible clinicians will mean that all responsible clinicians can identify the presence and severity of mental disorder and all will work in senior positions in mental health, so will therefore often have skills superior to those of a GP to enable them to determine if a person is of unsound mind.

27 It is the Government's view that, as the European Court of Human Rights has said on a number of occasions, the Convention is a "living instrument" which must be interpreted in the light of present day conditions. In modern day England and Wales, there have been changes in the way professional roles are considered. There is increasing multi-disciplinary working and allocation of functions on a competency basis – for example, members of professions other than doctors can now prescribe. Within a modern workforce, it is appropriate for Mental Health Act functions to be allocated to those who are competent to perform them, including allowing an approved clinician who has the competency to act as a responsible clinician, and who is the most appropriate professional to do so, to carry out this role.

28 In this light, it is our view that *Winterwerp* must be broadly interpreted. What is required is a person who is able to make a decision as to whether or not the person in question is of unsound mind. On detention, we have chosen to require that the application by the approved mental health professional ("AMHP") be based on the recommendations of two doctors, one of whom must be approved under section 12 of the 1983 Act as having special experience in the diagnosis or treatment of mental disorder. At this stage, we consider that the needs of the patient have not been assessed and doctors have the widest diagnostic skills. However, this is a matter of policy, not because we believe it is a legal requirement. Once the person has been assessed for admission, an approved clinician will be allocated as their responsible clinician. He will be selected because he is the most appropriate person to oversee the patient's case. He will not work in isolation but as part of a multi-disciplinary team. However, as the person in overall charge of the patient, it is right that the responsible clinician be the person to decide whether or not to renew the detention. The responsible clinician will have the skills to do so.

29 Before a person can be a patient's responsible clinician, they must be approved as an approved clinician. To be an approved clinician a person must be able to demonstrate to

[43] 41 D. & R 186.

the satisfaction of an approving body (which will be a Strategic Health Authority in England) that they have the competencies to be set out in directions. The competencies will include the ability to identify the presence and severity of mental disorder. Only professionals who have had the clinical training that would enable them to demonstrate this competency can be approved. Professionals that cannot demonstrate this competency will not be approved. The professions identified in the draft Directions for England[44] (available on the DOH website) as those which can be approved, are the key professions within the multi-disciplinary team, but only those members who can demonstrate the competencies mentioned above may be approved.

30 It is important also to consider what is involved in the decision to renew detention. Detention may only be renewed if the conditions set out in subsection (4) of section 20 of the 1983 Act are met. The conditions are that the patient is suffering from mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital, and it is necessary for their health or safety or the protection of others to receive treatment, and such treatment cannot be provided without detention, and that appropriate medical treatment is available.

31 As I have pointed out above, only a person who can identify the presence and severity of mental disorder may become a responsible clinician. Because a patient's responsible clinician has overall responsibility for the patient's case and the most appropriate expertise for the patient's needs, they will also be best placed to assess a patient's risk to self or others, and whether or not the appropriate response to this risk is the patient's detention for treatment in hospital. The person with overall responsibility for the patient, the responsible clinician, is best placed to know whether appropriate medical treatment is available. Medical treatment includes psychological intervention and specialist mental health habilitation, rehabilitation and care. The responsible clinician will have access to a multi-disciplinary team of professionals involved in the patient's care whose views will inform their decision-making.

32 We do not consider that *Winterwerp* was trying to lay down the sort of medical qualifications available in a national system that should or should not count when deciding on the renewal of detention. That is for each national authority to decide. The professions whose members may be approved as approved clinicians will be set out in directions from the Secretary of State and the Welsh Ministers. The draft directions for England are on the Government of Health website. We have consulted widely on the content of these (including with the Royal College of Psychiatrists), but remain open to views.

33 The same arguments support our view that any responsible clinician can provide the Tribunal with objective medical expertise when renewing detention. It is, of course, open to the Tribunal to seek further medical evidence, and the Mental Health Review Tribunal Rules allow them to seek such further information or reports as they wish and to subpoena witnesses. There is no requirement under the present Rules for the responsible medical officer (RMO) to give evidence, although it is usual practice. The Tribunal will want to have evidence from the person (or persons) best placed to give it and this will in general be the responsible clinician. He will have the best overall knowledge of the patient and the expertise most appropriate to the patient's case.

[44] The Draft Mental Health Act 1983 Approved Clinician Directions.

34 The Committee were unconvinced by the Government's explanation about why responsibility for the renewal of detention lay with the responsible clinician. Our view is that it is the application for admission to hospital (made in accordance with the Mental Health Act) that is authority for the hospital managers to detain the patient (see section 6(2) of the Mental Health Act). Continued detention is only in accordance with Article 5(1) (e) and the conditions laid down in *Winterwerp* if the persistence of the patient's medical disorder is kept under review. The responsible clinician is the person charged with this exercise on an ongoing basis, but in addition, he is charged with formally providing a report that the detention be renewed at intervals, and sending a copy of that report to the hospital mangers. It is the furnishing of the report that gives authority for the continued detention of the patient. *R v Warlingham Park Hospital Managers, ex p B*,[45] referred to by the Committee, upheld the view that the lawfulness of continued detention depended on the furnishing of the report to the hospital managers, not any consideration of that report by the hospital managers.

(4) The Nearest relative

8 In our view , clauses 21 to 24 appear to meet the terms of the friendly settlement in *JT v United Kingdom* . (Paragraph 34)

9 If, as appears to be the case, the Government's intention is to confine the patient's right to seek displacement of a nearest relative to situations of abuse or strongly suspected abuse, the test of suitability is too vague and broad to achieve this. In our view the Bill should be amended to provide effective safeguards on the face of the Bill. It may be necessary to consider the fact that often it is a near or nearest relative who may have sought the detention of the patient into the mental health facility. This may lead to a breakdown of trust and place a strain on such a relationship, making it inappropriate for such a person to determine the future of the patient. (Paragraph 37)

35 It is foreseeable that 'otherwise not a suitable person to act as such' could cover a variety of cases and we want the courts to be able to judge each case on its own particular merits. We do not consider that it would be appropriate to attempt to set out in the legislation every possible scenario in which a person may be judged 'not a suitable person to act as such' in this context. This is ultimately a matter to be decided by the courts. However, we intend to make clear, during the passage of the Bill, some of the things we have in mind by the phrase 'otherwise not suitable to act as such.'

36 The Government has carefully considered this recommendation and considers that the test of suitability strikes the right balance. The judgment of the suitability of a nearest relative involves careful consideration of the relationship between the patient and the nearest relative. It is not a judgment about how the nearest relative exercises their rights. We have retained the provisions which enable the displacement of a nearest relative in those limited and specific situations where the manner in which a person has exercised their rights as nearest relative should constitute grounds for displacement. The new ground of unsuitability is not designed to cover the same circumstances. It is not intended to be a judgment about how a nearest relative is exercising their rights, nor is it intended to act as an additional "catch all" category for covering "other" ways in which the actions of the nearest relative can be used to displace him or her.

[45] (1994) 22 BMLR 1.

37 Whilst we do wish "unsuitable" to cover more than just cases of abuse or strongly suspected abuse, we do not wish to restrict the nearest relative's ability to fulfil that role by allowing a patient to displace a nearest relative simply because that person was the one who applied for the patient's detention, or equally did not object to an application made by an AMHP.

38 We do not see a conflict in introducing displacement on the grounds that the nearest relative is not suitable and our retaining the right of the nearest relative to apply for the detention of the patient. The nearest relative's role is one that requires him or her to act independently of the patient. We recognise that this can sometimes mean acting in ways that are contrary to the wishes of the patient. Suffering with mental disorder is often a distressing and difficult time for the patient, and it is no less so for those who love and care for the patient. In that environment, we recognise there is potential for disagreement between a patient who may not wish to go to hospital, and a nearest relative who reluctantly accepts that this is the best course of action. We do not intend that a person will be deemed "not suitable to act" as a patient's nearest relative simply because the patient, or the AMHP, disagrees with how the nearest relative exercises their rights, or because the patient is upset with the nearest relative over a trivial matter.

39 However, we understand that each relationship between nearest relative and patient will be different and that there will be cases where a deterioration of this relationship will render a nearest relative unsuitable to act as such. We wish the courts to be free to make judgments about suitability in this context, taking into account the merits and circumstances of each individual case. In discharging this role, the Human Rights Act 1998 requires that the court must act in a manner which is compatible with the patient's Convention rights.

40 Whilst abuse, suspected abuse, and the risk of abuse do constitute one element of what could make a nearest relative unsuitable, the Government do not intend to equate unsuitable with these factors only. In addition to what has been said in the House of Lords during the passage of the Bill to date, the Government intends that a person is not suitable to be the nearest relative where that person has no relationship with - and intends to have no further relationship with - the patient. In addition, it is intended that a person is not suitable to be the nearest relative where the risk posed to the patient is by virtue of a third party and the nearest relative exposes the patient to that risk.

41 It is intended that the court will draw on their knowledge of the nearest relative, the views of the professionals involved in the case and other relevant persons known to the patient. The opinions and views of the patient will also form part of the courts' deliberations, but at the same time, we do not wish the court to feel prevented from displacing a nearest relative it deems unsuitable, even where the patient would wish that person to remain as the nearest relative. We are aware that there are times when a victim will act to protect his or her abuser, either out of fear of, or through a form of identification with, the abuser.

42 Finally, we do not intend that it should be possible to displace a nearest relative because there is another person who appears to be "more suitable".

(5) Community Treatment Orders

10 We consider that, if there is to be a procedure whereby the hospital managers authorise CTOs, in order to be compatible with the requirement that the interferences with private life must be "in accordance with the law", this should be in the legislation not in the Code of Practice, which as the House of Lords has said, may be departed from with good reason. (Paragraph 51)

43 The Government note what the Committee has said in its report about the need for any procedure whereby hospital managers authorise a Community Treatment Order ("CTO") to be in the legislation and not the Code of Practice in order for it to be compatible with the requirement under Article 8 of the Convention that interferences with private life must be "in accordance with the law". The Government also notes the Committee's observation that the procedure for making a CTO is not consistent with other procedures in the Act whereby an application is required to be made to the hospital managers.

44 The Government shares the Committee's view that there should be transparency on the face of the legislation in the procedure for making a CTO. However, the Government considers that although the procedure for making a CTO does not require an application to be made to the hospital managers or to any competent authority, this does not, of itself, render that procedure incompatible with Article 8(2) of the Convention. The Government considers that the procedure for making a CTO must be looked at as a whole for the purpose of determining whether that procedure includes sufficient safeguards for the patient and is otherwise compliant with Article 8 of the Convention.

45 In paragraphs 25 to 32 of my letter to the Committee of 17th January, I set out in detail why the Government considers that the procedure for making a CTO, as currently contained in the proposed new sections 17A and 17B of the Act, complies with the requirements of Article 8(2) of the Convention. The Committee is referred, in particular, to paragraph 30 of that letter for the reasons why the Government considers that the additional involvement of the hospital managers in that procedure is unnecessary.

46 The Government would like to clarify that it is not the policy intention to establish a procedure whereby the hospital managers *endorse* the making of a CTO either in the legislation or in the Code of Practice. As explained in my letter of 17th January, the Government considers that the decision to make a CTO in respect of a patient is a clinical decision and is therefore one which the responsible clinician, subject to the agreement of an AMHP, is best placed to make as the person with direct responsibility for the patient's treatment.

47 The reason why the Code of Practice states that the hospital managers should be sent a copy of a CTO is one of practical necessity (i.e. so as to ensure that they are informed that a CTO has been made in respect of a patient who is detained in their hospital). This would, for example, allow the hospital managers to ensure that arrangements are in place for the patient's discharge from hospital. It is not intended that the hospital managers should also give the seal of approval to the making of the CTO.

48 The Government notes what the Committee has said in paragraph 51 of its report about the provision in the legislation for the renewal of a CTO under which a report must

be furnished to the hospital managers before the CTO can be renewed. However, as stated above, this is a matter of practical necessity and does not amount to a requirement in the legislation for the hospital managers to endorse the renewal of a CTO. If the Government had intended that the hospital managers should formally authorise the making or renewal of a CTO then it is agreed that, for reasons of transparency, provision in this regard should be included the legislation and not in the Code of Practice. However, as stated above, this is not the case.

(6) Right to seek review of conditions in a Community Treatment Order

11 We do not consider that the need to obtain the AMHP's agreement as to the nature of the conditions to be imposed on a CTO represents a significant safeguard. (Paragraph 56)

12 In our opinion concerns expressed about the independence of the AMHP reinforce the need for some external safeguard that is more accessible than judicial review. (Paragraph 57)

13 We consider that the requirement that restrictions on conduct under a CTO be proportionate and that conditions may not be imposed which collectively amount to a deprivation of liberty should be enshrined in the statute, and that a patient should be entitled to seek review of the conditions before a Mental Health Review Tribunal. (Paragraph 58)

49 The Government notes the Committee's view that the legislation should specify that any restrictions on conduct are to be proportionate and that they should not collectively amount to a deprivation of liberty. The Government also notes the Committee's view that the need to obtain the agreement of an AMHP to the making of a CTO does not represent a significant safeguard for the patient and that there should be a more accessible means than judicial review for a patient to seek a review of the conditions imposed on a CTO.

50 As stated above, the Government considers that the procedure for making a CTO, including the ability to impose conditions which restrict behaviour, complies with the procedural obligation under Article 8 of the Convention. The Government also considers that this procedure must be looked at *as a whole* for the purpose of determining whether it includes sufficient safeguards for the patient and is otherwise compliant with Article 8 of the Convention. The reasons why the Government considers that the absence in the legislation of a right for a patient to seek a review of the conditions imposed on a CTO does not contravene a patient's rights under Articles 5 and 8 of the Convention were set out in my letter of 17th January (see in particular paragraph 35 of that letter).

51 For the reasons stated in the paragraphs below, the Government does not share the Committee's view that conditions are, in practice, likely to be imposed on a CTO that are so restrictive in nature as to collectively amount to a deprivation of liberty or that the involvement of an AMHP in agreeing the conditions of a CTO will not offer a significant safeguard for patients. In addition, it is unlikely that Supervised Community Treatment (SCT) will, in practice, be considered appropriate for a patient who is eligible if it is considered necessary to impose conditions on the patient's CTO that are so restrictive in nature as to amount to a deprivation of liberty because it is not possible to see how this

would be of greater clinical benefit to the patient than continued detention and treatment in hospital.

52 The conditions imposed on a CTO are intended as a means of setting a framework for the patient's successful living in the community. They are clinically driven in that they will be based on an assessment of what is considered clinically necessary to ensure that the patient continues to receive the care and treatment that he or she needs when residing in the community while at the same time providing sufficient protection for the patient or others. It is clear that the proposed new section 17B(3) of the Act merely provides examples of the type of conditions that can be imposed on a CTO and that the legislation does not *require* the imposition of conditions which restrict a patient's behaviour or which would collectively amount to a deprivation of liberty. The Code of Practice will provide guidance on the need to keep conditions to a minimum necessary to ensure that patients receive the treatment they need and to protect them and others from harm. This is intended to ensure that the conditions imposed will be proportionate in the circumstances of each individual case and that they will not be applied so as to collectively amount to a deprivation of liberty. It also reinforces the clear duty already incumbent on the responsible clinician and the AMHP, by virtue of them being public authorities under section 6 of the Human Rights Act 1998, to act compatibly with the Convention. The Government therefore considers that it is not necessary to further spell out this duty in the primary legislation and that the Code of Practice is the right vehicle to provide the necessary detail to practitioners about how the conditions should be applied.

53 To the extent the conditions imposed on a CTO could be said, either individually or collectively, to amount to an infringement of a patient's civil rights to the point where Article 6 of the Convention is engaged, the Government considers that sufficient *internal* safeguards already exist under the statutory procedure currently proposed, as supplemented by the Code of Practice, which would safeguard against this by preventing such conditions from being imposed at the outset and by enabling an effective review of the continued necessity or appropriateness of the conditions imposed. The Code of Practice will also encourage the involvement of the patient and those responsible for caring for him in the community in setting the conditions. This should further reduce the likelihood of any conditions imposed being unacceptable to the patient or not reasonably practicable for him to comply with. Although the exact nature of the conditions imposed on a CTO will ultimately be a matter for clinical decision in the light of the patient's individual circumstances, the current power in the proposed new section 17B (4) and (5) for the responsible clinician to vary or suspend the conditions recognises that those conditions may need to be altered from time to time having regard to a patient's individual circumstances. There is nothing in the legislation that would prevent this power from being used at the request of the patient or a person acting on his behalf.

54 The Government therefore disagrees with the Committee's view that there should be a right for a patient to seek an external review of the conditions of a CTO because such an external mechanism for review would introduce a further layer of complexity into the management of patients subject to SCT. The Government also does not consider that the MHRT would be better placed than any other external body to make decisions in this area because of the clinical and individual nature of the conditions imposed. The Tribunal does not have a role in making decisions as to suitability of a patient for SCT, other than a power

to recommend to the responsible clinician that he or she considers whether to make a CTO, so that a power to review the conditions imposed would appear inconsistent.

55 The Government also strongly disagrees with the Committee's views about the independence of an AMHP and considers that the involvement of an AMHP in the procedure for making a CTO, including the attachment of conditions, is a significant part of a sufficient package of patient safeguards that currently exists in the procedure for making a CTO. The Government's view is that the AMHP will bring an independent perspective, just as the approved social worker ("ASW") currently does in the making of key decisions under the Act. As with ASWs, an AMHP will be required to make an independent professional decision.

56 The standards to be set for those eligible to be AMHPs, including competencies and training, will ensure that individuals undertaking this role will be capable of taking an independent view and will not be unduly influenced by colleagues who may be their seniors. Local authorities will continue to have the role of approving AMHPs and must be satisfied that individuals have appropriate competence in dealing with people suffering from mental disorder, including the ability to take an independent view. An AMHP will always be acting on behalf of a local authority when undertaking their AMHP functions.

57 Training for AMHPs will ensure that standards are maintained. That training will be significant. In England, it will involve at least 600 hours including teaching and practice, which is required prior to approval as an AMHP, and the competency requirements for approval, will ensure that AMHPs from all professional backgrounds are able to take a social care perspective when considering matters relating to SCT. The Government will be working with the British Association of Social Workers and other organisations representing professionals on the implementation of the AMHP role.

58 It is also relevant to point out, as before, that the AMHP is a public authority under section 6 of the Human Rights Act 1998, and as such has a duty to safeguard the patient's rights under the Convention. He would be open to challenge if he agreed to the making of a CTO, or the imposition of conditions, in circumstances where he does not consider this to be in the best interests of the patient.

(7) The test for treatment without consent under section 58 of the 1983 Act

14. In our view, it is clear from the subsequent provisions of the Draft Code of Practice that reliance on the appropriateness test in the legislation, without more, will not be sufficient to ensure Convention compliance. (Paragraph 60)

15. We find the Government's reasoning, that the provisions relating to the administration of treatment are capable of operating compatibly with Articles 3 and 8 ECHR, hard to accept. We consider that the principal legitimate aim for which medical treatment may be imposed under Article 8(2) is health, even if incidental purposes may be the prevention of crime or the protection of the rights and freedoms of others. We therefore think that treatment must be necessary to protect health (clinically necessary), and a proportionate response. It must also be in accordance with the law, in the sense of being predictable in its effects to those subject to interference with their rights. For this reason in our view the full appropriateness test should be in the

legislation rather than in a Code of Practice, which may well only be accessible to professionals. (Paragraph 65)

59 The Government does not accept the Committee's conclusion that the full appropriateness test should be in the legislation rather than the Code of Practice.

60 The Government agrees that treatment under the 1983 Act must be for a health care purpose. The Government itself tabled an amendment at Report stage in the House of Lords which would have made explicit what is anyway implicit in the legislation – namely that the purpose of medical treatment under the Act is to alleviate, or prevent the worsening of, mental disorder, its symptoms or effects.

61 That is true of medical treatment for mental disorder throughout the 1983 Act. The Committee, however, was concerned specifically with the test which a second opinion appointed doctor (a SOAD) should apply when deciding whether to authorise treatment section 58 (medication and – for the time being, electro-convulsive therapy – for mental disorder.)

62 The Committee suggests that "the full test" for giving treatment without consent should be included in the legislation. Yet as I explained to the Committee in my letter of 17 January 2007, the Government does not believe that the Convention contains a single test for when such treatment is permissible.

63 The test of "medical necessity" (or "therapeutic necessity") has been developed by the European Court of Human Rights in the context of Article 3 of the Convention. By no means all treatment given without consent will come close to the threshold of severity in Article 3 of what might constitute inhumane or degrading treatment. Where medical treatment does not approach that threshold, then it is nonetheless likely to engage Article 8 of the Convention, and therefore falls to be justified under that Article (which, of course, includes consideration of the proportionality of the intervention).[46].

64 There is no authoritative case-law that the Government is aware of to suggest that the test for Article 8 is the same as the "medical necessity" test applied in the context of Article 3. Accordingly, it is not clear to the Government the basis on which the Committee concludes that the "full test" is that treatment "must be necessary to protect health ("clinically necessary") and a proportionate response".

65 The Government's view is that a requirement for a SOAD to decide whether treatment is "appropriate, taking into account the nature and degree of the patient's mental disorder and the other circumstances of [the patient's] case" would inevitably require the SOAD to consider the very issues which determine whether treatment is a medical necessity (where there is a question of it being contrary to Article 3) or whether it is justified under Article 8(2). That would be true, even if SOADs were not in any event required to act compatibly with Convention rights by section 6 of the Human Rights Act 1998.

[46] As mentioned at para. 49 of my response to the Committee of 17 January 2007, "In the Government's view, the relevant test in relation to Article 8(2) of the Convention is therefore to be found in the plain words of the Article and the conventional three-fold test of whether the treatment is: (i) in accordance with the law…(ii) for a legitimate aim; and (iii) necessary in a democratic society.

66 The Committee's recommendation appears, furthermore, to be based on an assumption that the Government has "chosen to address Convention compliance in the Code [of Practice] rather than in the legislation" (paragraph 63). The Government does not share this view.

67 As the Committee notes, the draft illustrative Code of Practice "reminds clinicians of their obligations under Articles 3 and Article 8" (paragraph 61). The Government agrees with the Committee that the Code is a reminder – a description – of what the law is. The Government also agrees that guidance given in the Code may be departed from where there are cogent reasons to do so. But that does not mean that practitioners can depart from the law, simply because it happens to be described in the Code.

68 The Government does not share the Committee's view that the Code of Practice "may well only be accessible to professionals". The Code is a published document which may be freely purchased. It is reproduced (along with the Act itself) in the standard text-book on the Act. It is also available on-line at no cost. It is certainly at least as accessible to the general public as the Act itself - in practice, it may well be more accessible. In addition, all hospitals in which patients are detained hold copies of the Code, and should make it available to patients on request.

69 Finally, the Committee may have noted that the House of Lords voted to retain the current wording of section 58, namely that the SOAD must certify that "treatment should be given" having regard to "the likelihood that the treatment will alleviate or prevent deterioration of, the patient's condition.

70 Were the Committee's conclusion about the "full test" required in section 58 correct, this current test would also be inadequate. For essentially the same reasons as set out above, the Government does not believe that is so. But it continues to believe that a test based on what is "appropriate" would be better than the current test.

16 Three months is a long time to be in receipt of compulsory psychiatric treatment without the opportunity for review and supervision of the responsible clinician's decision to impose that treatment, and we consider it is doubtful whether the Government's obligation under Article 8 to provide effective supervision and review of treatment without consent is discharged by such a long waiting time. (Paragraph 66)

71 We have considered very carefully the Committee's views. However, we remain of the view that the 1983 Act has the right balance in this respect between clinical freedom and safeguards for patients. There is additionally no empirical evidence that the 3 month period is too long**.**

72 There is no obligation under the Convention which requires a second opinion when considering the administration of medical treatment. We have similarly not identified any obligation under Article 8 to provide further safeguards beyond those in the Act already. Furthermore, it is only people who have been detained, or who are liable to be detained, for treatment, in accordance with the criteria and procedures in the Act, who may be treated without consent.

73 We would ask the Committee to also note that a patient and their nearest relative can themselves seek the opinion of another doctor, and the treating doctor can also seek

advice from colleagues. While the Mental Health Act Commission ("MHAC") does not arrange for these second opinions, they can be arranged through the NHS.

74 The Government is aware that the MHAC has expressed concern that the 3 month period is too long when a patient is receiving doses outside of the product guidelines for that medication or in combinations that constitute high doses. However, the Government considers that the use of high does and combinations of medications is a clinical issue that is best dealt with in clinical and professional guidance.

75 There is already a power in the existing 1983 Act (at section 58 (2)) for the existing 3 month period to be reduced by Order made by the Secretary of State. The legislation therefore already provides a mechanism by which this period can be altered should future evidence and practice support such change.

(8) Forcible feeding

17 We consider that the positive obligation under Article 8 as elaborated in *Storck v Germany* requires effective supervision and review of discussions to treat against an individual's will, and that the direction of the responsible clinician, even if that person is a medical practitioner, is not sufficient to provide such supervision and review. In relation to invasive treatments such as medicines for mental disorder and Electro Convulsive Therapy Parliament has seen fit to provide such supervision and review in the Mental Health Act 1983 by way of a statutory second opinion. Forcible feeding is equally, if not more, invasive of physical integrity. We therefore consider that it should be subject to the same safeguards, provided for in this Bill. (Paragraph 79)

76 The Government does not believe that a statutory second opinion is a requirement of the Convention, either for the treatments to which it currently applies or for forcible feeding. However, as I said to the Committee when giving evidence on 5 February 2007, the Government is prepared to consider whether existing powers in the 1983 Act should be used to include forcible feeding within the scope of the second opinion procedures.

(9) *HL v United Kingdom* and the Bournewood proposals

18 We consider that if it is known that a person will be taken from their home to a place where they will be prevented from leaving, and complete and effective control will be exercised over their movements, that person is deprived of liberty from the point of removal from their home. This is recognised in relation to detention under the Mental Health Act 1983, where a duly competed application is authority to take and convey the patient to hospital. The fact that the person is not resisting at the time does not, in our opinion, obviate the necessity for legal authority to detain from the point of deprivation of liberty. To require an order from the Court of Protection to take and convey would seem an unduly cumbersome procedure. We consider that a duly completed Bournewood authorisation should provide authority to take and convey the patient, as an incapacitated person who is initially not resisting, may subsequently become resistant to admission and legal authority to convey them to the place of residence will be needed. (Paragraph 89)

77 Our concern is to ensure that there are robust safeguards in place to protect the rights of people who lack capacity to consent to the arrangements made for their care when

those arrangements amount to a deprivation of liberty within the meaning of Article 5 of the Convention. For the reasons set out below, we do not think extending the scope of a Mental Capacity Act deprivation of liberty authorisation to cover conveying will add to those safeguards.

78 We consider that the conveyance of a person who lacks capacity to consent from their home, or another location, to a hospital or care home would not usually amount to a deprivation of liberty. In many cases there would be no intention to deprive the person of liberty at the time the conveyance took place, for example admission to hospital by ambulance in an emergency. Even where there was an expectation that the person would be deprived of liberty within the care home or hospital, we think it unlikely that the journey itself would be of a nature or sufficient duration to constitute a deprivation of liberty. We believe, therefore, that in most cases a person could be lawfully conveyed under the wider provisions of the Mental Capacity Act if it is considered to be in their best interests to be in the hospital or care home.

79 The best interests principle would apply to the conveying in the same way that it applies to any other acts done under the Mental Capacity Act. This would involve the consideration of best interests in deciding whether to convey someone, regardless of whether or not the conveyance took place before or after the deprivation of liberty assessment process had been undertaken.

80 A deprivation of liberty is more likely to arise in respect of acts subsequent to the conveying, for example by keeping the person in the hospital or care home in a totally restrictive manner. But the deprivation of liberty authorisation process already carries with it adequate safeguards around the assessment of, and rights to challenge, any such deprivation of liberty. The key issue is whether the person should be deprived of liberty in the care home or hospital and the safeguards that are being put in place to protect the person's human rights in this respect. We will reflect in the Code of Practice[47] the importance of considering the impact of any transportation as part of assessing best interests**.** In practice, many people who will become subject to the proposed Mental Capacity Act deprivation of liberty safeguards will already be accommodated in hospitals or care homes at the time that a change in their care regime brings them within the scope of the safeguards, so the conveying issue will not arise.

81 We do accept, however, that, in a very few cases, there may be exceptional circumstances, for example where it is necessary to do more than persuade or restrain the person for the purpose of conveyance, or perhaps if the journey was exceptionally long, where transportation may amount to a deprivation of liberty and it may be necessary to seek an order from the Court of Protection where additional consideration of the particular circumstances of the case would be an extra protection for the individual (or consider use of the 1983 Act). We do not therefore consider that it is desirable to extend authorisations to cover these rare cases, because we do not think it would strengthen the protections for the person concerned.

[47] The Code of Practice to the Mental Capacity Act 2005 covers both England and Wales, and as such the relevant part of this Code on the Bournewood proposals will also cover both England and Wales.

19 The proposals to amend the Mental Capacity Act are detailed and complex and we question whether they will be readily understood by proprietors of residential care homes, even with the benefit of professional advice. (Paragraph 90)

82 We recognise that there are challenges for the care home sector in implementing the deprivation of liberty safeguards and we are working with the care home representative organisations on how best to support their members. We also accept that it is essential to provide training and easy to use information and guidance on the deprivation of liberty safeguards. We are working on an implementation strategy to achieve this that will start from the premise of asking NHS and social care staff, service users and families what they would find useful.

83 The Government will be investing in a wide communications strategy to ensure that providers of care and treatment are aware of the new safeguards. This will include the provision of Code of Practice guidance, a first draft of which is available on the Government of Health website. It is intended that this Code of Practice guidance will be the subject of a formal consultation process once the deprivation of liberty provisions pass through the Parliamentary process.

84 We expect care homes to become increasingly familiar with, and confident in understanding and applying, the Mental Capacity Act provisions as they come into force. In that context, they will routinely be considering whether residents have the capacity to consent to elements of their care plan. We accept that identifying whether someone who lacks capacity is being deprived of liberty raises a new responsibility that may seem daunting when it is unfamiliar. However, care home managers are already required to consider how to promote choice, independence and involvement of residents and their friends and family in decision making and in practice their role is not likely to be burdensome because in the vast majority of cases it will be perfectly clear that the person is not deprived of liberty.

85 We remain confident that proprietors of residential care homes will be fully conversant with their responsibilities in respect of the deprivation of liberty safeguards in advance of implementation of the safeguards.

20 In our opinion, to charge someone for accommodation in which they are deprived of their liberty potentially engages civil rights and obligations, and therefore the right of access to a court to determine those rights under Article 6 of the Convention. There is a potential discrimination for the purposes of Articles 5 and 6 and Article 14, in that a person deprived of their liberty in their own best interests in a hospital will not be charged for the detention whereas a person deprived of their liberty in their own best interests in a care home will. (Paragraph 91)

86 As the Committee is aware, Article 6 of the Convention guarantees the right to a fair and public hearing to determine a person's civil rights and obligations. The Committee has raised concerns about the application of the means testing procedure for charges to care home residents who are detained. The Committee goes on to express concern over the right of access to a court for those people who may be liable to charges for accommodation in which they are detained.

87 It has been a longstanding national policy, applying to all, that healthcare is provided free and personal care is means tested. There are clear national rules on how the means testing system operates. Depending on ability to pay, some care home residents will have their personal care costs fully funded, some will have their care costs part funded and some will pay the full costs themselves. Nothing in the deprivation of liberty provisions calls into question these fundamental principles. The charging system is set nationally by the National Assistance (Assessment of Resources) Regulations 1992 with additional guidance on its operation in the Charging for Residential Accommodation Guide, both of which are amended annually to take account of inflation and any other changes deemed necessary. Complaints about the level of charges levied by a local authority are subject to the usual social services complaints procedures, and any decisions made on charges would be open to judicial review.

88 The national policy includes the provision of free care to care home residents whose primary need is for healthcare with a clear NHS continuing care appeal mechanism, including access to a Court, for cases where there is any dispute about the boundaries between health and personal care costs. Eligibility criteria for NHS funded continuing care are set locally by each Strategic Health Authority (SHAs) in England, and each Local Health Board in Wales, all based on the principle of whether the primary need is for healthcare. Assessment of an individual case against the eligibility criteria is carried out by the Primary Care Trust in England and the Local Health Board in Wales.

89 If a person or their family, or the local authority, wish to appeal against the way in which their case has been assessed against the criteria the first complaints tier is local dispute resolution. The second tier (formal resolution) is to apply to the SHA Independent Review Panel in England, and the Local Health Board Independent Review Panel in Wales. If the complaint is still unresolved, the complainant can follow the NHS Complaint Procedure in both England and Wales.

90 The provision of additional safeguards to protect the human rights of people who are not able to consent to arrangements made for their care is not a reason to alter the mechanisms that apply to commissioning and funding health and social care for all.

91 The Committee has drawn comparison between a person being deprived of their liberty in their own best interests in a hospital, who will not be charged for their care costs, and a person deprived of their liberty in their own best interests in a care home, who may be. However the circumstances are different, a person is in hospital because their primary need is for healthcare and it is necessary for them to be a hospital patient to receive that care. If a person is in a care home and is contributing financially that will be because their primary need is for personal care and not healthcare.

92 It should be highlighted that people receiving the deprivation of liberty safeguards will largely be those with severe learning disabilities and older people with severe dementia or similar problems. In most cases, the residential accommodation provided would be the person's main residence, and the need for the accommodation would have been assessed separately from the decision on deprivation of liberty. Any financial contribution they may make towards the cost of their care is determined by the national policy on means testing as detailed above. We believe that to provide free personal care for all people deprived of liberty in care homes would in fact create new, unacceptable, inequities and potential

discrimination between those care home residents who are deprived of liberty and those who are not.

93 People living in care homes can have a say in which home they reside in, even if a local authority is fully funding their care costs[48]. In the case of a person who is paying for their care, if they or their family wish to choose a different care home and one is available, then they could do so. If the person or their family dispute the deprivation of liberty authorisation because they do not consider that the person should be in a care home at all, they can make an application to the Court of Protection to challenge the authorisation.

(10) Omissions from the Bill

(a) Article 8 and the need for treatment safeguards for Bournewood patients

21 In our view consideration should be given to providing effective supervision and review of decisions to give treatment without consent for mental disorder, where that involves psychotropic medication or other significant interferences with physical integrity, such as Electro Convulsive Therapy. (Paragraph 97)

22 We remain of the view that effective supervision and review requires more than the common law or the Mental Capacity Act currently provide. (Paragraph 101)

23 We consider that where patients are to be given treatment such as sedative medication, Electro Convulsive Therapy or are subject to restraint or seclusion there is a need for some supervision and review, whether that be by a second opinion system or by a visiting inspectoral body such as the Mental Health Act Commission. (Paragraph 101)

94 A Mental Capacity Act deprivation of liberty authorisation only authorises deprivation of liberty. It does not authorise any course of treatment. The provision of treatment to a person being deprived of their liberty must be in accordance with the arrangements and safeguards contained in the Mental Capacity Act as it currently stands. We consider that these arrangements and safeguards comply with the requirements of Article 8 of the Convention. The provisions of Section 4 (Best interests), Section 5 (Acts in connection with care or treatment) and Section 6 (Section 5 acts: limitations) of the Mental Capacity Act are particularly relevant in this context.

95 Treatment decisions in respect of a person who is deprived of their liberty would therefore be governed by the provisions of the Mental Capacity Act in the same way as for any other person who did not have the capacity to consent. The fact that a person is deprived of liberty does not make them any better or worse placed to understand the treatment, or make decisions about it and so it does not alter their need for treatment safeguards.

96 We are confident that the provisions of the Mental Capacity Act relating to treatment decisions pursue the legitimate aim of protecting the health and well-being of individuals lacking capacity in a proportionate manner. The requirements governing decision-making when a person is not able to consent are robust, practical and were the

[48] National Assistance Act 1948 (Choice of Accommodation) Directions 1992 for England and the National Assistance Act 1948 (Choice of Accommodation) Directions 1993 in Wales.

subject of extensive scrutiny in Parliament during the passage of the Mental Capacity Act. They require that:

- Decisions must be taken on the basis of the person's best interests.
- The person must be helped to participate as fully as possible in the decision-making process.
- Their past and present wishes, feelings, beliefs and values, must be considered.
- A specified list of people, including family, friends and carers, must be consulted and their views taken into account in determining what is in the person's best interests.
- Where serious medical treatment is proposed, an Independent Mental Capacity Advocate (IMCA) must be instructed to support and represent the person if there is no one to consult among friends, family and carers.
- An IMCA, or any of the others who need to be consulted, has the right to request a second opinion.
- Treatment decisions may be determined by a valid and applicable advance directive, or by the consent of an attorney if within the authority given to them by the person, or by a deputy if within the authority granted by the Court of Protection.

97 Standards of care provided in hospitals and care homes, whether statutory or independent sector providers are already subject to a monitoring and inspection regime.

98 We consider that these safeguards protect the person's Article 8 rights. They would apply to the examples raised by the Committee of electro convulsive therapy and sedation. If a person is subject to a deprivation of liberty authorisation these safeguards apply in the same way, as do advance decisions. There is an additional safeguard in those cases in which the reason for deprivation of liberty is to enable treatment to take place, in that the benefits of receiving treatment would be considered as part of the independent best interests assessment, which would be subject to the deprivation of liberty review and challenge safeguards. This would be in addition to the other provisions relevant to treatment in the Mental Capacity Act, as outlined above.

99 It is important also to note that the Mental Capacity Act deprivation of liberty safeguards cannot be used to keep people in hospital for treatment for mental disorder if they object and the Mental Health Act could be used instead, except in a case where a donee of Lasting Power of Attorney, or a deputy appointed by the court, consents on the person's behalf to the admission or treatment. The eligibility requirement within the deprivation of liberty assessment process is specifically aimed at identifying whether detention under the Mental Health Act would be more appropriate and, where it is, a Mental Capacity Act deprivation of liberty authorisation could not be given. It is highly likely, for example, that a person who was in hospital for treatment for a mental disorder and who needed to be restrained or secluded would be regarded as objecting and detained under the Mental Health Act rather than being deprived of liberty under the Mental Capacity Act.

(b) Seclusion

24 We urge the Government to ensure that, whatever method of regulation is adopted, sufficient safeguards are included on the face of the bill to ensure that seclusion is only used when strictly necessary and that individuals subject to it should have access to review at intervals to ensure that it is brought to an end when no longer necessary. (Paragraph 110)

100 The Government has considered the recommendation of the Committee and confirms that it will continue with its policy of managing the issue of seclusion through guidance in the Code of Practice, issued under section 118 of the 1983 Act. Officials in the Welsh Assembly Government have indicated that a similar approach will be taken in the Code of Practice for Wales. As detailed in my letter of 17 January 2007 to the Committee, the Government is of the view that the use of primary or secondary legislation as a means of regulating the practice of seclusion does not provide the appropriate flexibility required to best manage patient safety. The Committee will be aware that the Code of Practice makes clear that the sole aim of the use of seclusion is to contain severely disturbed behaviour which is likely to cause harm to others.

101 The Government notes that this approach is consistent with the decision of the House of Lords in *R (Munjaz) v Mersey Care NHS and others*[49] ("*Munjaz*"). The outcome of that case clearly demonstrates that an overly prescriptive approach to the regulation of seclusion is not appropriate.

102 That case also makes it clear that whilst the use of guidance enables a degree of flexibility, in order for departures from the Code of Practice to be lawful there must be demonstrably justifiable cogent reasons for such departures, which the Courts will not shy from scrutinising. The Committee will be interested to note that the Government brought its own amendment to the Bill (see clause 10 (the fundamental principles)) in the House of Lords to codify the status of the Code of Practice in primary legislation, thus ensuring that the high standards of adherence to the guidance expected, as set out in the *Munjaz* judgement, are observed.

103 The Committee will also be interested to note that the draft illustrative Code of Practice and the existing Code of Practice, contain clear guidance to ensure seclusion is only used where necessary for the sole purpose for which it may be used and that review of any patient in seclusion occurs at regular intervals.

Appendix 1b: Letter dated 10 May 2007 from the Office of the Children's Commissioner for England and The Royal College of Psychiatrists

We understand that the Joint Committee on Human Rights (JCHR) may undertake further consideration of the Mental Health Bill and we are writing to endorse the need for a further review and support your suggestion that such a review should take into account issues relating to children and young people. We have written the enclosed paper jointly with colleagues at the Royal College of Psychiatrists who share our concerns.

[49] [2005] UKHL 58.

As you are aware, the question as to how to ensure that children and young people with mental health problems are placed in age appropriate settings has been the subject of intense debate. Other key issues of concern include the need for specialist mental health advocacy and ensuring that the refusal of treatment by Gillick-competent children is not overridden by those with parental responsibility. We hope that all these issues will be considered by the JCHR. However, we would urge that that the JCHR's review pays particular attention to community treatment orders (CTOs) and their likely impact upon children and young people and their families. This is because although the regime for CTOs has been subject to close scrutiny, the implications for applying CTOs to children and young people have not.

CTOs and children and young people

There is no age restriction for CTOs. Thus potentially a child of any age could be made subject to a CTO. Although the Government suggests in its draft Illustrative Code of Practice to the Mental Health Act 1983 that very few children and young people will be made subject to CTOs, no support is given for this statement. CTOs will only apply to individuals who have been admitted to hospital for treatment, but it is not known how many children and young people this will affect as currently data on the age of detained patients is not collected nationally. While the House of Lords' amendment places more stringent restrictions on the use of CTOs and would therefore be likely to reduce the number of people made subject to them, the Government has made clear that it intends to remove this amendment.

CTOs and community treatment provisions

We have very serious concerns about the provisions concerning treatment of community patients who lack capacity (in the case of those aged 16 or over) or competence (in the case of those aged under 16) to make treatment decisions. It is unclear how these provisions will work in practice and there are insufficient safeguards for individuals under the age of 18. The attached paper details our collective concerns in more detail which can be summarised as follows:

- Insufficient guidance on 'competence': Child community patients (individuals under 16 years) can be treated without their consent if they are not competent to consent to the treatment proposed. However, there is no definition of 'competence' in relation to child community patients and there is insufficient guidance on how to assess it.

- Lack of involvement of those with parental responsibility: The Bill makes no provision for those with parental responsibility to be consulted in relation to treatment decisions on behalf of child community patients who lack competence to make such decisions. It is not clear whether a person with parental responsibility for a young person aged 16 or 17 who lacks capacity would be consulted about the proposed treatment.

- There are fewer safeguards for children and young people under 18 years than for individuals aged 18 or over: The Bill makes provision for certain individuals authorised to act on the patient's behalf under the Mental Capacity Act 2005 (MCA 2005) to be consulted about treatment decisions in relation to an adult community patient who lacks capacity. However, there is no provision for any person to be consulted as to whether a child community patient who lacks capacity should be given the treatment

proposed. Although adult community patients are able to make advance refusals of treatment or appoint individuals ('donees') under the Lasting Power of Attorney provisions of the MCA 2005 to make decisions (including treatment decisions) on their behalf, these powers are not available to individuals under the age of 18. (The main provisions of the MCA 2005 do not apply to individuals under 16 years and the powers to make advance refusals of treatment or appoint a donee apply only to those 18 years or over.)

- Lack of clarity on the interrelationship with the Mental Capacity Act 2005: There may be cases in which the Court of Protection or a deputy appointed by the Court of Protection is engaged in decision making in relation to a young person aged 16 or 17 years but it is not clear how the role of deputies or the Court of Protection in authorising/refusing treatment in relation to community patients will work in practice.

- Lack of clarity on when a patient's objection to treatment may be overridden: The provisions relating to non-emergency treatment for both adult and child community patients provide that treatment can be given irrespective of the patient objection if it is not necessary to use force against the patient in order to give the treatment. However, 'force' is not defined. Thus it is not clear what action would fall within this term and therefore not be permitted and what action would be authorised.

- Inadequate safeguards for children and young people: The provisions relating to non-emergency treatment raise serious concerns for children and young people subject to CTOs. They will be particularly vulnerable to the threat of the use of 'force' and may allow treatment to be given without understanding its nature or purpose.

- Lack of clarity on circumstances in which emergency treatment may be given: The circumstances in which emergency treatment – and the use of force to provide such treatment - will be authorised are unclear. The power to forcibly treat children and young people in the community who may be actively resisting such treatment is very worrying. Further guidance on when emergency treatment would be appropriate is essential.

CTOs: human rights implications for children and young people

We believe that the concerns we have outlined above raise important human rights issues. For example, the assessment of an individual's capacity/competence and decisions to treat without consent (in some cases overriding the patient's objection and using force) are likely to engage Article 8 of the European Convention of Human Rights (the right to private and family life). Issues relating to the involvement of those with parental responsibility are also likely to engage Article 8.

The United Nations Convention on the Rights of the Child (UNCRC) is also of significance. As you know, two key principles of the UNCRC are that the best interests of the child must be a primary consideration in all actions concerning children (Article 3) and that children's views must be considered and taken into account in all matters affecting them (Article 12). We are concerned that insufficient attention has been given to these principles in the provisions relating to CTOs. In particular we are concerned that there is insufficient protection afforded to children subject to CTOs. Furthermore, there are no

provisions on the face of the Bill to ensure that the views of the child or young person subject to a CTO are taken into account.

For these reasons, we hope that the further review of the Mental Health Bill undertaken by your Committee will address issues relating to children and young people and, in particular, will inquire into the community treatment provisions of CTOs and how they might impact on children and young people.

We would welcome the opportunity of discussing our concerns with the JCHR in more detail.

Community Treatment Orders and Treatment in the Community

Mental Health Bill

Issues of Concern

Summary

1 This paper has been prepared on behalf of the Royal College of Psychiatrists and the Children's Commissioner for England.

2 The Children's Commissioner for England ('the Commissioner') was established under the Children Act 2004 as an independent organisation with the responsibility for promoting awareness of the views and interests of children in England.

3 The Royal College of Psychiatrists ('the RCP') is the leading medical authority on mental health in the United Kingdom and the Republic of Ireland and is the professional and educational organisation for doctors specialising in psychiatry.

4 Currently the Mental Health Bill [HL] ('the Bill') is being considered by the Mental Health Public Bill Committee in the House of Commons. The Commissioner's submission to this Committee is included as Appendix 1 of this paper.

5 This paper sets out the particular concerns of the Commissioner and the RCP in relation to the treatment provisions for community patients subject to CTOs who are under the age of 18.

6 The Government has stated on numerous occasions that CTOs are not intended to introduce powers to forcibly treat people in the community. However, under the provisions of the Bill, individuals subject to CTOs can be treated without their consent if they lack 'capacity' (in the case of a person 16 or over) or 'competence' (in the case of a person under 16) if certain conditions are met. In relation to emergency treatment the use of force may be permitted. The general concerns of the Commissioner and the RCP about these provisions are as follows:

- There are insufficient safeguards for treatment without consent.
- The provisions are complex, cumbersome and confusing.

- There is insufficient guidance in the Draft Illustrative Code on the Mental Health Act 1983 ('the draft Code') on how these provisions are intended to work.

7 The draft Code suggests that very few children and young people will be made subject to CTOs.[50] No support is given for this statement. Given the problems inherent in the CTO provisions, the disadvantages for children and young people under the age of 18 years would seem to far outweigh any purported benefits.

8 The RCP and Commissioner's specific concerns are as follows:

- Insufficient guidance on 'competence': Child community patients can be treated without their consent if they are not competent to consent to the treatment proposed. However there is no definition of 'competence' in relation to child community patients and there is insufficient guidance on how to assess it.

- Lack of involvement of those with parental responsibility: The Bill makes no provision for those with parental responsibility to be consulted in relation to treatment decisions on behalf of child community patients who lack competence to make such decisions. It is not clear whether a person with parental responsibility for a young person aged 16 or 17 who lacks capacity would be consulted about the proposed treatment.

- There are fewer safeguards for children and young people under 18 years than for individuals aged 18 or over: The Bill makes provision for certain individuals authorised to act on the patient's behalf under the Mental Capacity Act 2005 (MCA 2005) to be consulted about treatment decisions in relation to an adult community patient who lacks capacity. However, there is no provision for any person to be consulted as to whether a child community patient who lacks capacity should be given the treatment proposed. Although adult community patients are able to make advance refusals of treatment or appoint individuals ('donees') under the Lasting Power of Attorney provisions of the MCA 2005 to make decisions (including treatment decisions) on their behalf, these powers are not available to individuals under the age of 18. (The main provisions of the MCA 2005 do not apply to individuals under 16 years and the powers to make advance refusals of treatment or appoint a donee apply only to those 18 years or over.)

- Lack of clarity on the interrelationship with the Mental Capacity Act 2005: There may be cases in which the Court of Protection or a deputy appointed by the Court of Protection is engaged in decision making in relation to a young person aged 16 or 17 years but it is not clear how the role of deputies or the Court of Protection in authorising/refusing treatment in relation to community patients will work in practice.

- Lack of clarity on when a patient's objection to treatment may be overridden: The provisions relating to non-emergency treatment for both adult and child community patients provide that treatment can be given irrespective of the patient's objection if it is not necessary to use force against the patient in order to give the treatment. However, 'force' is not defined. Thus it is not clear what action would fall within this term and therefore not be permitted and what action would be authorised.

[50] Para. 31.37. The draft Code is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_062946.

- Inadequate safeguards for children and young people: The provisions relating to non-emergency treatment raise serious concerns for children and young people subject to CTOs. They will be particularly vulnerable to the threat of the use of 'force' and may allow treatment to be given without understanding its nature or purpose.

- Lack of clarity on circumstances in which emergency treatment may be given: The circumstances in which emergency treatment – and the use of force to provide such treatment - will be authorised are unclear. The power to forcibly treat children and young people in the community who may be actively resisting such treatment is of deep concern to the RCP and the Commissioner. Further guidance on when emergency treatment would be appropriate is essential.

Introduction

The Children's Commissioner for England

9 The Children's Commissioner for England ('the Commissioner') was established under the Children Act 2004 as an independent organisation with the responsibility for promoting awareness of the views and interests of children in England. Professor Sir Al Aynsley-Green became the first Children's Commissioner for England on his appointment in July 2005.

The Royal College of Psychiatrists

10 The Royal College of Psychiatrists ('the RCP') is the leading medical authority on mental health in the United Kingdom and the Republic of Ireland and is the professional and educational organisation for doctors specialising in psychiatry.

The Children's Commissioner's main concerns about the Mental Health Bill

11 The Mental Health Bill [HL] ('the Bill') is being considered by Mental Health Public Bill Committee in the House of Commons. The Commissioner's submission to this Committee is included as Appendix 1 of this report. The Commissioner's five key areas of concern relate to:

- Retaining the amendment to the Bill that requires children and young people to be admitted to age appropriate mental health facilities;

- Ensuring that the refusal of treatment by Gillick-competent children are not overridden by those with parental responsibility;

- Highlighting the need for specialist mental health advocacy services to be made available to children and young people receiving mental health services.

- Highlighting the need to improve discharge arrangements and care planning for children and young people detained under the MHA 1983.

- Raising questions about the likely effectiveness of the Bill's proposed community treatment orders (CTOs) in relation to children and young people and highlighting concerns about the treatment provisions for community patients who lack capacity/competence.

Purpose of this paper

12 This paper sets out the RCP and the Commissioner's particular concerns in relation to the treatment provisions for community patients subject to CTOs under the age of 18. It is unclear how these provisions will work in practice and there are insufficient safeguards for individuals under the age of 18. This paper sets out the reasons for the RCP and Commissioner's concerns.

Application of CTOs to children and young people

13 The RCP and Commissioner's general concern in relation to CTOs is that there is insufficient information on the effectiveness of such provisions in relation to children and young people. It is not clear why the Government has decided that such powers should be applicable to children and young people, particularly given that the powers that currently apply to individuals living in the community (guardianship and supervised discharge) have a lower age limit of 16.

14 The draft Illustrative Code of Practice to the Mental Health Act ('the draft Code') suggests that very few children and young people will be made subject to CTOs[51]. No support is given for this statement. Furthermore, given the problems inherent in the CTO provisions in relation to CTOs the disadvantages for children and young people under the age of 18 years would seem to far outweigh any purported benefits.

Overview of CTOs

15 Chapter 4 of the Bill sets out the general regime for CTOs. These include the criteria for making a CTO, the conditions that can be applied to a person subject to a CTO, the duration of the CTO, the power to recall a person subject to a CTO to hospital and the authority to treat individuals who are subject to a CTO and who have not been recalled to hospital. There is no age restriction on CTOs. The provisions will '*…allow some patients with a mental disorder to live in the community whilst still subject to powers under the 1983 Act…*' They will '*…remain under compulsion and liable to recall to hospital for treatment.*'[52]

Scope of the CTO treatment provisions

16 Clause 35 ('Authority to treat') introduces a range of consent to treatment provisions which will apply to those individuals who are subject to CTOs and have not been recalled to hospital. They cover 'adult community patients' (those aged 16 years and over) and 'child community patients' (those aged under 16 years). The provisions apply to 'relevant treatment' which includes medication for mental disorder but not treatments falling within section 57 MHA 1983 (treatment such as psycho-surgery) or ECT (electro-convulsive therapy)[53]. The Bill provides that relevant treatment cannot be given to a community patient unless there is authority to give the treatment. For certain types of treatment it will also be necessary for 'the certificate requirement' to be met[54].

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[51] Para. 31.37. The draft Code is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_062946.

[52] Explanatory Note to the Bill, para. 108.

[53] See clause 64A(b).

[54] A second opinion appointed doctor (SOAD) must certify in writing that the treatment may be given. This is not required for emergency treatment under clause 64G. Nor does it apply to the administration of medication for mental disorder for an initial period, of *'…one month from when a patient leaves hospital or three months from*

17 Individuals subject to CTOs who have capacity (or in the case of child community patients 'competence') to make treatment decisions can only be treated in the community if they consent to such treatment. If they refuse treatment this is likely to lead to their recall to hospital, where they can be treated without their consent.

18 The circumstances in which the Bill authorises the treatment of a community patient who lacks capacity/competence fall into three broad categories:

- Consent by a person authorised to make decisions on the patient's behalf: Clause 64G(2)(b) of the Bill provides that individuals authorised under the Mental Capacity Act 2005 (the MCA 2005)[55] to act on the patient's behalf may give consent to treatment being proposed where the patient lacks capacity to make such decisions.

- Non-emergency treatment: Adult and child community patients can be given non-emergency treatment without consent if they lack capacity/competence and specified conditions are met. (See clauses 64D and 64F.)

- Emergency treatment: An adult or child community patient who lacks capacity/competence can be given emergency treatment and in such cases the Bill provides that force can be used where it is a proportionate response to prevent harm to the patient. (See clause 64G.)

Comments on the Community Treatment Provisions

General concern: insufficient safeguards for treatment without consent

19 The Government has stated on numerous occasions that CTOs are not intended to introduce powers to forcibly treat people in the community. However, under the provisions of the Bill, individuals can be treated without their consent if they lack 'capacity' (in the case of a person 16 or over) or 'competence' (in the case of a person under 16) if certain conditions are met. In relation to emergency treatment the use of force may be permitted.

20 The CTO provisions relating to treatment in the community are complex, cumbersome and confusing. There is insufficient guidance in the Draft Illustrative Code on the Mental Health Act 1983 ('the draft Code') on how these provisions are intended to work.

21 Furthermore, for the reasons set out below, the RCP and the Commissioner believe that there are insufficient safeguards for those individuals receiving treatment in the community without their consent. There are particular concerns about the provisions relating to children and young people.

No definition of 'competence' and lack of guidance on how to assess it

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when the medication was first given to the patient (whether that medication was given in the community or in hospital) whichever is later).' (see Explanatory Note to the Bill para. 138, footnote 2).

[55] The MCA 2005 sets out the legal framework for making decisions (including treatment decisions) on behalf of people over the age of 16 who lack capacity to make such decisions for themselves. The main provisions are due to come into force in October 2007.

22 Adult community patients may be treated in community without their consent in certain circumstances provided that they have been assessed to lack capacity. The Bill makes clear that the person's capacity will be considered in accordance with the Mental Capacity Act 2005[56] ('the MCA 2005'). Child community patients may also be treated in the community without their consent in certain circumstances, provided that they have been assessed to lack 'competence'. However there is no definition of 'competence' in the Bill.

23 It is assumed that the term 'competence' refers to 'Gillick competence'. The Draft Illustrative Code on the Mental Health Act 1983 ('the draft Code') refers to a 'Gillick competent child'. In *Gillick v West Norfolk and Wisbech Area Health Authority*[57] the House of Lords held that a child under the age of 16 can give valid consent to any medical treatment if the child has the capacity to make such a decision for him/herself. The draft Code states that a 'Gillick competent child':

'…can give a valid consent to medical treatment. A child should be regarded as 'Gillick competent' if the doctor concludes that he or she has the capacity to make the decision to have the proposed treatment and is of sufficient understanding and intelligence to be capable of making up his/her own mind,' (31.9)

The draft Code provides very little guidance on assessing whether a child is 'Gillick competent' and there is no specific guidance on assessing a child community patient's competence to consent to treatment.

Lack of involvement of those with parental responsibility

24 The Bill provides that individuals authorized under the MCA 2005 to act on the adult community patient's behalf may give consent or object to treatment being proposed where the patient lacks capacity to make such decisions.

- There is no equivalent provision in relation to child community patients. Where the child is not competent to make such treatment decisions, would a person with parental responsibility be able to consent or object to the treatment on the child's behalf?

- The situation for individuals aged 16 or 17 is also unclear. This is because, although they are treated as adult community patients, some of the key provisions incorporating powers under the MCA 2005 do not apply to individuals under 18 years. These issues are discussed below. It is not clear whether a person with parental responsibility would be consulted about the proposed treatment.

Fewer safeguards for children and young people under 18 years

25 The Bill provides that adult community patients who lack capacity cannot be treated if giving such treatment conflicts with decisions made in accordance with powers under MCA 2005. Table 1 below sets out some of the conditions which must be met in non-emergency situations before a person can give treatment for mental disorder to patients who lack the capacity/competence to make treatment decisions.

[56] See 64K (2) and (3).

[57] [1985] 3 All ER 402.

Table 1: Conditions for non-emergency treatment

Adults 18 & over	Adults aged 16– 17 years	Child under 16
Patient does not object/force not required	Patient does not object/force not required	Patient does not object/ force not required
No conflict with advance refusal of treatment under Mental Capacity Act 2005		
No objection from donee of LPA		
No objection from deputy/ Court of Protection	No objection from deputy/ Court of Protection	

26 As Table 1 shows, there is a significant distinction between the provisions for adults and children and young people in relation to non-emergency treatment. For example:

- If an adult community patient had made an advance refusal of treatment when s/he had capacity, such treatment could not be given to the patient if s/he subsequently lacks capacity. Individuals under the age of 18 years cannot make advance refusals of treatment.

- If the person had appointed a person to make decisions on his/her behalf under a Lasting Power of Attorney (the donee), then the donee can object to the treatment being given. Individuals under the age of 18 years cannot appoint donees under the Lasting Power of Attorney provisions of the MCA 2005.

- If the Court of Protection had appointed a deputy to make decisions about the person's treatment then the deputy can object to the treatment being given. A deputy might be appointed to act on behalf of a 16 or 17 year old but not for a person under 16 years (the main provisions of the MCA apply to individuals aged 16 or over).

27 Whereas the Bill makes provision for certain individuals to be consulted in relation to the treatment of an adult community patient who lacks capacity, there is no provision for any person to be consulted as to whether a child community patient who lacks competence should be given the treatment proposed. There is no specific reference to individuals with parental responsibility either in the Bill or in the Code in relation to the provision of treatment to a child community patient who lacks competence. Presumably those with parental responsibility would need to be consulted but this needs to be clarified.

28 Individuals aged 16 or 17 years cannot make advance refusals of treatment or appoint donees under the Lasting Power of Attorney provisions of the MCA 2005. Thus, unless a deputy has been appointed to act on the person's behalf, those aged 16 and 17 who lack capacity to make treatment decisions will be in the same position as individuals under 16 who lack the competence to make treatment decisions. It is not clear whether in such cases those with parental responsibility would be consulted.

Lack of clarity on the interrelationship with the Mental Capacity Act 2005

29 As Table 1 shows, the Bill provides for the involvement of individuals authorised under the Mental Capacity Act 2005 (the MCA 2005) to act on the person's behalf in relation to adult community patients (i.e. those over 16) who lack capacity. As discussed above, the provisions relating to advance refusals of treatment and donees acting under the Lasting Power of Attorney provisions of the MCA 2005 do not apply to individuals under the age of 18 years.

30 There may be cases in which the Court of Protection or a deputy appointed by the Court of Protection is engaged in decision making in relation to a young person aged 16 or 17 years but it is not clear how the role of deputies or the Court of Protection in authorising/refusing treatment in relation to community patients will work in practice. For example, under the provisions of the Bill, adult community patients who lack capacity cannot be given non-emergency treatment if this conflicts with *'a decision made by a donee or deputy or the Court of Protection'*.[58] This raises a number of points requiring clarification:

- Deputies are required to act within the scope of their authority and in accordance with the MCA 2005. This means that when considering whether to object to the treatment being given the deputy must consider whether this is in the patient's best interests (see section 4 of the MCA 2005). What if the deputy refuses to agree to the treatment being given on the basis that it is not in the person's best interests? Would this be an issue that could be referred to the Court of Protection?

- Deputies are intended to be given powers that are *'as limited in scope and duration as is reasonably practicable'*. Given that the duration of a CTO is not fixed (CTOs will be made for an initial period of six months but can then be renewed) in what circumstances would the appointment of a deputy with powers to make decisions about treatment under a CTO be considered appropriate?

- In what circumstances is it likely that the Court of Protection would be asked to authorise treatment for a community patient and over what duration?

Lack of clarity on when a patient's objection to treatment may be overridden

31 The provisions relating to non-emergency treatment for both adult and child community patients provide that treatment can be given irrespective of the patient objection if it not necessary to use force against the patient in order to give the treatment. Treatment can be given if person giving the treatment has:

'…reason to believe that the patient so objects, but it is not necessary to use force against the patient in order to give the treatment.'

The draft Code gives little guidance on this, save to reiterate that it is permissible to treat a patient who objects if no force is needed[59]. There is no definition of 'force' in the Bill. Paragraph 16.23e of the draft Code states:

[58] A 'donee' is a person who has been appointed to act under the Lasting Powers of Attorney provisions of the MCA 2005. A deputy is a person who has been appointed by the Court of Protection to make decisions on behalf of a person who lacks capacity. The Court of Protection is a court with powers to make a range of decisions in relation to individuals who lack capacity, including determining disputes as to whether individuals lack capacity or not. For further information see the Mental Capacity Act 2005 and the Code of Practice to the Mental Capacity Act 2005.

[59] Para. 16.23e.

'Force here means the application of physical force (to whatever extent) to the patient.

It goes on to state:

'…However if force is needed and the person giving the treatment reasonably believes that the person objects to being given it, or would object if they were in a position to do so the treatment cannot be given in the community (unless it is an emergency) and recall to hospital may be necessary.'

32 Thus it is not clear what action would be authorised in treating a patient who is objecting. In comparison, the MCA 2005 places restrictions on the use of restraint, stating that a person restrains another if the person '*uses, or threatens to use, force to secure the doing of an act which P [the person who lacks capacity] resists*'[60]. The lack of definition of 'force' raises questions such as:

- Would injecting a person who has made clear that they object to the treatment being given be a use of 'force' even if the person did not resist this?
- Is the term 'force' limited to physical action or would psychological power, coercion or veiled threats be included? For example, would the threat of recalling the patient to hospital be considered to be 'force'?

Lack of clarity on circumstances in which emergency treatment may be given

33 In his message to the Mental Health Act Scoping Study Review Team (also known as the Richardson Committee) which was established by the government to advise on how the Mental Health Act 1983 could be reformed, Paul Boateng, then Parliamentary Under Secretary of State for Health stated:

'But let me be absolutely and unequivocally clear on one point about this. We are not talking about forcibly administering treatment over the individual's kitchen table. The new arrangements should only require compliance with treatment within an appropriate clinical setting and therefore may need powers for compulsory conveyance.'[61]

34 On 28th November 2006, during the Bill's Second Reading Debate, the Minister of State, Department of Health (Lord Warner), Mental Health Bill, stated that the provisions are:

'…not about forcing people to have treatment in the community'. [62]

However, as Lord Warner's additional comments acknowledge, despite these assertions the Bill does allow patients to be treated forcibly in the community in certain circumstances:

'Forcible treatment against a patient's will cannot be given in the community where the patient lacks the capacity to consent unless the treatment is immediately necessary—for example, to save the patient's life.'

[60] See section 6(4) MCA 2005.

[61] Appendix C, Report of the Expert Committee, Review of the Mental Health Act 1983, November 1999.

[62] House of Lords, col. 654.

35 The circumstances in which treatment can be forcibly administered are wider than to save the patient's life. The circumstances provided for by the Bill include being immediately necessary to prevent a serious deterioration of the patient's condition and preventing the patient from behaving violently. Paragraph 16.24a of the draft Code states:

'Within certain limits, section 64G permits force to be used in emergencies to treat a patient who lacks capacity or competence to consent to it. This is intended to be used where the patient's interests are better served by being treated with the use of force in the community than by being transported to hospital for treatment'.

The paragraph then goes on to state:

'*…Any decision to treat a patient without capacity or competence in an emergency under s64G by an approved clinician or by a person under the direction of that clinician must take the following considerations into account…*' [The considerations include that reasonable steps are required to ascertain whether the person has capacity/competence to consent and whether the force to be used is necessary.]

36 Although the draft Code refers to treatment being given by, or under the direction of, an approved clinician this is not included in the legislation. Although this is a condition for non-emergency treatment under clause 64D (adult community patients) and 64F (child community patients), Clause 64G (emergency treatment) does not include a requirement that the treatment is given by an approved clinician or by a person under the direction of that clinician.

37 Thus the circumstances in which emergency treatment – and the use of force to provide such treatment - will be authorised are unclear. The power to forcibly treat children and young people who may be actively resisting such treatment in the community is of deep concern to the RCP and the Commissioner. Further guidance on when emergency treatment would be appropriate is essential.

Bills and other documents reported on by the Committee (Session 2006-07)

*indicates a Government Bill

Bills which engage human rights and on which the Committee has commented substantively are in bold

BILL TITLE	*REPORT NO*
Bournemouth Borough Council Bill	2nd
Concessionary Bus Travel Bill*	**3rd**
Consolidated Fund Bill*	2nd
Consolidated Fund (Appropriation) Bill*	11th
Consumers, Estate Agents and Redress Bill*	**2nd and 11th**
Corporate Manslaughter and Corporate Homicide Bill*	**2nd**
Crossrail Bill*	2nd
Digital Switchover (Disclosure of Information) Bill*	2nd
Rating (Empty Properties) Bill*	15th
Finance Bill*	13th
Fraud (Trials without a Jury) Bill*	**2nd**
Further Education and Training Bill*	2nd
Greater London Authority Bill*	2nd
Income Tax Bill*	2nd
Investment Exchanges and Clearing Houses Bill*	2nd
Justice and Security (Northern Ireland) Bill*	**5th**
Legal Services Bill*	**3rd**
Local Government and Public Involvement in Health Bill*	**11th and 13th**
London Local Authorities Bill	2nd
London Local Authorities and Transport for London Bill	2nd
Manchester City Council Bill	2nd
Mental Health Bill*	**4th and 15th**
National Trust (Northern Ireland) Bill	2nd
Northern Ireland (St Andrews Agreement) Bill*	2nd
Northern Ireland (St Andrews Agreement) (No. 2) Bill*	13th
Offender Management Bill*	**3rd**
Parliament (Joint Departments) Bill*	11th
Planning-Gain Supplement (Preparations) Bill*	2nd
Pensions Bill*	2nd
Rating (Empty Properties) Bill*	15th
Serious Crime Bill	**12th**
Sexual Orientation Regulations	**6th and 11th**
Statistics and Registration Service Bill*	2nd
Tribunals, Courts and Enforcement Bill*	**2nd, 5th and 11th**

UK Borders Bill*	**13th**
Welfare Reform Bill*	**2nd and 11th**
Whitehaven Harbour Bill	2nd