Legislative Scrutiny: Mental Health Bill

Fourth Report of Session 2006-07

Ordered by The House of Lords to be printed 29 January 2007
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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

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<td>Lord Fraser of Carmyllie</td>
<td>Mr Douglas Carswell MP (Conservative, Harwich)</td>
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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: Nick Walker (Commons Clerk), Bill Sinton (Lords Clerk), Murray Hunt (Legal Adviser), Judy Wilson (Inquiry Manager), Angela Patrick (Committee Specialist), Jackie Recardo (Committee Assistant), Suzanne Moezzi (Committee Secretary) and James Clarke (Senior Office Clerk).

Contacts

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Summary

The Committee decided to conduct further scrutiny of this Bill on the basis of preliminary advice from its Legal Adviser that it raised significant human rights issues. It appointed Professor Philip Fennell, Professor of Law at Cardiff Law School, as a specialist adviser. In reaching the conclusions set out in this Report, the Committee has taken into account the Minister’s reply to its request for further information and explanation, as well as evidence from a range of bodies and individuals (paragraphs 1-3).

In the Committee’s view, the Bill raises nine main human rights compatibility issues and omits two means to enhance or promote human rights (paragraphs 4-6).

In relation to detention on grounds of unsoundness of mind, the Committee considers that, given the Bill’s new, broad definition of mental disorder, it is desirable to restate on the face of the Bill key non-discrimination principles so as to avoid discrimination on grounds of sexual orientation and sexual identity. In the Committee’s view the Bill’s provisions on procedures for lawful psychiatric detention appear broadly to comply with the case law on Article 5 (1) (e) of the Convention (paragraphs 7-16).

As to conditions of compulsion, in the Committee’s view there appears to be no Convention obstacle to replacing “treatability” with “availability of appropriate treatment” as a condition of detention. Nevertheless, the Committee is mindful of the strongly held view of psychiatrists that in any replacement of the “treatability” test the treatment available should be likely to be of therapeutic benefit to the patient (paragraphs 17-20).

As regards renewal of detention, the Committee is concerned that, while initial detention would still be based on objective medical expertise, as required for compatibility with Article 5 ECHR, the Bill proposes renewal of detention by the responsible clinician, who need not be a doctor, reporting to the managers of the hospital that the conditions justifying detention continue to be met. The Committee does not agree with the Government’s wider definition of objective medical expertise. The Committee is also concerned that under the Bill a report renewing detention, not necessarily by a medical practitioner, is subject to no scrutiny by any higher authority other than the Mental Health Review Tribunal (MHRT) and takes the view that it may be difficult for responsible clinicians to provide the Tribunal with objective medical expertise (paragraphs 17-30).

In the Committee’s view the Bill’s provisions for a patient to displace his nearest relative meet the terms noted by the European Court of Human Rights in a recent case. The Committee considers however that effective safeguards on the suitability of nearest relatives should be made more explicit on the face of the Bill (paragraphs 31-37).

The Committee considers that any procedure whereby hospital managers authorise Community Treatment Orders should be in the legislation not the Code of Practice so as to be compatible with the Convention requirement that interferences with private life must be in accordance with the law (paragraphs 38-51).

The Committee considers in relation to the right to seek review of conditions in a Community Treatment Order that the requirement that restrictions on conduct 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 (paragraphs 52-58).

As regards treatment without consent, the Committee considers that the principal legitimate aim for which medical treatment may be imposed under Article 8(2) ECHR is health. It must also be in accordance with law. For this reason, in the Committee’s view the full appropriateness test should be in the legislation rather than in a Code of Practice (paragraphs 59-66).

The Committee considers that forcible feeding should be subject to the same safeguards as apply to other invasive forms of treatment (paragraphs 67-69).

As regards the treatment of mentally incapacitated patients, the Committee is mindful of the Strasbourg Court’s ruling that, where a compliant incapacitated person is to be deprived of his liberty, this must be done in accordance with a procedure prescribed by law. Since the bill’s proposals to amend the Mental Capacity Act are detailed and complex, the Committee questions whether they will be readily understood by proprietors of residential care homes. In the Committee’s 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 (paragraphs 70-91).

The Committee regrets the bill’s omission of any provision for effective supervision and review of decisions to give treatment without consent for mental disorder to patients deprived of their liberty under mental capacity legislation, where the treatment involves psychotropic medication or other significant interferences with physical integrity. The Committee considers that where patients are so treated or are subject to restraint or seclusion there is need for some supervision and review by a second opinion system or by a visiting inspectoral body such as the Mental Health Act Commission (paragraphs 92-101).

Similarly the Committee urges the Government to make provision for sufficient safeguards to ensure that seclusion is used only when strictly necessary and that individuals subject to it should have access to review at intervals so that it is brought to an end when no longer necessary (paragraphs 102-110).
1. Introduction

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<td>HL Bill 34</td>
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1. This is a Government Bill introduced in the House of Lords on 16 November 2006. Lord Warner of Brockley has made a statement of compatibility with Convention rights under s. 19(1)(a) of the Human Rights Act 1998. The Explanatory Notes which accompany the Bill set out the Government’s view of the Bill’s compatibility with Convention rights at paragraphs 214-223. We also received a letter dated 17 November 2006 from Rosie Winterton MP, Minister of State for Health Services, drawing out particular issues relating to human rights that the Government has sought to address in the Bill. A Draft Illustrative Code of Practice has also been published by the Department to show how the Mental Health Act 1983 Code of Practice would be likely to change in the light of the Bill.

2. On 27 November 2006 we decided to conduct further scrutiny of this Bill on the basis of preliminary advice from our Legal Adviser that it raised significant human rights issues. Given the complexity of the Bill and of mental health law, we appointed Professor Philip Fennell, Professor of Law at Cardiff Law School, as a specialist adviser to assist us with our scrutiny of the Bill. On the basis of Professor Fennell’s advice, we wrote to the Minister on 19 December asking for further information or explanation on a number of points. We received a response on 18 January, which we have taken into account in reaching the conclusions set out in this Report. We received written evidence from the Mental Health Alliance and the Council on Tribunals, published as Appendices to this Report, and have taken into account briefings prepared by JUSTICE and the Law Society for Second Reading of the Bill in the Lords. We have also seen a legal opinion dated 6 March 2006 given to MIND by Paul Bowen of Doughty Street Chambers concerning the amendments to the Mental Health Act 1983 which would be necessary to ensure its compatibility with the ECHR. We are most grateful to all those who have assisted us in our scrutiny of this complex Bill.

3. The Bill received its Second Reading in the Lords on 27 and 28 November 2006, and concluded its Committee stage on 29 January 2007.

The Bill’s main provisions

4. The Bill has a number of key provisions:

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1 HL Bill 1-EN.
2 Appendix 1.
3 www.dh.gov.uk/assetRoot/04/14/07/68/04140768.pdf.
4 Appendix 2.
5 Appendix 3
6 Appendix 4 and Appendix 5 respectively.
• It alters the statutory criteria for compulsory admission to psychiatric hospital by broadening the definition of mental disorder, and by removing the requirement that medical treatment in hospital must be likely to alleviate or prevent deterioration in the patient’s condition, replacing it with a new test, that appropriate treatment must be available. This raises the question of the compatibility of the new compulsory admission procedures with the right to liberty in Article 5 ECHR.

• It removes the exclusion in the Mental Health Act 1983 that a person shall not be treated as suffering from mental disorder by reason only of sexual deviancy.

• It seeks to comply with the settlement in JT v United Kingdom, relating to the right to respect for privacy under Article 8 ECHR, by conferring on the patient the right to challenge the suitability of his or her ‘nearest relative’ to act as such for the purposes of the Act.

• It introduces a Community Treatment Order with a view to imposing an effective obligation on patients to accept treatment for mental disorder while resident in the community. This raises issues under Article 8, and potentially under Article 5 ECHR.

• It alters the test for treatment without consent from one where the decision-maker is required to have regard to the likelihood that the treatment will alleviate or prevent deterioration in the patient’s condition to the test that it is appropriate for the treatment to be given. This raises issues under Article 8 ECHR.

• It replaces the requirement that every detained patient have a responsible medical officer (“RMO”) who must be a doctor in charge of their treatment and responsible for renewing detention, by conferring these functions on a responsible clinician (“RC”) who need not be a doctor.

• It replaces the Approved Social Worker (currently the professional responsible for applying for detention under the Mental Health Act) with the Approved Mental Health Professional (“AMHP”).

• It seeks to comply with the ruling of the European Court of Human Rights in HL v United Kingdom by introducing a procedure for the detention of compliant mentally incapacitated adults who need to be deprived of their liberty in their own best interests. This will be achieved by amendments to the Mental Capacity Act 2005. This raises issues of compatibility with Article 5(1) and 5(4) ECHR.

5. Following our scrutiny of the Bill, we consider that its provisions raise nine main human rights compatibility issues, and that there are two significant omissions from the Bill which could have enhanced the protection and promotion of human rights. We consider each of these issues in turn in the remainder of this Report.

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Human rights compatibility issues

(1) Detention on Grounds of Unsoundness of Mind

6. 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. Article 5(1) provides that no-one shall be deprived of his liberty unless the deprivation is carried out in accordance with a procedure prescribed by law and is necessary in a democratic society on one of a number of grounds. One of those grounds, set out in Article 5(1)(e) is deprivation of liberty on grounds of unsoundness of mind. The case law of the European Court of Human Rights specifies that any of the exceptions to the right to liberty in Article 5(1) must be construed narrowly.\(^9\) The case law of the European Court of Human Rights has imposed various limits on the power to detain on grounds of mental disorder, most notably those set out in Winterwerp v the Netherlands.\(^10\) A true mental disorder requires more than mere deviancy from society’s norms. The Winterwerp requirements for a lawful psychiatric detention must be met:

“The very nature of what has to be established before the competent national authority - that is, a true mental disorder - calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder.”\(^ {11} \)

7. Detention under the Mental Health Act 1983, as it would be amended by the Mental Health Bill, requires that the person must be suffering from ‘any disorder or disability of mind.’ The Convention requires that there be a ‘true mental disorder’ established by objective medical evidence. The new broad definition of any disorder or disability of mind has been criticised by JUSTICE as being ‘too broad and sweeping’.\(^ {12} \) Psychiatrists might view a true mental disorder as being one which appears in either the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV-R) or the International Classification of Diseases of the World Health Organization (ICD-10). The problem is that these classificatory systems contain a wide range of conditions including disorders of sexual preference, and dependence on alcohol or drugs, which have not previously come within the scope of national mental health legislation, although dependence on alcohol or drugs may be a ground of detention under Article 5(1)(e).

8. The Government considers that the definition of "mental disorder" is consistent with Article 5(1)(e) which uses the term unsoundness of mind. In Winterwerp v The Netherlands\(^ {13} \) the Court declined to give a definitive definition of ‘unsoundness of mind’ as it was a term whose meaning is constantly evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society’s attitude to mental illness

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\(^9\) Litwa v Poland (2001) 33 EHRR 53.
\(^10\) Winterwerp v the Netherlands (1979) 2 EHRR 387.
\(^11\) Ibid., para 39.
\(^12\) JUSTICE Mental Health Bill Briefing for House of Lords Second Reading November 2006, para 6.
\(^13\) (1979) 2 EHRR 387.
changes, in particular so that a greater understanding of the problems of mental patients is becoming wide-spread.

9. One ground of criticism advanced by JUSTICE relates to the lack of clarity in the scope of the exclusions from the definition of mental disorder. The exclusion in clause 1(3) of the Bill states that dependence on alcohol or drugs is not considered to be a disorder or disability of mind. This is then explained in the Draft Code of Practice as not excluding other mental disorders relating to the use of alcohol or drugs, and the example is given of acute uncomplicated intoxication (drunkenness). The Code therefore creates the possibility that Mental Health Act powers may be used in relation to drunk people, but at the same time states that such a condition would 'only rarely justify the use of powers under the Act'.

10. Currently a person may not be treated as suffering from a mental disorder by reason only of sexual deviancy. This, in the Government's view presents 'an arbitrary obstacle to the use of the Mental Health Act 1983 where it is clinically justified.' The Government's intention is to ensure that paedophiles can be subject to indeterminate detention under the Mental Health Act 1983, without the need for any other accompanying mental disorder. Persons who pose a risk of sexual offences would be open to detention on grounds of personality disorder, but the Government is concerned that the sexual deviancy exclusion might give clinicians discretion not to detain such persons, and wishes to remove that possibility.

11. JUSTICE has expressed concern at the removal of the exclusion in relation to sexual deviancy and the possible bringing of transsexualism, masochism and fetishism within the scope of compulsory powers. JUSTICE considers it entirely inappropriate that all sexual preferences and behaviours classified as psychiatric disorders should be brought within the scope of the legislation, and suggests that the exclusion for sexual deviancy be retained, but that a specific exception be made for paedophilia. The Department has clarified that it wishes to include the paraphilias (abnormalities of sexual preference) which appear in standard classifications of mental disorders, 'where they reach a level of clinical significance.' The level of clinical significance necessary to cross the paraphilia threshold is described in the DSM-IV-R of the American Psychiatric Association as being reached when the behaviours or fantasies lead to a clinically significant level of distress or impairment (e.g. are obligatory, result in sexual dysfunction, require participation of non-consenting individuals, lead to legal complications, or interfere with social relationships). The DSM-IV-R states that the paraphilia of fetishism is not diagnosed where the fetishes are limited to articles of female clothing used in cross dressing, as in transvestic fetishism. Transsexualism has been held to be an aspect of private life which must be respected under Article 8.

12. In light of the above, we asked the Government why it had chosen to remove the exclusion in relation to sexual deviancy rather than retain it with an exception for

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15 Appendix 3, para 3.
16 Justice Mental Health Bill Briefing for House of Lords Second Reading November 2006, paras 11-16.
paedophilia, and to provide us with a more detailed explanation of the Government’s intention to treat paedophilia as a mental disorder.

13. The Government’s explanation is that if a situation arises where ‘the relevant professionals (and if appropriate the relevant court) believes it appropriate that action should be taken because a patient suffers from such a disorder it is the needs of the patient and risk which determine whether action is taken under the Act.’17 The Minister was at pains to emphasise in the Government response that the Department does not consider transsexualism to fall within the current sexual deviancy exception, and it will therefore not be affected by the changes proposed in the Bill to remove this exclusion. Gender identity disorder is included in the DSM-IV-R as a mental disorder.

14. As we have stated, 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 Identity 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.

15. At the Committee stage in the House of Lords Baroness Neuberger quoted from the evidence of the Disability Rights Commission, who said:

   In relation to non-discrimination principles we believe it is not merely desirable but necessary to restate and reinforce key principles which feature in other legislation. The existing public sector duties to promote disability and race equality need practical reinforcement in a legislative framework in which people may be deprived of their liberty and where prejudiced and discriminatory judgments can so easily come into play.18

Given the breadth of the new definition of mental disorder, we consider that the same argument about the need for principles 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.

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

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17 Appendix 3, para 4.
18 HL Deb 8 January 2007, col 44.
procedures appear broadly to comply with the case law on Article 5(1)(e) of the Convention.

(2) Conditions of Compulsion: Replacing ‘Treatability’ with Availability of Appropriate Treatment.

17. The Government proposes replacing the current ‘treatability’ condition of detention (medical treatment in hospital is likely to alleviate or prevent deterioration in the patient’s condition) with a new condition of compulsion that appropriate treatment must be available for the patient. The Government has said that its intention is (inter alia):

To remove ground for argument about the efficacy or likely efficacy of a treatment which can be used to prevent detention of people who present a risk to themselves or others.\(^{19}\)

18. A further goal is to ensure that the fact that a patient with personality disorder is refusing to co-operate with psychological treatment would not be a ground for release because the fact that he is refusing treatment means it is not likely to alleviate or prevent deterioration in his condition.

19. As the Government points out,\(^{20}\) the criteria set out in Winterwerp do not include a requirement that the patient be treated, and so the Government does not consider that Convention rights are affected. In Winterwerp the Court held that a mental patient’s right to treatment appropriate to his condition cannot as such be derived from Article 5(1)(e). The Strasbourg Court has held subsequently that detention on grounds of unsoundness of mind must take place in a hospital, clinic, or similar institution.\(^{21}\) Beyond that the Court has declined to impose requirements as to treatment under Article 5(1)(e). In Hutchison Reid v United Kingdom (2003) the Court held that Article 5(1)(e) imposed no requirement that detention in a mental hospital was conditional on the illness or condition being of a nature or degree amenable to medical treatment.\(^{22}\) The Court held (paragraph 51) that confinement under Article 5(1)(e) may be necessary not only where a person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons.

20. We are mindful of the strongly held views of psychiatrists during the Committee stage in the House of Lords, that if the so-called ‘treatability’ test is to be abolished, it should be replaced with the test that treatment is available which is likely to be of therapeutic benefit to the patient. This is to avoid a perceived risk of psychiatrists becoming mere custodians rather than therapists, and psychiatric detention becoming perceived as preventive detention. Counsel’s opinion obtained by MIND at para 13.3.2 noted that the decision in Reid v United Kingdom pre-dated Council of Europe Recommendation No (2004)10 of the Committee of Ministers to Member States concerning the human rights and dignity of

\(^{18}\) Appendix 1.
\(^{20}\) Ibid.
\(^{21}\) Aerts v Belgium.
\(^{22}\) See also Koniarska v. the United Kingdom, no. 33670/96, decision of 12 October 2000, unreported.
persons with mental disorder. Article 17(1)(iii) of the Recommendation requires that detention has a ‘therapeutic purpose’ which is broadly defined (Article 2(3)) as ‘including prevention, diagnosis, control cure or treatment.’ Although the Recommendation may represent an international consensus, the UK Government has reserved the right not to comply with the recommendation as a whole. 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.

(3) Renewal of Detention: the requirement of a true mental disorder established by objective medical expertise

21. Initial detention under the Act as amended will still be based on objective medical expertise, in the form of reports from registered medical practitioners. However, renewal of detention will be carried out by the responsible clinician, who need not be a doctor, furnishing a report to the managers of the hospital that the conditions justifying detention continue to be met. If initial detention must be based on objective medical expertise to be compatible with Article 5 ECHR, there is an argument, following Winterwerp, that the same should apply to its prolongation. The Bill proposes that the person in charge of a detained patient’s treatment should no longer be the responsible medical officer (RMO), who must be a doctor, but would in future be the responsible clinician (RC) who need not be medically qualified.

22. The desired effect is described in paragraph 52 of the Explanatory Notes:

“The RC may be any [approved clinician] who has been approved for that purpose. Approval need not be restricted to medical practitioners, and may be extended to practitioners from other professions, such as nursing, psychology, occupational therapy and social work.”

23. The Government takes the view that ‘the responsible clinician does not necessarily need to be a registered medical practitioner in order to satisfy the requirements of the Convention.’ Acknowledging that Winterwerp requires that deprivation of liberty must be based on “objective medical expertise”, the Government argues that

“[T]his means relevant medical expertise, and not necessarily that of a registered medical practitioner. For example, a psychologist would have relevant skills in this context and be able to recognise that a person was suffering from a mental disorder and the knowledge to go to someone else with the appropriate expertise when needed.”

24. We asked the Government to explain further its view that medical expertise need not necessarily involve a doctor. In particular, we asked whether it was envisaged that nurses, social workers or occupational therapists should furnish the objective medical expertise necessary to renew detention, and whether the Government considered that a process of detention and renewal that need not be based on a medical report from a doctor complied

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23 Appendix 1.
24 Ibid.
with the requirements for a lawful detention on grounds of unsoundness of mind as set out in Winterwerp v the Netherlands.

25. The Department takes the view that ‘the phrase ‘medical expertise’ as referred to by 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.’ 25 The Government has clarified that ‘it is envisaged that psychologists, nurses, social workers or occupational therapists approved as approved clinicians and therefore able to act as the responsible clinician will be able to furnish the objective medical expertise necessary to renew detention. The Government relies on the fact that responsible clinicians ‘will have to meet minimum criteria which will include a requirement that the person seeking approval is able to identify the presence of mental disorder and the severity of the disorder.’26

26. **We do not agree with the Government’s definition of objective medical expertise.** In Varbanov v Bulgaria27 the Strasbourg Court gave every indication in the following paragraphs that objective medical expertise involved reports from psychiatrists who are doctors. The Court made it clear that the opinion of a medical expert who is a psychiatrist is necessary for a lawful detention on grounds of unsoundness of mind. This requirement would have been met had the doctors present at the admission furnished an opinion that the applicant needed to be detained for psychiatric examination. This indicates that the opinion justifying detention should come from a medically qualified expert who is a who has recognised skills in psychiatric diagnosis and treatment.

47. The Court considers that no deprivation of liberty of a person considered to be of unsound mind may be deemed in conformity with Article 5 § 1 (e) of the Convention if it has been ordered without seeking the opinion of a medical expert. Any other approach fails short of the required protection against arbitrariness, inherent in Article 5 of the Convention.

The particular form and procedure in this respect may vary depending on the circumstances. It may be acceptable, in urgent cases or where a person is arrested because of his violent behaviour, that such an opinion be obtained immediately after the arrest. In all other cases a prior consultation is necessary. Where no other possibility exists, for instance due to a refusal of the person concerned to appear for an examination, at least an assessment by a medical expert on the basis of the file must be sought, failing which it cannot be maintained that the person has reliably been shown to be of unsound mind (see X v. the United Kingdom judgment of 5 November 1981, Series A no. 46).

48. In the present case the applicant was detained pursuant to a prosecutor’s order which had been issued without consulting a medical expert. It is true that the purpose of the applicant’s detention was precisely to obtain a medical opinion, in order to assess the need for instituting judicial proceedings with a view to his psychiatric internment.

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25 Appendix 3.
26 Ibid., para 10.
The Court is of the opinion, however, that a prior appraisal by a psychiatrist, at least on the basis of the available documentary evidence, was possible and indispensable. There was no claim that the case involved an emergency. The applicant did not have a history of mental illness and had apparently presented a medical opinion to the effect that he was mentally healthy. In these circumstances, the Court cannot accept that in the absence of an assessment by a psychiatrist the views of a prosecutor and a police officer on the applicant's mental health, which were moreover based on evidence dating from 1993 and 1994, sufficed to justify an order for his arrest, let alone his detention for twenty-five days in August and September 1995.

It is also true that when he was arrested the applicant was taken to a psychiatric clinic where he was seen by doctors.

However, there is no indication that an opinion as to whether or not the applicant needed to be detained for an examination was sought from the doctors who admitted him to the psychiatric hospital on 31 August 1995. The applicant’s detention for an initial period of twenty days, later prolonged, had already been decided by a prosecutor on 27 January 1995, without the involvement of a medical expert.28

27. JUSTICE have raised a further issue in relation to renewal of detention which deserves consideration. In R v Warlingham Park Hospital Managers, ex p B29 the Court of Appeal held that the lawfulness of continued detention depends on the furnishing of a report by the responsible medical officer (RMO) to the hospital managers. The Court of Appeal held that it was not necessary for the managers to consider the report before detention could be renewed. It was enough to renew the authority to detain that the RMO’s report had been despatched to them. In Winterwerp v the Netherlands the European Court of Human Rights held that the notion underlying the phrase ‘in accordance with a procedure prescribed by law’ in Article 5 ECHR is ‘one of fair and proper procedure, namely that any measure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary’.30 The appropriate authority which detains non offender patients is the hospital managers.31 JUSTICE urge that section 20 be amended so that it is made clear that any report provided by the (now) responsible clinician must be considered by the hospital managers in order to renew the authority for detention.

28. In light of this concern, we asked the Government whether it considered it necessary to provide for consideration by the hospital managers of renewal reports in order to comply with Article 5(1)(e), and if not, why not.

29. The Government responded that the Convention does not require the formal renewal of a patient’s detention but merely for the ‘patient’s case to be kept under review’, and it is the responsible clinician who performs this review function. The Department also considers that the responsible clinician is the appropriate authority for the renewal of the
patient’s detention. The Government’s argument is that after initial admission the hospital managers cease to be the detaining authority and responsibility for the patient’s case passes to the responsible clinician.\footnote{Appendix 3, paras 18-22.} We find this argument unconvincing. Currently the hospital managers are responsible for scrutinising the documents authorising initial detention and have the power to rectify certain defects if they become apparent within the first 14 days. It is not apparent to us how and by what process the responsible clinician becomes the competent authority for Convention purposes. Given that the right to liberty in Article 5 ECHR is engaged it is of considerable concern that the report which renews detention need not come from a medical practitioner, and is subject to no scrutiny by any higher authority, other than the Mental Health Review Tribunal (MHRT). It is of concern that the responsible clinician who represents the detaining authority before the MHRT may not be medically qualified. In their evidence to us the Council on Tribunals note that the Tribunal generally relies on the evidence of the patient’s Responsible Medical Officer to confirm that the conditions justifying detention continue to be met.\footnote{Appendix 5.} Although in some circumstances it might be appropriate for a clinical psychologist to provide the tribunal with the objective medical expertise, 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 MHRT may be required to seek additional medical evidence to verify that the conditions of detention continue to be met.

(4) The Nearest Relative

30. In \textit{JT v United Kingdom},\footnote{(2000) 30 E.H.R.R CD 77.} the UK was held to be in breach of the right to respect for privacy under Article 8 ECHR, because the patient had no right to displace her nearest relative in the county court. Her complaint was that her nearest relative was her mother, who was living with a man who JT alleged had abused her in the past. Each time JT applied for discharge from detention to a Mental Health Review Tribunal, the tribunal rules required that her mother as nearest relative, be informed. JT objected to her mother being given information about her life. The Mental Health Act 1983 allows for the nearest relative to be displaced, but as noted above there is currently no provision for the patient to nominate or replace his/her nearest relative.

31. In \textit{JT v. United Kingdom} the European Commission of Human Rights concluded that this deficiency contravened the right to respect for private and family life under Article 8.\footnote{The case was decided before the abolition of the Commission under Protocol 11 to the ECHR.} The Commission stated that the absence of any possibility to apply to the County Court to change the applicant’s nearest relative rendered the interference with her rights under Article 8(1) disproportionate to the aims pursued. The judgment of the European Court noted that a friendly settlement was reached between JT and the UK Government, whereby the Government undertook to introduce reform proposals to (1) enable a patient to make an application to the court to have his nearest relative replaced where the patient objected on reasonable grounds to a particular individual acting in that capacity, and (2) prevent certain persons from acting as the nearest relative of the patient.
32. Clauses 21 to 24 of the Bill amend the provisions of sections 26-29 of the Mental Health Act 1983 concerning nearest relatives. The provisions make it possible for the patient to seek displacement of the person who, according to the statutory formula in section 26, is the nearest relative. Such applications may be made on the grounds that the person is unsuitable to act as the nearest relative. The patient will be able to nominate any person of their choice to act as their nearest relative (new s. 29(2)(za)). Once an unsuitable person has been displaced and an acting nearest relative is appointed by the court, that appointment can be made indefinite so that an “unsuitable” person will not resume the role of nearest relative following the discharge from compulsion of the patient, hence meeting the goal required by the friendly settlement of preventing an unsuitable person from acting as nearest relative again in the future if there is a break in the patient’s detention.

33. Given that the unsuitability ground applies not just to applications by the patient, but also by others (e.g. hospital authorities or local authorities), concerns have been expressed by JUSTICE that the unsuitability ground might be used to displace a ‘difficult’ nearest relative, who might not meet the ground of having unreasonably objected to detention or unreasonably exercised the power of discharge:

> “However, we are concerned that the breadth of the ground may allow for inappropriate considerations being used to justify removal of a nearest relative. We note that nearest relatives frequently have a tense relationship with those detaining and treating patients, and we have serious concerns that applications may be made to remove a nearest relative on the basis of suitability, when, in essence, the detaining/treating authority is making the application on the basis that they are ‘difficult customers’. In the circumstances, we would urge strongly that clause 21(5) be amended so as to provide sufficient protection to nearest relatives falling into this category. One way in which this could be done would be to outline considerations that must be taken into account when determining whether a nearest relative is a suitable person to act as such.”

In our view, clauses 21 to 24 appear meet the terms of the friendly settlement in JT v United Kingdom.

35. However, since the removal of a nearest relative will usually involve an interference with the patient’s right to respect for their private and family life in Article 8 ECHR, we agree with JUSTICE that the breadth of clause 21(5) raises a human rights issue. We therefore asked the Government whether it planned to introduce safeguards to protect the right of a nearest relative to be ‘difficult’ in the sense of opposing compulsion, short of unreasonably opposing admission for treatment or unreasonably exercising the power of discharge, which are already grounds for displacement.

36. The Department in its response has confirmed that it does not want to restrict the nearest relative role by allowing for displacement for acting independently in this way. The response continues by saying that the judgment of unsuitability is not a question of 'how

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36 JUSTICE Mental Health Bill Briefing for House of Lords Second Reading November 2006, paras 36-38. JUSTICE consider that this is all the more important if the former nearest relative displaced under new s.29(3)(e) MHA 1983 is to have their right of access to the county court to have the order discharged under s.30 MHA 1983 restricted: the effect of new s.30(1A), introduced by clause 22(3) of this Bill. They would also be unable to make an application to the MHRT under s.66 MHA 1983: see clause 23.
well he exercises his powers’ but ‘relates to the suitability of him having this type of relationship with the patient.’37 The Department then declares its intention that ‘not a suitable person to act as such’ should cover cases in which it would be detrimental to the welfare of the patient to have such a relationship with the patient, and undertake to detail during the passage of the Bill the cases it has in mind. Lord Hunt of King’s Heath offered some amplification of the Government’s approach during the Committee Stage in the Lords when he said:

We do not believe that a person is unsuitable to be the patient’s nearest relative simply because the patient may be upset with the nearest relative over a trivial matter. We know that suffering with mental disorder is often a distressing and difficult time for the patient and that it is no less so for those who love and care for the patient. In that environment there can be potential for disagreement between a patient who may not wish to go to hospital, for example, and the nearest relative who reluctantly accepts that that is the best course of action. Such a disagreement should not in itself be grounds for removing important powers from the nearest relative.

We have in mind situations where a nearest relative’s occupation of that role and its powers under the Act pose a real and present danger to the health or well-being of the patient. Where a nearest relative has abused the patient, for instance, he should not be allowed to exercise the rights of the nearest relative. It is not important how recently the abuse took place. If the patient or others who know or are close to the patient have a genuine fear that the abuse may be repeated—or even that a relationship with a formerly abusive nearest relative may cause the patient distress—we intend that such a person should be considered unsuitable to act as the nearest relative of the patient. These applications will be heard, as they now are, in the county court. The court will not be asked to sit in judgment of any of the past actions or deeds of the nearest relative. Their role will be to determine whether the nearest relative is otherwise unsuitable to act as such.

The opinions and views of the patient will be very important and we fully expect that they will form part of the court’s deliberations. However, we do not wish the court to feel constrained if the patient would wish that person to remain as their nearest relative. I would instance cases where the victim of an abuser actually acts to protect the abuser, either out of fear of the abuser or through a form of identification with him. We do not wish the court to feel constrained in such circumstances in displacing a nearest relative it finds unsuitable.38

37. The Government’s approach to suitability suggests that the concept is both too broad and too narrow. It is too narrow to enable a patient to displace a nearest relative with whom they emphatically do not get along, unless there is some undercurrent of abuse. Yet if left undefined it is also potentially too broad in enabling a nearest relative who is in conflict with mental health professionals to be removed on the initiative of those professionals. The case of R(E) v Bristol City Council39 provides that, in order to ensure compatibility with Article 8, the Approved Social Worker’s duty to consult the nearest

37 Appendix 3.
38 HL Deb 17 Jan 2007: Column 672.
relative about compulsory admission if appropriate and practicable does not apply if the patient objects to that person being consulted as the nearest relative. Under the Bill this will remain good law, and the patient can choose who will not be consulted as their nearest relative, but the only way of displacing a nearest relative, and replacing them with someone acceptable to the patient, will be if they are ‘unsuitable.’ The Government appears to equate unsuitable with abusive, whether or not that abuse is proven. Lord Patel of Bradford observed during the Committee stage that the Draft Code says that ‘a nearest relative cannot be unsuitable on the basis that another person is deemed to be more suitable’ and that this ‘sits uneasily with the intent to address the unwarranted interference with patients’ private lives.’ If, as appears to be the case, the Government’s intention is to confine the patient’s right to seek displacement 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 strain on such a relationship, making it inappropriate for such a person to determine the future of the patient.

(5) Procedure for making Community Treatment Orders

38. Currently there are three methods of imposing compulsory powers on patients in the community under the Mental Health Act 1983: (1) extended leave under section 17; (2) guardianship under section 7; (3) after-care under supervision under sections 25A-J, a procedure introduced by the Mental Health (Patients in the Community) Act 1995. Neither guardianship nor after-care under supervision are much used, and it would appear that section 17 leave is the most frequently used vehicle for imposing control over patients in the community.

39. Section 17 leave is granted by the Responsible Medical Officer (RMO). If the Bill becomes law, this power will pass to the responsible clinician. There has been considerable case law on section 17. A patient may be granted leave subject to such conditions as the RMO thinks necessary in the interests of the patient or for the protection of other persons. This power has been used to provide the equivalent of a community treatment power by the RMO granting leave subject to a condition that the patient takes his or her medication. The patient remains liable to be detained, in the sense that unless the patient is discharged from section, he or she may be recalled to hospital by the RMO if necessary for the patient’s health or safety or for the protection of others. Current case law holds that the patient’s liability to detention may be renewed repeatedly while they continue to live in the community, so long as the patient needs some of their treatment in hospital, not necessarily as an in-patient.40

40. The proposal in the Bill is that section 17 leave will remain, but in a reduced role, and that after care under supervision will be replaced by community treatment orders (“CTOs”). Clause 25 introduces new sections 17A-17G which set out how CTOs are to be made, and how they will work.

41. Although section 17 leave will remain, before granting section 17 leave for seven days or more, the responsible clinician must first consider whether the patient should be dealt with under section 17A instead. Only patients who have been detained in hospital under section 3 (admission for treatment for up to six months), or who are detained under one of the provisions for detaining offender patients under Part 3 without restrictions on discharge, are eligible for a CTO (s 17A(1),(2)). Although the Government clearly sees CTOs as preferable to section 17 leave, clinicians may well continue to use section 17 leave as an alternative to the new CTO.

42. It may be noted in passing that in terms of the nomenclature adopted by the 1959 and 1983 Act the term community treatment order is a misnomer, since under the scheme of the Act, orders are made by courts. None of the civil powers to detain operate by orders, but by applications to the hospital managers. A CTO is defined in s 17A(1) as an order in writing by the responsible clinician discharging a detained patient from hospital subject to his being liable to recall in accordance with section 17E. There appears to be no requirement for an application to the hospital managers. The order is made by the RC. The RC must be of the opinion that the relevant criteria are met, and must also obtain the written opinion of an Approved Mental Health Professional (AMHP) that the relevant criteria are met, and that an order is appropriate.

43. In *L v Sweden*, the European Commission on Human Rights held that a decision provisionally to release someone who had been detained in a psychiatric hospital constitutes an interference with his right to respect for private life. However, the Commission went on to declare the application manifestly ill-founded, holding that the measure was justified in the interests of the person’s health under Article 8(2) which provides that ‘There shall be no interference with this right except such as is in accordance with the law and is necessary in a democratic society for ... the protection of health’ and the applicant could not be said to have an ‘arguable claim’ of a violation of Article 8. If granting a CTO is necessary on grounds of health or to protect the rights and freedoms of others, there would be no interference provided it is necessary in a democratic society and is done in accordance with law.

44. The relevant criteria are—

a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;

b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;

c) subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital;

d) it is necessary for his health or safety or for the protection of other persons that he should be liable to be recalled to hospital for medical treatment; and

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45. A CTO must specify conditions to which the patient is to be subject while the order remains in force (s 17B(1)), but conditions may only be specified in the order with the agreement of the AMHP.

46. The conditions which may be specified include ((s 17B(3))—

a) a condition that the patient reside at a particular place;

b) a condition that the patient make himself available at particular times and places for the purposes of medical treatment;

c) a condition that the patient receive medical treatment in accordance with the responsible clinician’s directions;

d) a condition that the patient make himself available for examination;

e) a condition that the patient abstain from particular conduct .

47. The Draft Code of Practice states at 12A.23:

“This last condition may be appropriate, where, for example, the patient needs to avoid usage of illegal drugs because it is known that if he does not do so, the likelihood of relapse will be greater. It should not be used unless the conduct in question is directly relevant to the patient’s medical condition.

The above is not an exhaustive list of conditions which may be applied - there may be others depending on the patient’s individual circumstances.”

48. Concerns were expressed about the potential breadth of these conditions at the Committee stage in the House of Lords, that ‘CTOs may be widened, using the Code of Practice in any way clinicians see fit.’ 43

49. On the face of the law, the possibility exists that a CTO may be imposed on a patient with restrictive conditions as to behaviour potentially interfering with rights under Article 8, on the authority of a Responsible Clinician (who need not be a doctor) and an Approved Mental Health Professional. This authority lasts six months before renewal is required. In light of this, we asked the Government whether it considered that the procedure envisaged, without need for the managers of the hospital to consider and endorse the application, was sufficient to comply with the requirement in Article 8(2) of being in accordance with law.

50. There does not appear to be a procedure in the statute whereby an application is required to be made to the managers of the hospital, or any competent authority. The draft Code of Practice envisages a procedure as follows, but there is nothing in the statute to require it:

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12A.20 On completion, the CTO should be signed by the responsible clinician and the AMHP and sent to the Hospital Managers. The CTO will be effective from the date on which the patient is discharged from detention.

51. A CTO patient is not discharged from detention: authority to detain is suspended for the duration of the CTO. There is provision for renewal of a CTO after six months (s 20A), whereby the responsible clinician must examine the patient and provide a written report to the managers before the CTO can be renewed. **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 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.**

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

52. The effect of the CTO provisions is to allow for up to 72 hours’ detention following recall on the authority of the responsible clinician. The RC may release the patient at any time within 72 hours of recall, and as long as the CTO has not been revoked, the patient will retain his or her community patient status. Currently the possibility exists that a CTO patient might repeatedly be subject to a number of short-term detentions for up to 72 hours for the purpose of enforcing medication, and unless the CTO is revoked, it appears that there will be little by way of effective redress, other than an appeal against the order to a Mental Health Review Tribunal (MHRT), which can only review the need for an order and cannot review the conditions of an order.

53. JUSTICE have expressed concern that

> “[T]he MHRT has no power to review the conditions imposed on a CTO. Instead, the power of the MHRT is limited to discharging a patient from a CTO. We are deeply concerned that the imposition of conditions could in some cases amount to a deprivation of a patient’s liberty (if for example there were conditions that a patient had to reside in a certain institution, and was subject to an extensive curfew or supervision). In such cases the patent inability of the MHRT to review the conditions would amount to a breach of the patient’s Article 5 ECHR rights.”

54. It may also be the case that a patient does not dispute the need for a CTO but they do object to a condition which might amount to an interference with a Convention right under Article 5 or Article 8. In such a case it might be argued that there is a breach of Article 13, in that there is no effective remedy. We therefore asked the Government whether it was its intention that there should be no right to seek review of the conditions of a CTO, and, if so, what had persuaded the Government that this approach is compatible with Articles 5 and 8 ECHR.

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44 *R (Munjaz) v Mersey Care NHS Trust and others [2005] UKHL 58.*

45 JUSTICE Mental Health Bill Briefing for House of Lords Second Reading November 2006, para. 46.
55. The Government response is that the need to obtain the agreement of the AMHP as to the making of the CTO and as to the nature of the conditions to be imposed is intended to provide protection against arbitrariness. The Government relies on the fact that both these persons will be public authorities and therefore required to act compatibly with Convention rights as a justification for providing no further safeguards.\(^\text{46}\) As to the potential breadth of the conditions, the Department’s view is that it will be appropriate only to attach conditions that are considered clinically necessary to ensure that the patient continues to receive the treatment he needs, or which relate to his own safety or the protection of others. The Department has stated that the Codes of Practice will provide guidance to the effect that conditions attached to a CTO will be kept to a minimum consistent with ensuring that the patient gets the treatment he needs and to protect the patient and others from harm.

56. **We do not consider that the need to obtain the Approved Mental Health Professional’s agreement represents a significant safeguard.** Under the 1983 Act Approved Social Workers appointed by local authorities made the application, and doctors employed by the NHS made medical recommendations, and the creative tension between these two independent professionals provided the safeguard for the patient. The position will be different following the introduction of AMHPs to replace ASWs. During the Committee stage in the House of Lords considerable concerns were expressed as to the independence of AMHPs in the decision-making process, particularly as they may be employed in the same team as the responsible clinician.\(^\text{47}\) The Government is relying on the training for RCs and AMHPs to emphasise the need for independence.

57. **In our opinion, these concerns about the independence of the AMHP reinforce the need for some external safeguard that is more accessible than judicial review.** The 2004 Draft Bill provided for the approval of conditions and treatment plans by the Mental Health Tribunal. Under this Bill the only safeguard will be a Second Opinion Doctor. As to the potential breadth of the conditions, a requirement in the Code that they be kept to the minimum necessary to prevent risk to self or to others would not prevent the imposition of a curfew or similar restrictions which cumulatively might amount to a deprivation of liberty. Although the Statute and the Code allow for a broad range of conditions as to behaviour to be imposed, the Department views the Committee’s concern as misplaced because it ‘does not consider that it would be appropriate for the RC and the AMHP to impose conditions on a CTO which are so restrictive in nature that they would effectively amount to a deprivation of liberty.’\(^\text{48}\) The Government seems to rely on the fact that people subject to CTOs have been deprived of their liberty already by detention under section 3 or equivalent, and therefore little by way of further regulation is needed. The potential breadth of conditions may well mean that a civil right could be infringed and Article 6 engaged, or at the very least that the procedural obligation under Article 8 might be engaged.

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\(^\text{46}\) Appendix 3, para 31.

\(^\text{47}\) HL Deb 17 January 2007, Col 748.

\(^\text{48}\) Appendix 3, para 38.
58. The lack of safeguards contrasts with other areas where Article 8 is engaged, such as the Regulation of Investigatory Powers Act 2000, and this could also be argued in respect of control orders under the Prevention of Terrorism Act 2005. We consider that the requirement that restrictions on conduct 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.

(7) The test for treatment without consent under section 58 of the 1983 Act – that it is appropriate for the treatment to be given

59. Section 58 of the 1983 Act authorises treatment using medicines or ECT subject to supervision by a system of second opinion doctors appointed by the Mental Health Act Commission. The test to be employed by second opinion doctors in authorising treatment without consent under section 58 is currently that ‘the treatment ought to be given having regard to the likelihood that it will alleviate or prevent deterioration in the patient’s condition.’ This will be replaced by a new test – that it is appropriate for the treatment to be given. The policy intention appears to be that there will not be much difference in practice between the two tests in relation to treatment without consent. The definition of medical treatment for mental disorder under the 1983 Act has been held to include not merely treatment directed at the core disorder, but also treatment of the ‘symptoms and sequelae’ of the disorder. Paragraph 2A4 of the Draft Code of Practice offers the following definition of appropriateness:

“Medical treatment can only be considered appropriate if it is intended to address the mental disorder(s) from which the patient is suffering and which (alone or in combination) form the basis of the decision to detain (or continue to detain) the patient. “Intended to address” means that the purpose of the medical treatment is to alleviate, prevent deterioration in or otherwise manage the disorder itself, its symptoms or manifestations or the behaviours arising from it.”

60. The key question is whether the appropriateness test is sufficient to meet the requirements of Articles 3 and 8 of the Convention. The Draft Code recognises the importance of these rights and offers the opinion that ‘Scrupulous adherence to the requirements of the legislation and good clinical practice should ensure that there is no incompatibility.’ But, in our view, it is clear from the subsequent provisions of the Code that reliance on the appropriateness test in the legislation, without more, will not be sufficient to ensure Convention compliance.

61. The Draft Code of Practice reminds clinicians of their obligations under Article 3 and Article 8 in the following terms:

“• compulsory administration of treatment which would otherwise require consent is invariably a breach of Article 8 of the Convention (right to respect for physical integrity as an aspect of private life). Such a breach can be justified where it is in

49 B v Croydon District Health Authority [1995] 1 All ER 683.
50 Draft Code of Practice, para 15.2e.
accordance with law, and it is proportionate to a legitimate aim (in this case, the reduction of the risk posed by a person’s mental disorder and the improvement of their health.)

- compulsory treatment is capable of being inhuman treatment (or in extreme cases even torture) contrary to Article 3, if its effect on the person concerned reaches a sufficient level of severity. However, it will not be a breach if it is convincingly shown to be a medical necessity.\(^{51}\)

62. The Draft Code then draws on the case law on section 58, and in particular \(R\) (on the application of \(N\)) \(v\) Dr \(M\) and others\(^{52}\), to list the factors to be considered in determining whether treatment without consent is a clinical necessity and therefore lawful:

“In determining whether treatment is a medical necessity, the questions a court will ask itself include:

a) how certain is it that the person suffers from a treatable mental disorder;
b) how serious a disorder it is;
c) how serious a risk is presented to others;
d) how likely is it that, if the patient does suffer from such a disorder, the proposed treatment will alleviate the condition;
e) how much alleviation there is likely to be;
f) how likely it is that the treatment will have adverse consequences for the patient; and how severe may they be.

These are no more than the questions which a clinician would naturally consider before prescribing or administrating treatment.”

63. The inference naturally to be drawn from all of these supporting documents is that the appropriateness test in relation to treatment without consent must address the issues of medical necessity and the likelihood that the treatment will alleviate or prevent deterioration. It cannot however, be said, as the Code does, that this will be achieved by scrupulous adherence to the requirements of the legislation. The Draft Code applies the Convention tests, which are not found in the legislation itself. There are drawbacks in this approach of leaving the issue of Convention compliance to be addressed in the Code, which may be departed from with good reason, rather than in the primary legislation. The language of the Code seems more accurately to reflect Convention case law, than that of the statute. In the light of these factors, we asked the Government why it had chosen to address Convention compliance in the Code rather than in the legislation, and whether consideration would be given to making the “medical necessity” requirements of Articles 3 and 8 explicit on the face of the Bill.

\(^{51}\) Ibid.

64. The Government response is that medical necessity is only an issue under Article 3, which will only be engaged if the effects of the treatment reach a minimum level of severity that is unlikely to be reached. The Government considers ‘that the European Court of Human Rights has not developed an equivalent of ‘medical necessity’ in relation to Article 8. In the Department’s view the relevant test under Article 8(2) is therefore whether the treatment is (i) in accordance with the law; (ii) for a legitimate aim; and (iii) necessary in a democratic society.’ Therefore the Government considers that the provisions relating to the administration of treatment are capable of operating compatibly with Articles 3 and 8, independently of the Code.\(^53\)

65. We find the Government’s reasoning 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 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 test should be in the legislation rather than in a Code of Practice, which may well only be accessible to professionals.

66. Although an immediate second opinion is required for any administration of Electro Convulsive Therapy (ECT), in relation to medicines for mental disorder, the patient does not become entitled to a second opinion until three months have elapsed from the first time when medicine was administered during that period of detention. The justification for this different treatment was that ECT is seen as a more controversial treatment, and at the time it was felt a three month ‘stabilizing period’ was necessary to assess the effectiveness of treatment. There is now a recognition that the effects of some psychiatric drugs may be as unacceptable to patients as ECT, and that the likely efficacy of a particular antipsychotic medication may be assessed within one month rather than three.\(^54\) The Mental Health Act Commission Eleventh Biennial Report expresses the view that the 1983 Act provides insufficient protection to patients’ Article 8 rights in relation to drug treatment without consent, and an amendment was tabled at Committee Stage in the House of Lords seeking to reduce the three month period to one month.\(^55\) 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.

\(^{53}\) Appendix 3, paras 50-51.


\(^{55}\) HL Deb 15 January 2007, cols 490-495.
(8) Forcible Feeding

67. Forcible feeding as a treatment for mental disorder can be given without consent to a detained patient under section 63 of the Mental Health Act 1983 without the need for a statutory second opinion.\(^{56}\) Given that forcible feeding is potentially a breach of Article 3 and Article 8,\(^ {57}\) and if imposed involves a significant and potentially traumatic invasion of physical integrity, it may be questioned why it is not subject to regulation by the same system of second opinions which applies to Electro Convulsive Therapy under section 58 of the 1983 Act. We therefore asked the Government whether it considered that it was necessary to provide more effective supervision and review of decisions to forcibly feed a patient than is currently provided by section 63 of the 1983 Act.

68. The Government considers that ‘While section 58 provides an additional safeguard of a SOAD (Second Opinion Approved Doctor) in relation to certain treatments, there is no requirement in the Convention for a second opinion. With respect to the Committee, the key question is whether the provisions of the Act which provide for the forcible feeding of patients without consent, with or without a second opinion, are compatible with the Convention. The Department considers that they are.’\(^ {58}\)

69. We consider that the positive obligation under Article 8 as elaborated in \textit{Storck v Germany}\(^ {59}\) requires effective supervision and review of decisions 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.

(9) \textit{HL v United Kingdom} and the Bournewood Proposals

70. Following the case of \textit{In re F}\(^ {60}\) in 1989 the English courts have developed the common law jurisdiction to grant declarations that certain actions in respect of incapacitated adults would be lawful as being necessary in the best interests of the person concerned. The common law doctrine of necessity confers a power, and in certain circumstances a duty on doctors to provide treatment which is necessary in a mentally incapacitated patient’s best interests. This was extended by the House of Lords in \textit{R v Bournewood Community and Mental Health NHS Trust, ex parte L (Secretary of State for Health and others intervening)}\(^ {61}\) to confer a power on a doctor to restrain and detain a mentally incapacitated adult if it was necessary in his or her best interests. \textit{Bournewood} was decided just before the Human Rights Act came into force. An application was made on L’s behalf to the Strasbourg Court

\(^{56}\) Re KB [1997] 2 FLR 180.
\(^{57}\) \textit{Nevmerzhitsky v Ukraine} Judgment of 5 April 2005.
\(^{58}\) Appendix 3, para 67.
\(^{60}\) 1990] 2 AC 1.
which held in *HL v United Kingdom* that, where a compliant incapacitated patient is to be deprived of his liberty, this must be done in accordance with a procedure prescribed by law.

71. HL has autism and profound intellectual disability. He lacked capacity to consent or dissent to being in hospital. He had lived with his carers, the Es, for three years. One day he became agitated and disturbed at a day centre, was given valium, and was taken to the learning disability hospital run by the Bournewood Trust and kept there. His doctor instructed staff that he was to be stopped from leaving if he tried to do so. Although he never did attempt to leave the hospital, his carers, the Es, were prevented from visiting, in case he might want to go home with them. He showed symptoms of abandonment, withdrawing, becoming sad, and losing weight. He was also on higher doses of sedative medication in hospital than were ever necessary in the community. His psychiatrist admitted him under the common law doctrine of necessity, rather than using the powers of detention under the Mental Health Act 1983.

72. The carers challenged the common law detention on the grounds that the procedure prescribed by law, namely using Mental Health Act powers of detention, had not been followed. The House of Lords in *Bournewood* ruled by a 3-2 majority that HL had not been detained for the purposes of the law of false imprisonment. They also ruled unanimously that there was a power at common law to restrain and detain a mentally incapacitated person in their best interests.

73. The European Court of Human Rights in *HL v United Kingdom* held that, whatever the position under English law, the removal of HL to the hospital, and his retention there without access to his carers, amounted to a deprivation of liberty under the Convention, and had to be carried out in accordance with a procedure prescribed by law, as required by Article 5(1)(e) of the Convention, Moreover, he was entitled to the opportunity, by himself, or through a proxy, to challenge the lawfulness of that detention under Article 5(4).

74. The Strasbourg Court refused to treat compliant incapacitated patients as on a par with capable patients who were consenting, reaffirming the importance of the right to liberty (para 90):

“"The right to liberty in a democratic society is too important for a person to lose the benefit of Convention protection simply because he has given himself up to detention, especially when it is not disputed that that person is legally incapable of consenting to, or disagreeing with, the proposed action."

75. The Court emphatically rejected the argument that a compliant incapacitated patient should be treated on the same basis as a capable consenting patient.

76. The ruling in *HL v United Kingdom* came at a very late stage in the Parliamentary passage of the Mental Capacity Bill. The Mental Capacity Act 2005 currently provides that the power to restrain a person under section 6 does not extend to ‘deprivations of liberty.’ In order to comply with the ruling in *HL v United Kingdom* a procedure prescribed by law must be followed when a person is deprived of his or her liberty. A distinction must be made between deprivations of liberty, governed by Article 5, and restrictions on liberty
governed by Article 2 of the Fourth Protocol which states that ‘Everyone lawfully within the territory shall, within that territory, have the right to liberty of movement and freedom to choose his own residence.’ The United Kingdom is not a signatory to Article 2 of the Fourth Protocol. This is a distinction which can be difficult to make in practice.  

77. The Strasbourg case law operates on the Guzzardi principle that the starting point in assessing whether there has been a deprivation of liberty is ‘the concrete situation’ in which the individual is placed and ‘account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question.’ The Court went on to state that ‘The difference between deprivation of liberty and restriction upon liberty is nonetheless merely one of degree or intensity, and not one of nature or substance.’ The Court acknowledged in Guzzardi that ‘the process of classification into one or other of these categories sometimes proves to be no easy task in that some borderline cases are a matter of pure opinion’, nevertheless, the court ‘cannot avoid making the selection upon which the applicability or inapplicability of Article 5 depends.’

78. In HL v United Kingdom the Court reiterated the Guzzardi principles, and identified as the key factor ‘whether those with care of the patient exercise complete and effective control over his care and movements.’ This includes strict control over: assessment, treatment, contacts, including with carers, movement, and residence. A person can still be deprived of his liberty without ever having tried to leave, it is enough that there is an intention to prevent them from leaving should they attempt to do so. Similarly, it is ‘not determinative’ whether the ward is locked or lockable. It is the intention to prevent the patient leaving which counts. Applying these tests the Court held that (para 91) ‘the concrete situation was that the applicant was under continuous supervision and control and was not free to leave.’ HL was therefore deprived of his liberty.

79. The Government argument in HL v United Kingdom had relied strongly on the Strasbourg Court’s judgment in HM v Switzerland, where it was held that the placing of an elderly applicant in a foster home, to ensure necessary medical care as well as satisfactory living conditions and hygiene, did not amount to a deprivation of liberty. However, in HL the Court held that each case has to be decided on its own particular “range of factors” and, while there were similarities between HL and HM, there are also distinguishing features. In particular, it was not established that HM was legally incapable of expressing a view on her position, she had often stated that she was willing to enter the nursing home and, within weeks of being there, she had agreed to stay. She was therefore consenting. This combined with a regime entirely different to that applied to the present applicant (the foster home was an open institution which allowed freedom of movement and encouraged contacts with the outside world) allowed the court to conclude that the facts of HM were not of a “degree” or “intensity” sufficiently serious to justify the conclusion that she was detained.

80. Clause 38 of the Bill inserts new sections 4A, 4B and 16A into the Mental Capacity Act 2006. This makes it lawful to deprive a person of their liberty only if a standard or urgent  

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62 R (Gillan) v Metropolitan Police Commissioner [2004] EWCA Civ 1067, para [38], where it was held that a short detainment pursuant to a stop and search power will normally fall outside Article 5.
63 Guzzardi v Italy, Judgment of 6 November 1980 para 92.
64 Ibid., para 93.
authorisation (under the new Schedules A1 and 1A to the 2005 Act) is in force or the Court of Protection has ordered a deprivation of liberty in deciding a personal welfare matter. Standard or urgent authorisations may be sought after the person has already been deprived of his or her liberty.

81. In *HL v United Kingdom* the Court made important statements about what is required by a procedure prescribed by law. The Court found striking ‘the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted’, and noted the significant contrast between the lack of regulation of admissions of compliant incapable patients and the extensive network of safeguards applicable to psychiatric committals covered by the 1983 Act (Para [120]).

82. A number of key ingredients of a procedure prescribed by law were missing in the court’s opinion. These were:

a) The lack of any formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions.

b) There is no requirement to fix the exact purpose of admission (for example, for assessment or for treatment) and, consistently, no limits in terms of time, treatment or care attach to that admission.

c) There was no specific provision requiring a continuing clinical assessment of the persistence of a disorder warranting detention.

d) There was no provision for the appointment of a representative of a patient who could make certain objections and applications on his or her behalf, a procedural protection accorded to those committed involuntarily under the 1983 Act and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities (para [120]).

83. The proposed system in the Bill to remedy these defects relies upon the managing authority of the institution depriving the person of their liberty to apply for authorisation. An authorisation may be applied for if the patient is about to be accommodated in circumstances amounting to a deprivation of liberty, or *already being so accommodated*. It is not envisaged that there will necessarily be an admission process, but a process of seeking authority to deprive of liberty after admission without consent. In *HL v United Kingdom* the Court held that the very purpose of procedural safeguards is to protect individuals against any “misjudgments and professional lapses” (Para [121]) There is a possibility that there may be professional misjudgements or lapses in assessing whether someone is deprived of their liberty. There is a right for the person’s representative to seek review by the supervisory authority and the representative of the person deprived of their liberty may apply to the Court of Protection to have the authority terminated. Permission is not required for an application to the Court to review a *Bournewood* authorisation.

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66 Para 2 of Schedule 8 to the Bill would insert a new s 21A into the Mental Capacity Act 2005.
67 Para 9 of Schedule 8 to the Mental Health Bill would insert a new s 50(1)(A) into the Mental Capacity Act 2005.
Article 5(4) requires that access to such review be speedy, and that legal representation be available.  

84. JUSTICE has argued that it is necessary for ‘deprivation of liberty’ to be defined in the statute (not the Code of Practice, which may be departed from with good reason\textsuperscript{69}) to ensure the following:

i. the provisions apply to the individuals for whom they are intended (there are dangers to individuals and the public with both over-inclusion and over-exclusion);

ii. there is certainty in the law, particularly since it is concerned with interference with fundamental rights;

iii. unnecessary time and costs in the Courts are not expended on arguments about what does and does not amount to a deprivation of liberty within the meaning of the Bill;

iv. decisions that vitally affect the well-being of incapable persons are not delayed by reason of uncertainty and argument about whether arrangements amount to a deprivation of liberty.\textsuperscript{70}

We asked the Government whether it had considered seeking to define deprivation of liberty in the statute, and if so, why it had decided against it. The Government replied that it considered defining deprivation of liberty in the statute, but felt that this was not possible.\textsuperscript{71} The Government felt that since the distinction between a restriction on liberty and a deprivation of liberty was a matter of degree rather than substance, it would not be appropriate to define it in the statute. The Government directed us to the draft Illustrative guidance on Bournwood, which notes that the following factors are identified as ‘contributing to deprivation of liberty’:

- Restraint was used, including sedation, to admit a person who is resisting;
- Professionals exercised complete and effective control over care and movement for a significant period;
- Professionals exercised control over assessments, treatment, contacts and residence;
- The person would be prevented from leaving if they made a meaningful attempt to do so;
- A request by carers for the person to be discharged to their care was refused;
- The person was unable to maintain social contacts because of restrictions placed on access to other people;

\textsuperscript{68} Megyeri v Germany [1992] 15 EHRR 584.
\textsuperscript{69} R (Munjaz) v Mersey Care NHS Trust and others [2005] UKHL 58.
\textsuperscript{70} JUSTICE Mental Health Bill Briefing for House of Lords Second Reading November 2006, para. 49.
\textsuperscript{71} Appendix 3, para 52.
• The person lost autonomy because they were under continuous supervision and control.72

86. We consider that deprivation of liberty is a less flexible and elusive concept than might be thought from the draft illustrative guidance. Since we posed this question to the Government, Munby J has delivered judgment in *JE and DE v Surrey County Council and EW*, holding that the crucial issue in determining whether there is a deprivation of liberty is not so much whether the person’s freedom within the institutional setting is curtailed, but rather whether or not the person is free to leave.73 In this case DE, although lacking decision-making capacity, was clearly expressing his wish to be allowed to live with his wife, even though his wife could not cope without support from social services. In *HL v United Kingdom* although HL was not expressing a desire to leave, his carers wanted him to come home to live with them. Neither was free to leave. Both were deprived of their liberty. It is not necessary for all the elements identified in the list of factors contributing to a deprivation of liberty to be present. There will be a deprivation of liberty if it is known that a person is to be prevented from leaving the place where they are being taken to reside.

87. We asked the Government whether it was satisfied that the proposed arrangements fully meet the requirements of a procedure prescribed by law as those requirements were explained by the European Court of Human Rights in *HL v UK*.

88. The Government is satisfied that the arrangements fully meet the requirements as explained in *HL v United Kingdom*, and that the usual way in which the provisions should be applied is by ensuring that an authorisation is in place before a person is detained. The Government also acknowledges that the Bournewood amendments do not give any additional powers to convey a person to a hospital or care home. The Department does not consider that such powers are needed because it is unlikely that such transportation alone would amount to a deprivation of liberty under Article 5. In the rare case where it was only possible to transport a patient to hospital by detaining them then legal authority would be needed such as an order from the Court of Protection.74

89. **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.

90. In _HL v United Kingdom_ the Court held (at para 114) that ‘an important ingredient of lawfulness is that all law must be sufficiently precise to allow the citizen – if need be with appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action might entail.’ **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.**

91. The Government has indicated in response to amendments tabled at Committee stage in the House of Lords that the principle of means testing will apply to persons deprived of their liberty in residential care homes, who will therefore be liable to charges for the accommodation in which they are detained. 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.

**(10) Omissions from the Bill**

92. In our scrutiny of the Bill we have considered whether there are any significant omissions, which would have promoted or enhanced human rights. There would appear to be two main omissions.

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

93. Since the ruling in _HL v United Kingdom_, the European Court of Human Rights has delivered a further important ruling in _Storck v Germany_ which contains important statements not only about the right to protection against arbitrary detention under Article 5 and but also concerning the right to physical integrity as an aspect of respect for private life under Article 8. The applicant had been admitted at age 15 to a children and young person’s unit and spent seven months there in 1974-5. From July 1977 to April 1979 she was placed in a locked ward at a private psychiatric clinic, without any judicial order, as required by German law. She was brought back in March 1979 by police after she escaped. The private clinic was not entitled under German law to receive detained patients.

94. The Court held that there was a positive obligation for the state to take measures to protect the right to liberty under Article 5 and the right to personal integrity under Article 8 against infringements by private persons, and that both Article 5 and Article 8 had been infringed. The Court stated that ‘Insofar as the applicant argued that she had been 

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75 _HL Deb 17 January 2007, col 764 (Baroness Ashton of Upholland)._  
76 _Storck v Germany_ Judgment of 16 June 2005.
medically treated against her will while detained, the court reiterates that even a minor interference with the physical integrity of an individual must be regarded as an interference with the right of respect for private life if it is carried out against the individual’s will.”

95. This statement suggests that the crucial factor in identifying a breach of Article 8 is the fact that the intervention is carried out against the individual’s will, in other words that there is some resistance. However, in *HL v United Kingdom* the Strasbourg Court refused, for the purposes of Article 5, to treat compliant incapacitated patients as on a par with capable patients who were consenting. Reaffirming the importance of the right to liberty, the Court said:

“The right to liberty in a democratic society is too important for a person to lose the benefit of Convention protection simply because they have given themselves up to detention, especially when they are not capable of consenting to, or disagreeing with, the proposed action.”

96. The Court emphatically rejected the argument that a compliant incapacitated patient should be treated on the same basis as a capable consenting patient in relation to deprivations of liberty under Article 5. There are strong grounds for believing that the same principle applies to interferences with physical integrity. The right is too important to be lost simply because a person has given themselves up to the intervention, especially if they lack capacity to consent.

97. In our view consideration should therefore 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.

98. It is important also to bear in mind the statement of the scope of the positive obligation under Article 8, as outlined in para 150 of the Judgment in *Storck*:

150. The Court … considers that on account of its obligation to secure to its citizens the right to physical and moral integrity, the state remained under a duty to exercise supervision and control over private psychiatric institutions. (emphasis added) [The court noted that in the sphere of interferences with a person’s physical integrity, German law provided for strong penal sanctions and for liability in tort and went on to say that]. Just as in cases of deprivation of liberty, the Court finds that such retrospective measures alone are not sufficient to provide appropriate protection of the physical integrity of individuals in such a vulnerable position as the applicant. The above findings as to the lack of effective state control over private psychiatric institutions at the relevant time are equally applicable as far as the protection of individuals against infringements of their personal integrity is concerned. The Court therefore concludes that the respondent state failed to comply with its positive obligation to protect the applicant against interferences with her private life as guaranteed by Article 8(1).

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99. In the light of this, we asked whether the Government considered that the positive obligation under Article 8 to provide effective supervision and review of interferences with physical integrity was discharged by the Bournewood amendments.

100. The Government’s response is that any patients who are deprived of their liberty under a Bournewood authorisation can be treated in accordance with the provisions of the Mental Capacity Act 2005 and the common law.79

101. The Mental Capacity Act 2005 and the common law provide a retrospective defence for a person who gives treatment which they reasonably believe to be in a patient’s best interests, provided they have taken reasonable steps to assess the person’s capacity and reasonably believe the person to lack capacity. As the European Court noted in Storck ‘such retrospective measures alone are not sufficient to provide appropriate protection of the physical integrity of individuals.’ We therefore remain of the view that effective supervision and review requires more than the common law or the Mental Capacity Act currently provide. The Healthcare Commission’s recent investigation into Merton and Sutton learning disability services found many unchecked abuses of the right of physical integrity of service users, including the case of a man who had no speech, sight or hearing who was tied to his bed or wheelchair for up to 16 hours a day.80 Lord Patel of Bradford tabled an amendment seeking to extend the powers of the Mental Health Act Commission to visit patients subject to a Bournewood authorisation to review the way in which they are being treated.81 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.

(b) Seclusion

102. Seclusion is defined in the Code of Practice on the Mental Health Act 1983 as ‘the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.’ The Code further prescribes a number of principles that seclusion should only be used as a last resort and for the shortest period possible, a reflection of principles of both common law (necessity) and of the European Convention case law (proportionality).82 Seclusion is regulated by the Code of Practice, not by law, and the House of Lords held in R (Munjaz) v Mersey Care NHS Trust and others that hospitals are free to depart from the Code if they have a good reason for doing so.83

103. In its 2004 report on Deaths in Custody84 the previous Joint Committee on Human Rights supported the recommendation of the Mental Health Act Commission and called for regulation of seclusion and other forms of restraint. The Mental Health Act

79 Appendix 3, para 57.
81 Ibid., cols 728-731.
83 [2005] UKHL 58.
Commission has renewed its call for legal regulation in its *Eleventh Biennial Report* ‘not least because of the widespread failure of services to meet the Code’s requirements.’\(^{85}\) In *Munjaz*, the Court of Appeal considered that seclusion was a potential breach of Article 8, and therefore would require justification in terms of Article 8(2) as being necessary for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.\(^{86}\) The House of Lords held that, assuming Article 8 to be engaged, it was not necessary for seclusion to be regulated by legal rules rather than the ‘soft law’ Code in order to comply with the requirement in Article 8(2) that ‘interferences be in accordance with law.’ The Mental Health Act Commission remains of the view that legal regulation is necessary: ‘Given that seclusion has potential to infringe Articles 3 and 8 of the ECHR it is essential to meet obligations of Government and Service providers that its implementation is premised upon consistent and predictable standards and that all hospitals employ the same approach.’\(^{87}\)

104. The *Eleventh Biennial Report* of the Mental Health Act Commission suggests that the Government may have been prepared to consider legal regulation when the Commission state that ‘The Government has informed us that it intends to pursue the statutory regulation of seclusion through the mechanism of the new Mental Health Bill concerned with medical treatment.’\(^{88}\) The Commission considered that seclusion should not be considered a form of treatment, but should be legally regulated as a management technique. The Strasbourg Court has held in *Raninen v Finland* that conditions during detention may produce effects on physical or moral integrity which might not reach a level of severity to breach Article 3, but might nevertheless infringe Article 8.\(^{89}\)

105. Lord Bingham delivered the leading speech in *R v Ashworth Hospital ex parte Munjaz*. He considered that whilst it was obvious that seclusion improperly implemented could infringe Article 8, seclusion properly implemented and for the shortest period necessary would not. Even if Article 8 were engaged, properly implemented seclusion for the shortest periods necessary would find justification in Article 8(2). Lord Bingham went on to say that the purpose of the requirement in Article 8(2) that interferences with the right to respect for privacy be in accordance with law is ‘intended to ensure that any interference is not random and arbitrary but governed by clear pre-existing rules, and that the circumstances and procedures adopted are predictable and foreseeable by those to whom they are applied.’ Although compliance with Article 8 could have been achieved by statutory provisions or regulations, ‘that was not the model Parliament adopted. It preferred to require the Secretary of State to give guidance and (in relation to seclusion) to call on hospitals to have clear written guidelines. Given the broad range of institutions in which patients may be treated for mental disorder, a matter on which Mr Gordon places special emphasis, it is readily understandable why a single set of rules, binding on all, was thought to be undesirable and perhaps impracticable.’\(^{90}\)

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\(^{86}\) [2003] EWCA Civ 1036.


\(^{89}\) Judgment of 17 December 1997, paras 63-64.

\(^{90}\) [2005] UKHL 58, para 34.
106. Lord Bingham stated that the ‘in accordance with law’ requirement was directed at substance not form, but it should be remembered that the argument in the House of Lords in Munjaz was directed against the compatibility of Ashworth’s policy with the ECHR. Colonel Munjaz did not allege that his Convention rights had been infringed on the occasions he had been secluded. It seems safe to proceed on the assumption adopted by both the European Court in Raninen and the Court of Appeal in Munjaz, but only somewhat reluctantly accepted by Lord Bingham in the House of Lords in Munjaz that Article 8 is potentially engaged in relation to seclusion. Therefore any authorisation of seclusion must be in accordance with law and necessary to meet one of the aims in Article 8(2). The Court of Appeal in Munjaz tried to narrow the grounds on which departure from the Code could be allowed, in the belief that to allow such departures on anything but the most exceptional of grounds would risk infringing the ‘in accordance with law requirement’ in Article 8. The House of Lords was prepared to sanction departure from the Code for good reason, and accepted that the fact that a hospital was a high security hospital with difficult patients was a good reason.

107. It can be argued that a Code which can be departed from and where the Courts will retrospectively decide whether the departure has been for good reason does not provide the requisite degree of predictability of consequences for those subject to seclusion to comply with Article 8(2). This argument has been rejected by the House of Lords, however. It is less certain whether the Strasbourg Court would follow suit. In Storck v Germany the Strasbourg Court held even a minimum interference with physical integrity would breach Article 8 if carried out against the individual’s will and that states were required to provide effective supervision and review of interferences with physical and moral integrity. Retrospective challenge by tort action or criminal proceedings was not enough to meet this requirement. One way of seeking to ensure that seclusion is in accordance with law is to provide a system of regulation by statute, or statutory instrument where the circumstances in which seclusion may be authorised are clearly defined, and the procedures to be followed for its implementation and continuation are clearly set out.

108. We asked the Government whether it had changed it s mind about regulating seclusion by law rather than via the Code, and, if a decision had been taken to remain with regulation by Code, what the reasons were for this.

109. The Government’s position is that it intends to use the Code of Practice to regulate this important area of human rights practice, and that seclusion will be monitored by the Health and Adult Social Care Commission which will replace the Mental Health Act Commission. The new commission will have a duty to receive information about the use of Mental Health Act powers including the power to seclude.

91 Storck v Germany Judgment of 16 June 2005, para 139.
92 Ibid., para 150.
93 The Mental Deficiency Regulations 1948 S.I. 1948 No 1000 provided a rudimentary means of regulating seclusion. The regulations defined seclusion and required recording in a register of seclusion or mechanical restraint of each instance, its duration, and the reasons for its implementation. This would then be inspected by the Board of Control on their visits to institutions.
94 Appendix 3, paras 61-62.
110. **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.**
3 Conclusions and recommendations

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 Identity 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. 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)

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)(c) of the Convention. (Paragraph 16)

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)

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)

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 strain on such a relationship, making it inappropriate for such a person to determine the future of the patient. (Paragraph 37)

**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 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)

**Right to seek review of conditions in a Community Treatment Order**

11. We do not consider that the need to obtain the Approved Mental Health Professional’s agreement as to the nature of the conditions to be imposed on a Community Treatment Order 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)

**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 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)

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)

Forcible feeding

17. We consider that the positive obligation under Article 8 as elaborated in Storck v
Germany requires effective supervision and review of decisions 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)

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 90)

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 91)

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)

**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 of interferences with physical integrity 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)

**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)
Formal Minutes

Monday 29 January 2007

Members present:

Mr Andrew Dismore MP, in the Chair

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

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Draft Report [Legislative Scrutiny: Mental Health Bill], proposed by the Chairman, brought up and read.

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

Paragraphs 1 to 110 read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Fourth 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.

Ordered, That the provisions of House of Commons Standing Order No. 134 (Select committees (reports)) be applied to the Report.

[Adjourned till Monday 5 February at 4.00pm.]
Appendices

Appendix 1: Letter dated 17 November 2006, from The Rt Hon. Rosie Winterton MP, Minister of State, Department of Health

1. I am writing to you to draw out particular issues relating to human rights that we have sought to address in the Mental Health Bill. I attach a copy of the Bill and a copy of the Explanatory Notes for the Bill. The Bill amends the Mental Health Act 1983 (“the 1983 Act”) and introduces a new set of safeguards into the Mental Capacity Act 2005 in response to the so-called Bournewood case.

2. Special attention has been given in the Bill to ensure that it is fully compliant with Convention rights because mental health patients are a particularly vulnerable group. Although wherever possible people with mental health problems are treated without compulsion, where this is not the case, the Department recognises that the necessary curtailment of their rights must be within a legislative framework that is compatible with Convention rights with proper safeguards to protect those rights. The amending bill in itself is compliant with the ECHR and in addition, we have conducted an ECHR audit of the 1983 Act, and we are not seeking to leave in place any provisions which we know or suspect to be incompatible.

Background

3. The foundations of modern mental health law were put in place in the 1950s, with some revision and consolidation in the 80s, and some further additions in the mid 1990s. Thinking on human rights has developed in this period, and the 1983 Act has been subject to scrutiny by both the domestic courts and the European Court of Human Rights (the “European Court”) on a number of occasions since the advent of the Human Rights Act 1998.

4. The Committee are aware of the two declarations of incompatibility affecting the 1983 Act. In 2001, the Court of Appeal declared a section of the act to be incompatible with Article 5(1) and (4) on the grounds that it imposed a burden on a patient to show his detention is no longer justified, rather than the authorities showing that his detention is justified. A remedial order was made by the Department using the urgency procedure to rectify this defect (the Mental Health Act (Remedial) Order 2001 (SI 2001/3712)). This amended ss.72(1) and 73(1) of the 1983 Act to provide that a Mental Health Review Tribunal shall direct the discharge of a patient if they are not satisfied that the criteria justifying his detention in hospital for treatment continue to exist.

5. There has also been another declaration of incompatibility against the 1983 Act in the case or R (on the application of M) v Secretary of State for Health [2003] EWHC 1094 (Admin), (“the M case”), which concerned section 26 of the Mental Health Act (the choice of nearest relative) which the Bill addresses. This followed an acknowledgment by the Government that this section was incompatible with Article 8 in the friendly settlement reached in JT v the UK and FC v the UK in 1999 [2001] 1FLR 909 (“JT”).
6. The Bill, as is apparent in the attached Explanatory Notes, in its approach to Supervised Community Treatment, the Mental Health Review Tribunal, and other amendments made – takes account of the need for domestic law measures to be compliant with rights under the convention, in order to ensure their full compliance. The Bill raises issues under Article 3 (no one shall be subjected to torture or to inhuman or degrading punishment); Article 5 (right to liberty and security of the person); Article 8 (protection of private and family life); Article 14 (prohibition of discrimination); and Article 3 of Protocol 1 (right to free elections).

**Definition of “mental disorder”**

7. The definition of “mental disorder” in section 1 of the 1983 Act, and references to the categories of mental disorder elsewhere in the 1983 are amended in the Bill to provide a simplified approach and remove the references to categories. This has no effect on Convention rights. It is considered that the definition of “mental disorder” is consistent with the interpretation given by the European Court to the phrase “persons of unsound mind” in Article 5 (see Winterwerp v The Netherlands (1979) 2 EHRR 387 (“Winterwerp”)). It is a broad definition, in line with the views expressed in that case by the European Court. In that case, the court held that the phrase “persons of unsound mind” cannot be given a definitive interpretation, “it is a term whose meaning is constantly evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society’s attitude to mental illness changes, in particular so that a greater understanding of the problems of mental patients is becoming wide-spread”.

**Criteria for detention**

8. The criteria for detention for treatment in the 1983 Act are in sections 2&3 for civil patients and various provisions of Part 3 for patients concerned in criminal proceedings. Many of these provisions include a criterion that for certain categories of mental disorder treatment must be likely to alleviate or prevent deterioration in the condition. This is to be changed in the Bill to become a test that appropriate treatment is available (which will not be restricted only to particular categories of disorder). The intention is (inter alia) to remove ground for argument about the efficacy or likely efficacy of a treatment which can be used to prevent detention of people who present a risk to themselves or others. The criteria set out in Winterwerp do not include a requirement that the patient be treated, and so the Department does not consider that Convention rights are affected.

**Responsible clinicians and approved clinicians**

9. The name and qualifications of the responsible medical officer in the 1983 Act are to be changed in the Bill, and the new term will be “responsible clinicians”. These must be approved clinicians, but may be drawn from a wider pool of professions with relevant skills, and not necessarily be registered medical practitioners. The Department considers that the responsible clinician does not necessarily need to be a registered medical practitioner in order to satisfy the requirements of the Convention. The case of Winterwerp sets out that deprivation of liberty must be based on “objective medical expertise”. The Department’s view is that this means relevant medical expertise, and not necessarily that of
a registered medical practitioner. For example, a psychologist would have relevant skills in this context and be able to recognise that a person was suffering from a mental disorder and the knowledge to go to someone else with the appropriate expertise when needed. It is our intention that only those persons with such training, experience and skills will be able to be approved clinicians and therefore able to act as a patient’s responsible clinician.

Nearest relative

10. There are also measures in the Bill to give the patient power to have removed, as their nearest relative, a person to whom they reasonably object, thereby correcting the ECHR incompatibility found in the M case, and the decision of the European Court in JT. These provisions introduce an ability for the patient to apply to the county court to discharge his/her nearest relative. They also introduce a new ground on which an application may be made, which concerns the suitability of the person to be the patient’s nearest relative. It will also be the case that when an acting nearest relative is appointed by the court, that appointment can be made indefinite so that an “unsuitable” person will not resume the role of nearest relative following the discharge from compulsion of the patient. These measures therefore enable the amended 1983 Act to be compatible with the patient’s article 8 rights.

Provisions to introduce Supervised Community Treatment (“SCT”)

11. There are provisions in the Bill to introduce the ability to treat patients who have previously been detained in hospital in the community. Care has been taken to ensure that a person who is made subject to a community treatment order can only be recalled or have their community treatment order revoked in a manner and on a basis that is compatible with Convention rights and so as to avoid arbitrariness. In order for a patient to be recalled to hospital, or for the community order to be revoked, thereby making them subject to detention, the patient will have to satisfy the Winterwerp criteria for detention in order to be compatible with Article 5. The assessment of whether their mental disorder warrants detention will be made at the time of the proposed detention by the responsible clinician with the agreement of an approved mental health professional. The reason for recalling a patient to hospital when they are subject to a community treatment order must therefore be related to their need to be treated in hospital and the safety of themselves or others in order to ensure the patient’s Article 5 and 8 rights are not breached.

12. Article 5 rights of access to a court are met in SCT cases. Those patients will be given a new right to apply to the Tribunal when they are made subject to a community treatment order. If a patient who is subject to a community treatment order is recalled to hospital from SCT, he will be automatically referred to the Tribunal by the hospital managers if he is detained for 72 hours or more without release and his community treatment order is revoked. In addition, when a patient’s community treatment order is revoked, he will have the right to apply to the Tribunal in the six month period after revocation.

Mental Health Review Tribunals

13. The Tribunal in England and Wales will continue to be the forum for review of detention decisions. All types of civil cases (including guardianship order patients...
transferred to hospital, but not part 3 hospital order patients) are, under the amendments, to be referred to the Tribunal by the hospital managers at the expiry of 6 months from the applicable date (generally being the date the patient was initially detained under the Mental Health Act) unless an application has already been made, for example by the patient or his nearest relative, or the case has otherwise been referred to the Tribunal. This satisfies the requirements of Article 5 that detained patients have speedy access to a “court” to decide its lawfulness and protects the rights of the patient to be free of arbitrary detention under Article 5.

Members of Parliament

14. Section 141 of the Mental Health Act provides for the seats of Members of Parliament and the devolved assemblies to be vacated where the member is detained under mental health legislation for a particular period. At present this applies only when the member is detained on the grounds of mental illness. Schedule 1 extends this to mental disorder generally. This engages Article 3 of Protocol 1 which has been interpreted to include a right to stand for electoral office. The Department’s view is that this interference pursues a legitimate aim, namely the removal of a member in specified circumstances when he is not able to fulfil his role due to mental disorder, and is proportionate.

Bournewood gap

15. Part 2 of the Bill sets out to remedy the finding of incompatibility with the ECHR by the European Court in the case of HL v United Kingdom (Application No. 45508/99, 5 October 2004). (“HL v UK”). In that case, the Court held that admission to and retention in hospital under the common law of necessity amounted to a breach of Article 5.1 ECHR (deprivation of liberty) and of Article 5.4 (right to have lawfulness of detention reviewed by a court). In relation to Article 5.1, the court held that the common law doctrine of necessity could provide a legal basis for detention but that it lacked the sort of safeguards which would be necessary for detention under it to be in accordance with a procedure prescribed by law. There is provision in the Bill to set out a procedure in law and provide relevant safeguards to close the “Bournewood gap”. This is achieved by amending the Mental Capacity Act to permit authorisation of deprivation of liberty if certain qualifying requirements are met.

16. In particular, the Court drew attention to:

- the lack of any formalised procedures indicating who can propose admission, for what reasons, and what medical or other assessments were required;
- the absence of any requirement to fix the purpose of admission;
- the absence of limits in terms of the time, treatment or care attaching to the admission;
- the absence of any requirement for continuing clinical assessment of the persistence of the disorder warranting detention; and
- the absence of any nomination of a representative able to make objections and applications in relation to the detention.
17. Having regard to the features highlighted by the European Court set out above, the Department has addressed them in the provisions in Part 2 of the Bill. This sets out a formalised procedure for an authorisation for any person suffering from mental disorder (within the meaning of the 1983 Act, but disregarding any exclusion for persons with learning disability) to be detained in a hospital or care home for the purpose of being given care or treatment, in circumstances that amount to a deprivation of liberty. It can only apply to a person who lacks capacity to decide whether or not he should be resident in a hospital or care home for treatment or care.

18. The provisions set out who can apply for such authorisations, the basis on which they can apply, and the need for objective medical expertise. The authorisation can last only up to 12 months though it may be renewed. As part of the assessment process, carers and others interested in the person’s welfare will be consulted, and if the person who lacks capacity is “unbefriended”, an independent Mental Capacity advocate will be appointed. Conditions may be attached to the authorisation.

19. Where an authorisation is granted, a relevant person’s representative will be appointed for the person lacking capacity and that person will be entitled to copies of all the information given to the person who lacks capacity. There will be a duty on the managers of the hospital or care home will be under a duty to keep the deprivation of liberty under review and if it appears that the relevant person no longer fulfils the criteria for detention or there has been a relevant change, then they must request a review of the authorisation. The person who lacks capacity and their personal representative are also able to request a review at any time.

20. There will be an effective means of challenging the granting of, or the continuation of authorisations for deprivation of liberty before the Court of Protection. In particular the person lacking capacity, or the relevant person’s representative, will have the right to take the case before the Court of Protection, without needing to obtain permission.

21. The Department now considers that the is a procedure that is fully compliant with the ECHR for what was known as the “Bournewood gap”.

Appendix 2: Letter dated 19 December 2006, from the Chairman to Lord Warner of Brockley, Minister of State, Department of Health

The Joint Committee on Human Rights is considering the human rights compatibility of the Mental Health Bill. Having undertaken initial scrutiny of the Bill, the Committee would be grateful if you could provide a fuller explanation of the Government’s view that the proposals in the Bill are compatible with the Convention rights guaranteed by the Human Rights Act 1998, in the following respects.

(1) Detention on Grounds of Unsoundness of Mind

Currently a person may not be treated as suffering from a mental disorder by reason only of sexual deviancy. The Government’s intention is to ensure that paedophiles can be detained under the Mental Health Act 1983. Justice has expressed concern at the removal
of the exclusion in relation to sexual deviancy and the possible bringing of transexualism, masochism and fetishism within the scope of compulsory powers.

1. Why has the government chosen to remove the exclusion in relation to sexual deviancy rather than retain it with an exception for paedophilia?

2. We would be grateful for a more detailed explanation of the Government’s intention to treat paedophilia as a mental disorder.

(2) Renewal of Detention

Initial detention under the Act as amended will still be based on objective medical expertise, in the form of reports from registered medical practitioners. However, renewal of detention will be carried out by the responsible clinician, who need not be a doctor, furnishing a report to the managers of the hospital that the conditions justifying detention continue to be met. The Bill proposes that the person in charge of a detained patient’s treatment should no longer be the responsible medical officer (RMO), who must be a doctor, but would in future be the responsible clinician (RC) who need not be medically qualified. The Department acknowledges that Winterwerp requires that deprivation of liberty must be based on “objective medical expertise”, but takes the view that

“[T]his means relevant medical expertise, and not necessarily that of a registered medical practitioner. For example, a psychologist would have relevant skills in this context and be able to recognise that a person was suffering from a mental disorder and the knowledge to go to someone else with the appropriate expertise when needed.”

3. We would be grateful if the Department can explain further its view that medical expertise need not necessarily involve a doctor. In particular:

a) The explanatory notes envisage that responsible clinicians could be nurses, social workers or occupational therapists. Is it envisaged that such a person should furnish the objective medical expertise necessary to renew detention?

b) Does the Department consider that a process of detention and renewal that need not be based on a medical report from a doctor complies with the requirements for a lawful detention on grounds of unsoundness of mind as set out in Winterwerp v the Netherlands?

In R v Warlingham Park Hospital Managers, ex p B95 the Court of Appeal held that the lawfulness of continued detention depends on the furnishing of a report by the responsible medical officer to the hospital managers. The Court of Appeal held that it was not necessary for the managers to consider the report before detention could be renewed. It was enough to renew the authority to detain that the RMO’s report had been despatched to them. In Winterwerp v the Netherlands the European Court of Human Rights held that the

95 (1994) 22 BMLR 1.
notion underlying the phrase ‘in accordance with a procedure prescribed by law’ in Article 5 ECHR is ‘one of fair and proper procedure, namely that any measure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary.’\textsuperscript{96} The appropriate authority which detains non-offender patients is the hospital managers.\textsuperscript{97} Justice urge that section 20 is amended so that it is made clear that any report provided by the (now) responsible clinician must be considered by the hospital managers in order to renew the authority for detention.

4. **Does the Government consider that it is necessary to provide for consideration by the hospital managers of renewal reports in order to comply with Article 5(1)(e)?**\textsuperscript{98} If not, why not?

(4) **The Nearest Relative**

Clauses 21-24 of the Bill amend the provisions of sections 26-29 of the Mental Health Act 1983 concerning nearest relatives. The provisions make it possible for the patient to seek displacement of the person who, according to the statutory formula in section 26, is the nearest relative. Such applications may be made on the grounds that the person is unsuitable to act as the nearest relative.

Given that the unsuitability ground applies not just to applications by the patient, but also by others (e.g. hospital authorities or local authorities), concerns have been expressed by Justice that the unsuitability ground might be used to displace a ‘difficult’ nearest relative, who might not meet the ground of having unreasonably objected to detention or unreasonably exercised the power of discharge.

5. **Does the Government plan to introduce safeguards to protect the right of a nearest relative to be ‘difficult’ in the sense of opposing compulsion, short of unreasonably opposing admission for treatment or unreasonably exercising the power of discharge, which are already grounds for displacement?**

(5) **Procedure for making Community Treatment Orders**

It appears that the possibility exists that a CTO may be imposed on a patient with restrictive conditions as to behaviour potentially interfering with rights under Article 8, on the authority of a Responsible Clinician (who need not be a doctor) and an Approved Mental Health Professional. This authority lasts six months before renewal is required.

6. **Does the Government consider that the procedure envisaged, without need for the managers of the hospital to consider and endorse the application, is sufficient to comply with the requirement in Article 8(2) of being in accordance with law?**

\textsuperscript{96} (1979) 2 EHRR 387 at para 45.


\textsuperscript{98} See also Koendjhibarrie v The Netherlands (1990) 13 EHRR 820 and Keus v The Netherlands (1990) 13 EHRR 701.
(6) Right to seek review of the conditions in a CTO

The effect of the CTO provisions is to allow for up to 72 hours’ detention following recall on the authority of the responsible clinician. The RC may release the patient at any time within 72 hours of recall, and as long as the CTO has not been revoked, the patient will retain his or her community patient status. Currently the possibility exists that a CTO patient might repeatedly be subject to a number of short-term detentions for up to 72 hours for the purpose of enforcing medication, and unless the CTO is revoked, it appears that there will be no form of redress, other than an appeal against the order to a Mental Health Review Tribunal, which can only review the need for an order and cannot review the conditions of an order. It therefore appears that there will be no right of appeal against the conditions in a CTO.

7. Is the Government’s intention that there should be no right to seek review of the conditions of a CTO? If so, what has persuaded the Government that this approach is compatible with Articles 5 and 8 ECHR?

(7) Treatment without consent

The key question is whether the appropriateness test is sufficient to meet the requirements of Articles 3 and 8 of the Convention. The Draft Code recognises the importance of these rights and offers the opinion that ‘Scrupulous adherence to the requirements of the legislation and good clinical practice should ensure that there is no incompatibility.’

The inference naturally to be drawn from the Draft Code of Practice is that the appropriateness test in relation to treatment without consent must address the issues of medical necessity and the likelihood that the treatment will alleviate or prevent deterioration. The Draft Code applies the Convention tests, but these are not found in the legislation itself. The Code may be departed from with good reason.

8. Why has the Government chosen to address Convention compliance in the Code rather than in the legislation, and will consideration be given to making the “medical necessity” requirements of Article 3 and 8 explicit on the face of the Bill?

(8) The Bournewood Proposals

Clause 38 of the Bill makes it lawful to deprive a person of their liberty only if a standard or urgent authorisation (under the new Schedules A1 and 1A to the 2005 Act) is in force or the Court of Protection has ordered a deprivation of liberty in deciding a personal welfare matter. Standard or urgent authorisations may be sought after the person has already been deprived of his or her liberty. This raises a potential compatibility problem in that it does not provide for the initial stage where the mentally incapacitated person is taken to the place where they are to reside without giving consent. It introduces regulation only after liberty has already been taken away.

99 Draft Code of Practice, para 15.2e.
9. Has the Government considered seeking to define deprivation of liberty in the statute, and if so, why have they decided against it?

10. Bearing in mind that the Bill only introduces regulation after liberty has already been taken away, is the Government satisfied that the proposed arrangements fully meet the requirements of a procedure prescribed by law as those requirements were explained by the European Court of Human Rights in *HL v UK*?

(9) Treatment safeguards for compliant incapacitated patients

The European Court of Human Rights has recognised in *Storck v Germany* a positive obligation on the State to take measures to protect the right to personal integrity under Article 8. Arguably that obligation requires 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.

11. Does the Government consider that the positive obligation under Article 8 to provide effective supervision and review of interferences with physical integrity is discharged by the *Bournewood* amendments?

(10) Seclusion

Seclusion is regulated by the Code of Practice, not by law, and the House of Lords held in *R (Munjaz) v Mersey Care NHS Trust and others* that hospitals are free to depart from the Code if they have a good reason for doing so.\(^{100}\) In its 2004 report on *Deaths in Custody*\(^ {101}\) the Joint Committee on Human Rights supported the recommendation of the Mental Health Act Commission and called for regulation of seclusion and other forms of restraint. The Mental Health Act Commission has renewed its call for legal regulation in its *Eleventh Biennial Report* ‘not least because of the widespread failure of services to meet the Code’s requirements.’\(^ {102}\) The House of Lords in *Munjaz* held, however, that, assuming Article 8 to be engaged, it was not necessary for seclusion to be regulated by legal rules rather than the ‘soft law’ Code in order to comply with the requirement in Article 8(2) that ‘interferences be in accordance with law.’

The Mental Health Act Commission remains of the view that legal regulation is necessary: ‘Given that seclusion has potential to infringe Articles 3 and 8 of the ECHR it is essential to meet obligations of Government and Service providers that its implementation is premised upon consistent and predictable standards and that all hospitals employ the same approach.’\(^ {103}\) In its *Eleventh Biennial Report* it suggests that the Government may have been prepared to consider legal regulation: ‘The Government has informed us that it intends to

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100 [2005] UKHL 58.
pursue the statutory regulation of seclusion through the mechanism of the new Mental Health Bill concerned with medical treatment.’ One way of seeking to ensure that seclusion is “in accordance with law” is to provide a system of regulation by statute, or statutory instrument, where the circumstances in which seclusion may be authorised are clearly defined, and the procedures to be followed for its implementation and continuation are clearly set out.

12. Has the Government changed its mind about regulating seclusion by law rather than via the Code?

13. If a decision has been taken to remain with regulation by Code, what are the reasons for this?

(11) Forcible feeding

Forcible feeding as a treatment for mental disorder can be given without consent to a detained patient under section 63 of the Mental Health Act 1983 without the need for a statutory second opinion.\(^\text{104}\) Given that forcible feeding is potentially a breach of Article 3 and Article 8,\(^\text{105}\) and if imposed involves a significant and potentially traumatic invasion of physical integrity, it may be questioned why it is not subject to regulation by the same system of second opinions which applies to Electro Convulsive Therapy under section 58 of the 1983 Act.

14. Does the Government consider that it is necessary to provide more effective supervision and review of decisions to forcibly feed a patient than is currently provided by section 63 of the 1983 Act?

I would be grateful for your response by 19 January 2007.

Appendix 3: Letter dated 17 January 2007, from The Rt Hon. Rosie Winterton MP, Minister of State, Department of Health

1. Thank you for your letter of 19 December 2006 to Norman Warner. I am replying as Minister responsible for the Bill.

2. I am grateful for this opportunity to provide a fuller explanation of our view that the proposals in the Mental Health Bill published on 16 November 2006 (“Bill”) are compatible with Convention Rights guaranteed by the Human Rights Act 1998 in the following respects. It is one of the aims of developing new mental health legislation that it should be compliant with the European Convention on Human Rights (“Convention”). We address these concerns point by point and hope your Committee finds this explanation of our approach helpful.

(1) Detention on Grounds of Unsoundness of Mind

\(^{104}\) Re KB [1997] 2 FLR 180.

\(^{105}\) Nevmerzhitsky v Ukraine Judgment of 5 April 2005.
1. Why has the government chosen to remove the exclusion in relation to sexual deviancy rather than retain it with an exception for paedophilia?

2. We would be grateful for a more detailed explanation of the Government’s intention to treat paedophilia as a mental disorder.

3. The Department’s purpose in removing the exclusion for sexual deviancy is to take away an arbitrary obstacle to the use of the Mental Health Act 1983 (“Act”) where it is clinically justified. There are various abnormalities of sexual preference (paraphilias) – including sexual fetishism and sexual masochism as well as paedophilia – which appear in standard classifications of mental disorders. The Department’s understanding, therefore, is that these paraphilias would, where they reach a level of clinical significance, be regarded by clinicians as mental disorders.

4. If a situation arises in which the relevant professionals (and, if appropriate, the relevant court) believes it appropriate that action should be taken under the Act because a patient suffers from such a disorder – whatever it is – the Department believes the Act should permit that action, subject, of course, to the normal criteria. In other words, with these disorders as with others, it is the needs of the patient and the risk posed by their disorder which should determine whether action is taken under the Act. Removing the exclusion in relation to sexual deviancy (rather than retaining it with an exception for paedophilia) is consistent with this policy objective.

5. The Department does not think that transsexualism would be in any way affected by the removal of the exclusion. It does not see how it could reasonably be classed as “sexual deviancy” – certainly that is not how the Department regards it. It is not related to sexual thrill, psychological comfort or compulsion. It is a disorder of gender identity, not sexuality. In other words, as transsexualism does not, in the Department’s view, currently fall under the exclusion for sexual deviancy in the Act, it will not be affected by the changes proposed in the Bill to remove this exclusion.

6. It is considered that the removal of the sexual deviancy exclusion (for the purposes of the definition of mental disorder) has no effect on Convention Rights. As mentioned in paragraph 7 of the letter to you of 21 November 2006, it is considered that the definition of mental disorder is consistent with the interpretation given by the European Court of Human Rights to the phrase “persons of unsound mind” in Article 5 (see Winterwerp v the Netherlands106 (“Winterwerp”)), which is a broad and evolving definition that cannot be given a definitive interpretation.

(2) Renewal of Detention

3. We would be grateful if the Department can explain further its view that medical expertise need not necessarily involve a doctor. In particular:

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106 (1979) 2 EHRR 387.
a. The explanatory notes envisage that responsible clinicians could be nurses, social workers or occupational therapists. Is it envisaged that such a person should furnish the objective medical expertise necessary to renew detention?

b. Does the Department consider that a process of detention and renewal that need not be based on a medical report from a doctor complies with the requirements for a lawful detention on grounds of unsoundness of mind as set out in Winterwerp v the Netherlands?

7. In Winterwerp, the European Court of Human Rights held that–

“except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of ‘unsound mind’. The very nature of what has to be established before the competent national authority – that is, a true mental disorder – calls for objective medical expertise”. 107

The Department is of the view that the phrase “medical expertise” as required by Winterwerp, was used in the wider sense and the Court was not seeking to lay down which sort of medical qualifications available in a national system would be acceptable and which would not. The term means relevant medical expertise and not necessarily a doctor.

8. In terms of a decision on the renewal of detention, the requirement for relevant medical expertise will be fulfilled provided the responsible clinician has (a) sufficient medical training to recognise, at the very least, that a person was suffering from a mental disorder and (b) the knowledge to go to someone else with the appropriate expertise if in any doubt whether the patient’s mental disorder was continuing or was continuing at a level requiring them to be detained in hospital.

9. A patient’s responsible clinician will be the approved clinician with overall responsibility for the patient’s case. An approved clinician is a person approved by the Secretary of State (in relation to England) or by the Welsh Ministers (in relation to Wales) to act as an approved clinician for the purposes of the Act.

10. In order to be approved, professionals will need to meet minimum criteria determined by the Secretary of State or Welsh Ministers. It is intended that these criteria will include, among other things, a requirement that the person seeking approval is able to identify the presence of mental disorder and the severity of the disorder. In England, the Secretary of State is intending to direct Strategic Health Authorities to carry out the function of approving approved clinicians. A draft of the proposed directions has been published to inform consideration of the Bill during the remainder of its passage through Parliament and is attached in the Annex for your consideration.

11. So, in answer to question (a), it is envisaged that psychologists, nurses, social workers or occupational therapists approved as approved clinicians and therefore able to act as the

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107 See Winterwerp at [39].
responsible clinician will furnish the objective medical expertise necessary to renew detention.

12. Under the Act at present there is a difference between initial detention, which requires the approval of 2 doctors, and the position once a person is detained, where a single responsible medical officer makes decisions in relation to the patient. The Bill is not seeking to change the requirements on initial detention, but notes that this 2-doctor requirement is a high hurdle, which it was decided to impose in domestic legislation, but is not required to meet the criteria in Winterwerp.

13. The decision to renew detention is distinguishable because it is taken against the background of detention where the clinician with responsibility for the patient will have knowledge of the patient as well as access to a range of in-house expertise, in contrast with a situation of initial detention.

14. So, in answer to question (b), the Department considers that a process of renewal of detention that need not be based on a medical report from a doctor does comply with the requirements for a lawful detention on grounds of unsoundness of mind as set out in Winterwerp because the responsible clinician will be able to provide the necessary relevant medical expertise alone to satisfy Winterwerp.

4. **Does the Government consider that it is necessary to provide for consideration by the hospital managers of renewal reports in order to comply with Article 5(1)(e)? If not, why not?**

15. The Department does not consider it necessary to provide for consideration by the hospital managers of renewal reports in order to satisfy Article 5(1)(e).

16. The Department accepts that the notion underlying the phrase “in accordance with a procedure prescribed by law” in Article 5 of the Convention is “one of fair and proper procedure, namely that any measure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary”.108

17. The commentary109 the Committee refers to takes the view that the failure to provide a role for the hospital managers, as the original detaining authority, to consider the report of the responsible medical officer (to be replaced with the responsible clinician under the Bill) before the renewal of the patient’s detention might constitute a breach of Article 5(1)(e).

18. It is not the case that the hospital managers authorise the initial detention of the patient. Section 6(2) of the Act provides that the application for admission to hospital is sufficient authority for the managers to detain the patient in hospital in accordance with the provisions of the Act. In the case of patients involved in criminal proceedings detained under Part III of the Act, it is the hospital order issued by the court under section 37 of the Act which provides the authority for detention and authorises the hospital managers to detain the patient.

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108 See Winterwerp at [45].
19. It is also the Department’s view that the Convention does not require a formal renewal of a patient’s detention. In fact, in the case of a patient subject to special restrictions under section 41 of the Act, there is no such renewal. What Winterwerp requires is the persistence of a mental disorder to warrant continuing detention, and therefore for the patient’s case to be kept under review. It is the responsible clinician that fulfils this review function. In the case of unrestricted patients, the Act goes beyond what is required in Winterwerp by requiring a formal renewal of the patient’s detention.

20. The initial detention of an unrestricted patient is for a fixed period. When that period expires, although a process of formal renewal is provided for under the Act is not a requirement of the Convention, it is nevertheless, in the words of Winterwerp, the measure that deprives the person of his liberty. As a result, the Department accepts that the renewal needs to issue from and be executed by an appropriate authority and should not be arbitrary.

21. The Department does not consider the renewal process to be arbitrary; a clear procedure for renewal of detention is set down in section 20 of the Act. That section places a duty on the responsible clinician to, two months before the expiry of the patients liability to detention, examine the patient and where it appears to him or her that the patient continues to meet the conditions for detention, to furnish a report to the hospital managers to that effect. The furnishing of such a report renews the authority for detention.

22. The Department also considers the responsible clinician to be the appropriate authority for the renewal of the patient’s detention. After the patient is initially detained by the hospital managers, the authority for such detention being on the application for admission, the patient falls within the ambit of the Act and comes under the care of the responsible clinician, who is responsible for the patient’s case. The responsible clinician, having knowledge of the patient’s case, is clearly in a position to be able to determine whether the patient meets the conditions for detention under the Act and is therefore an appropriate authority to renew the detention of the patient in accordance with the procedure set down in the Act.

(4) The Nearest Relative

5. Does the Government plan to introduce safeguards to protect the right of a nearest relative to be ‘difficult’ in the sense of opposing compulsion, short of unreasonably opposing admission for treatment or unreasonably exercising the power of discharge, which are already grounds for displacement?

23. The nearest relative role provides an important patient safeguard, particularly when the decision to detain for treatment is made. It is vital for the effectiveness of this safeguard that the nearest relative should be free to exercise his powers in the way that he feels is in the best interests of the patient. The Department does not wish to restrict this role by allowing for the displacement of a nearest relative for acting independently in this way. It does not wish to restrict the independence of this role in any way but at the same time it
does not think it is necessary to include a specific preventative safeguard for the reasons below.

24. The displacement of a nearest relative should never be about how well that nearest relative is exercising his powers, except where he has unreasonably objected to detention or exercised the power of discharge without due regard to the welfare of the patient or the interests of the public. The Department has retained the existing provisions for displacement of the nearest relative on these grounds precisely because it proposes that suitability should address the issue set out below and not the issue of how well a nearest relative exercises his powers. The judgement of ‘unsuitability’ in relation to a nearest relative is, then, not a judgement of how well he exercises his powers but rather relates to the suitability of him having this type of relationship with the patient in question.

25. The unsuitability of a nearest relative and, indeed, the precise definition of ‘not a suitable person to act as such’ in this context, will be decided by the courts. The court is a public authority for the purposes of section 6 of the Human Rights Act 1998 and will be obliged to act in a way that is compliant with the Convention. It is the Department’s intention that ‘not a suitable person to act as such’ should cover cases in which it would be detrimental to the welfare of the patient to have such a relationship with the person who is the nearest relative. The Department will detail, during the passage of the Bill, the cases it has in mind by this provision.

(5) Procedure for making Community Treatment Orders

6. Does the Government consider that the procedure envisaged, without need for the managers of the hospital to consider and endorse the application, is sufficient to comply with the requirement in Article 8(2) of being in accordance with law?

26. The Committee expresses the view that a patient may be made subject to a Community Treatment Order (“CTO”) which specifies conditions with which he is to comply while the order remains in force and observes that those conditions may be imposed on the authority of a responsible clinician (who need not be a doctor) and an Approved Mental Health Professional (“AMHP”) and that such conditions could restrict a patient’s behaviour in a manner which potentially interferes with his rights under Article 8 of the Convention. The Committee appears to be concerned that the procedure for making a CTO, which does not involve the hospital managers, may not be sufficient to comply with the requirement in Article 8(2) of the Convention of being in accordance with the law.

27. In order to ensure compliance with the law for the purposes of Article 8(2) of the Convention, it is necessary to ensure that:

- the legislative objective pursued is sufficiently important to justify limiting a fundamental right;
- there is a rational connection between the objective and the measure in question; and
• the means used to impair the right are no more than necessary to accomplish the objective.

28. As the Committee is aware, the procedure for making a CTO is set out in the proposed new sections 17A and 17B of the Act. Section 17A of the Act gives the responsible clinician the power to make a CTO discharging a patient from hospital subject to his being liable to recall. However, the responsible clinician cannot make such an order under that section unless an AMHP agrees with his opinion that the relevant criteria for making the order (set out subsection (5)) are met and that it is appropriate to make the order in the patient’s case. Section 17B of the Act gives the responsible clinician the power to attach conditions to a CTO of the type described in paragraphs (a) to (e) of subsection (3) of that section. The AMHP must also agree with the conditions of the order. Subsections (4) and (5) of section 17B of the Act give the responsible clinician the power to vary or suspend the conditions of a CTO. A patient’s failure to comply with a condition specified in a CTO may be taken into account when deciding whether to exercise the power of recall in the proposed new section 17E of the Act.

29. Supervised Community Treatment (“SCT”) is intended to provide a compulsory treatment regime in a less restrictive community setting for persons suffering from a mental disorder who have previously been detained in hospital under sections 3, 37, 45A and 47 of the Act. In so far as the legislative objective is concerned, the Department considers that the objective of SCT is equivalent to, and therefore equally as important as, detention in hospital under section 3 of the Act for the purposes of providing compulsory medical treatment for mental disorder. SCT patients are still subject to compulsory treatment.

30. However, it is important to note that a patient who is made subject to a CTO is not in an analogous position to a patient who has been completely discharged from detention in hospital under section 3 of the Act. Such a patient will remain subject to compulsion under the Act in so far as the provision to him of medical treatment for his mental disorder is concerned. This is evident from the ability to attach conditions to a CTO designed to ensure that the patient continues to receive the care and treatment that he needs while residing in the community together with the need for such a patient to be liable to recall to hospital for further medical treatment should this become necessary. The Department therefore considers that it is imperative that the SCT regime is subject to safeguards imposed both for the protection of the health and safety of the patient and of others. This is the rational connection between the legislative objective of providing compulsory treatment in the community and the imposition of measures designed to ensure that this objective continues to be met once a patient is discharged from detention in hospital subject to a CTO.

31. The Department considers that a decision to make a patient subject to a CTO is a clinical decision and is therefore one which the responsible clinician, as the person with direct responsibility for the patient’s treatment, is best placed to make. The need to obtain the agreement of an AMHP both as to the making of a CTO and the nature of the conditions to be imposed is intended to provide protection against arbitrariness in this respect. Both the responsible clinician and the AMHP are public authorities for the
purposes of Article 8 of the Convention and, as such, have a duty to act compatibly with
the patient’s Convention Rights at all stages in the procedure. The Department does not
consider that the additional involvement of the hospital managers in this process is
therefore necessary.

32. As far as the nature of the conditions attached to a CTO is concerned, the Department’s
view is that it is appropriate only to attach conditions that are considered clinically
necessary to ensure that the patient continues to receive the treatment that he needs while
residing in the community or which relate to his own safety and that of others - including a
condition that would operate to restrict the behaviour of a patient. The Codes of Practice
for England and for Wales will provide guidance to the effect that the conditions attached
to a CTO should be kept to a minimum consistent with ensuring that the patient gets the
treatment he needs and to protect the patient and others from harm. The Codes will also
encourage the involvement of the patient, and those who are to provide care to him in the
community, from the outset in setting the conditions of a CTO so that there is perhaps
little likelihood in practice that the conditions imposed will be ones with which it is not
reasonably practicable for the patient to comply or which are not accepted by the patient.
In addition the power to vary or suspend the conditions of a CTO means that it is not
inevitable that conditions imposed at the outset will last for the duration of the order.

33. The Department therefore considers that the ability to attach conditions to a CTO is
the least restrictive measure that can be devised in order to ensure that the legislative
objective is met. The alternative would be likely to be detention in hospital for compulsory
medical treatment under the Act. To the extent that the imposition of conditions could
potentially interfere with a patient’s rights to respect for private and family life under
Article 8 of the Convention, the Department considers that this would be necessary and
proportionate and in accordance with law.

(6) Right to seek review of the conditions in a CTO

7. Is the Government’s intention that there should be no right to seek review
of the conditions of a CTO? If so, what has persuaded the Government
that this approach is compatible with Articles 5 and 8 ECHR?

34. The Committee notes that the effect of the CTO provisions is to allow a community
patient to be recalled to hospital on the authority of the responsible clinician and detained
there for up to 72 hours without the CTO being revoked. The Committee also notes that,
unless the CTO is revoked, this process of short term detention could happen repeatedly
for the purpose of enforcing medication without any apparent form of redress other than
appeal against the CTO to the Mental Health Review Tribunal which can only review the
CTO and not the conditions imposed. The Committee appears to be concerned that the
absence of a right to seek a review of the conditions of a CTO may not be compatible with
Articles 5 and 8 of the Convention.

35. The Committee has correctly observed that there is no express provision in the Bill that
gives a community patient the right to seek a review of the conditions of a CTO. The
Department confirms that this is the intention.
36. The reasons why the Department considers that the procedure for making a CTO, including the imposition of conditions, is compliant with Article 8 of the Convention have already been addressed in the above response to the Committee’s sixth question. The Department does not consider that the absence of a right in the legislation to seek a review of the conditions of a CTO is incompatible with a patient’s Article 8 rights in view of the power in the proposed new section 17B of the Act to vary or suspend the conditions of a CTO which it will be appropriate for the responsible clinician to consider using if he becomes aware that the conditions imposed are no longer necessary or do not remain appropriate in the individual circumstances of the patient. This is intended to be coupled with guidance in the Codes of Practice to the effect that conditions imposed should be kept to the minimum that is necessary to ensure that the legislative objective is met and that variation or suspension of conditions should only take place if a relevant change of circumstances has occurred.

37. It is not clear why the Committee considers that the absence of the right to seek a review of the conditions of a CTO may be incompatible with a patient’s Article 5 rights to liberty and security given that a community patient will have been subject to lawful detention under the Act, in compliance with Article 5 of the Convention and the criteria for detention set out in Winterwerp immediately prior to the making of the CTO. The legal authority to detain such a patient will not end when he is made subject to a CTO. Indeed, this is the very basis upon which there will be lawful authority to restrict the patient’s Article 8 rights to respect for private and family life while he is receiving treatment in the community and also the basis upon which the patient may be recalled to hospital for further medical treatment should this prove to be necessary for the protection of his own safety or that of others.

38. However, it is assumed that the Committee is concerned about compliance with Article 5 because of the fact that a failure to comply with the conditions of a CTO could result in the patient being recalled to hospital for enforced medication on more than one occasion without a right of redress, except in cases where the CTO is revoked. This assumption has been made because the Department does not consider that it would be appropriate for the responsible clinician and the AMHP to impose conditions on a CTO which are so restrictive in nature that they would effectively amount to a deprivation of liberty for the purposes of Article 5 of the Convention. As stated in the above response to the Committee’s sixth question, both the responsible clinician and the AMHP are public authorities for the purposes of Article 8 of the Convention and, as such, have a duty to act compatibly with the patient’s Convention rights at all stages in the procedure.

39. On the basis of the above assumption, the Department would like to clarify that, although the proposed new section 17E(2) of the Act provides that the responsible clinician may recall a patient to hospital if the patient fails to comply with a condition imposed under subsection (3)(d) of the new section 17B of the Act, it is not intended that failure to comply with this or any other condition of a CTO will automatically result in a decision to recall the patient to hospital. New section 17B(6) provides only that failure to comply with a condition may be taken into account for the purpose of determining whether the power of recall should be exercised. Indeed, such a failure cannot result in a decision to recall a
40. The Department does not consider that the fact that the patient may be recalled to hospital for up to 72 hours pursuant to the exercise of the recall power is unlawful detention for the purposes of Article 5 of the Convention. A decision to recall a patient to hospital on a short term basis in order to administer medication, by force if required, to the extent that it involves a deprivation of liberty contrary to Article 5 of the Convention is necessary and in accordance with the law and is a proportionate response to the risk that would be posed to the patient or to others if the patient’s condition were to be allowed to deteriorate without intervention to the point where he needed to be detained in hospital for medical treatment in the longer term.

41. If a patient were to be recalled to hospital on a repeated basis without his CTO being revoked, the Department considers that this would call into question whether SCT remained suitable for the patient. As such, the continued appropriateness of SCT for a patient will be kept under review by the responsible clinician and the AMHP. This is a protection available to the patient in addition to the rights of the patient to apply to the tribunal for discharge, or, if the patient does not apply, for his case to be automatically referred. It is also in addition to the power of the nearest relative and hospital managers to discharge patients. A community patient will also have the right to apply for judicial review of any decision to recall him to hospital.

42. Accordingly, the Department does not consider that it is necessary to provide a statutory right of appeal against the conditions of a CTO in order to ensure that the power to recall a patient to hospital and to treat him without his consent where necessary is exercised in compliance with Articles 5 and 8 of the Convention.

7. Treatment without consent

43. The Department’s opinion is that the key issue is whether the provisions in the Bill regarding the administration of treatment without consent are compatible with Articles 3 and 8 of the Convention. The Department is satisfied that they are. It is not the case, therefore, that it has chosen to address Convention compliance in the Code rather than in the legislation and so it does not fall to be considered, as mentioned by the Committee, whether the Code is being departed from with good reason.

44. Sections 58(3)(b) and 63 of the Act provide for the administration of treatment without consent. Currently, as regards section 58, a second opinion doctor (SOAD) must certify that treatment should be given, “having regard to the likelihood of the treatment alleviating or preventing deterioration of the patient’s condition”. This is being replaced with the “appropriateness test” (as the Committee describes it) in subsection (2)(b) of clause 6 of the
Bill. The effect is to require a SOAD instead to certify that it is appropriate for the treatment to be given. Clause 6(3) adds a new subsection to section 64 which explains what it means for treatment to be appropriate in this context. The wording is consistent with that used in the “appropriate treatment” test to be added to the criteria for detention under the Act by clauses 4 and 5. It requires that the treatment must be appropriate in the patient’s case, taking into account the nature and degree of the mental disorder from which he is suffering and all other circumstances of his case.

45. As regards section 63, treatment can be given to a patient for the mental disorder from which he is suffering without his consent, not being treatment falling within sections 57 or 58 (treatment administered under section 57 does, of course, require the patient’s consent). The only change to this section is the substitution of “the responsible medical officer” with “the approved clinician in charge of the treatment”.

46. Article 3 is about torture and inhumane treatment. In R. (on the application of PS) v Dr G and Dr W\(^{110}\) Silber J held at paragraph 107 that where medical treatment is administered to a patient against his or her will, Article 3 will be contravened if: (i) the treatment reaches the minimum level of severity of ill-treatment; and (ii) the medical (or therapeutic) necessity for the treatment has not been convincingly been shown to exist.

47. Most medical treatment without consent will not come near to reaching that threshold. It is therefore neither necessary, nor appropriate, to cast the requirements of the Act in relation to treatment without consent generally in terms of Article 3.

48. Although some medical treatment without consent may reach the threshold of severity to be within the scope of Article 3, as mentioned above the European Court of Human Rights has held that there will not be a breach where the treatment is convincingly shown to be a medical necessity. But again, the Department considers that it is unnecessary to put this test in the Bill. Clinicians are public authorities for the purposes of section 6 of the Human Rights Act 1998 and will be obliged to act in a way that is compliant with the Convention. Where the threshold is reached in relation to the provision of treatment under sections 58 or 63, clinicians will need to consider whether the treatment can convincingly be shown to be a medical necessity in order to comply with Article 3 of the Convention.

49. While most treatment without consent will not reach the Article 3 threshold, it is, however, likely to engage Article 8 and therefore require justification under Article 8(2). The European Court of Human Rights has not developed an equivalent test of “medical necessity” in relation to Article 8, as it has in the context of Article 3. In the Department’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 (see paragraph 26 above); (ii) for a legitimate aim; and (iii) necessary in a democratic society.

50. The Department’s view, as set out in the draft illustrative Code of Practice for England, is that adherence to the Act – which in turn implies adherence to good clinical practice – will be sufficient to meet this test. Treatment may be given without consent only in

accordance with Part 4 of the Act (and the new Part 4A in relation to patients subject to community treatment orders). It is inherent in the scheme of the Act that that such treatment may not be given arbitrarily, but only in pursuit of the aims of detention and community treatment, namely to protect patients and other people from the suffering caused and risks posed by their mental disorder.

51. For these reasons the Department considers that the provisions relating to the administration of treatment without consent are capable of operating compatibly with Articles 3 and 8 of the Convention, independent of the Code.

(8) The Bournewood Proposals

9. Has the Government considered seeking to define deprivation of liberty in the statute, and if so, why have they decided against it?

52. The Department considered defining deprivation of liberty in the statute but felt that this was not possible. There is no definitive legal test for what will amount to a deprivation of liberty within the meaning of Article 5 of the Convention. The European Court of Human Rights (ECtHR) has instead addressed this as a case specific decision based on the facts of each situation. In the case of HL v United Kingdom111 (“HL v UK”) the ECtHR confirmed that the distinction between restriction and deprivation of liberty is a matter of intensity rather than substance. It was therefore felt that it would not be appropriate to incorporate a binding legal test into the statute. Instead the Department has issued draft illustrative Guidance for England, which will form part of the statutory Code of Practice provided for under section 42 of the Mental Capacity Act 2005. The guidance is based on the main principles that can be drawn from the key relevant cases on deprivation of liberty decided by the ECtHR and domestic courts. The guidance seeks to offer practical interpretations of the principles along with examples to aid practitioners in their evaluation of each case. More information can be found at pages 9 – 12 of the Draft Illustrative Guidance on Bournewood, which can be accessed on the Department of Health website.

10. Bearing in mind that the Bill only introduces regulation after liberty has already been taken away, is the Government satisfied that the proposed arrangements fully meet the requirements of a procedure prescribed by law as those requirements were explained by the European Court of Human Rights in HL v UK?

53. The Department is satisfied that the proposed arrangements fully meet the requirements of a procedure prescribed by law as those requirements were explained by the ECtHR in HL v UK. Authorisation should be sought in advance wherever possible. Under paragraph 24 of Schedule 6 to the Bill the managing authority is required to seek a standard authorisation not only for anyone who may already be detained but also for anyone who is likely to be detained in a hospital or care home and meet the qualifying requirements, within the next 28 days. The Bill therefore makes provision to ensure an authorisation is in place before a person is detained and this should be the usual way in

which the provisions are applied. An urgent authorisation may be issued while the
assessment process takes place only in an emergency situation if the care home or hospital
considers that a person meets the qualifying requirements and that the need for the
restrictions on their freedom which would amount to deprivation of liberty is so urgent
that they should begin before a decision has been reached on the application.

54. We recognise that initially there will be some people who are already deprived of their
liberty – although the Department’s 2004 guidance will have reduced this – but
implementation of the Bournewood provisions should mean that this is rare in future. The
Bill also therefore provides for applications to be made for an authorisation where a person
is already being deprived of their liberty and meets (or will meet) the qualifying
requirements. This is also necessary to enable an authorisation to be granted where an
individual has been lawfully deprived of liberty under a different regime such as the
Children’s Act 1989, the Mental Health Act 1983 or an order from the Court of Protection,
but is now eligible to benefit from the protection of the Bournewood provisions.

55. It should also be emphasised that any decisions or actions taken regarding a person
who lacks capacity to consent to care or treatment must comply with the provisions of the
Mental Capacity Act, and this would include any decision made regarding change of
residence. The Bournewood safeguards are not an alternative to compliance with the rest
of the Mental Capacity Act, but provide additional safeguards.

56. The Bournewood amendments do not give any additional powers to convey a person to
hospital or to a care home. The Department does not consider that additional powers are
needed. The Department believes that it is unlikely that such transportation alone would
amount to a deprivation of liberty within the meaning of Article 5. In the rare case where it
was only possible to transport a patient by detaining them then legal authority would be
needed such as an order from the Court of Protection.

(9) Treatment safeguards for compliant incapacitated patients

11. Does the Government consider that the positive obligation under Article
8 to provide effective supervision and review of interferences with
physical integrity is discharged by the Bournewood amendments?

57. The Bournewood amendments do not provide any new legal authority for treating
patients who lack capacity. Any patients who are deprived of liberty under a Bournewood
authorisation in a care home or hospital can only be treated in accordance with the
provisions of the Mental Capacity Act 2005 and the common law rules. Supervision and
review of treatment will therefore also be governed by existing legal provisions. The
Department is confident that the provisions of the Mental Capacity Act relating to
treatment decisions are compliant with Article 8 in that they are in accordance with the law
and pursue the legitimate aim of protecting the health and well-being of individuals lacking
capacity in a proportionate manner. A Bournewood authorisation is solely concerned with
deprivation of liberty where this is in the person’s best interests for their care or treatment
– the decision as to what care and treatment is appropriate falls outside the remit of the
Bournewood amendments.
Seclusion

12. Has the Government changed its mind about regulating seclusion by law rather than via the Code?

13. If a decision has been taken to remain with regulation by Code, what are the reasons for this?

58. The Committee asks whether the Department has changed its mind about regulating seclusion by law rather than via the Code, and if a decision has been taken to remain with regulation by Code, the reasons for this.

59. It is not the case that the Department had decided it would regulate, by law, the use of seclusion. In our response to the PLS committee report of March 2005 (Recommendation 81) - that we provide on the face of legislation what is currently provided for in guidance - we confirmed that we were exploring how best to safeguard the interests of patients subject to these interventions in the context of the new legislation.

60. During 2004 and 2005, the Department conducted a number of discussion seminars when we fully explored this issue. Following these considerations, it was decided that setting out – whether in primary or secondary legislation – the use of seclusion and restraint, may unduly fetter a Hospital’s ability to manage patients safely. It was also thought that an overly prescriptive approach may create the danger of preventing seclusion in circumstances where seclusion was clearly necessary. The Department has therefore concluded that the most appropriate approach to this practice issue is to provide for it through guidance in the Codes of Practice issued under the Act. The use of seclusion is a clinical judgment – its use should be informed by detailed professional guidance that is updated and amended in line with clinical practice. Furthermore, the effect of the House of Lords judgment in the Munjaz\(^\text{112}\) case as to the status of guidance in the Codes, is that such guidance is not “take it or leave it” guidance – it must be considered with great care and decision makers can only depart from it if they have cogent reasons for doing so (per Lord Bingham at paragraph 21 of the Judgment). The courts will scrutinise the reasons for any departure from the Codes with the intensity which the importance and sensitivity of the subject matter requires.

61. The Committee will be aware that the Mental Health Act Commission’s Biennial report for the period 2003-2005 states at paragraph 4.221 that:

   “It appears from the Department of Health’s discussions with us that it is minded to use the Code of Practice as the regulatory mechanism in this important area of human-rights practice.”

We confirm this is the Department’s position.

62. The Department intends to create a new regulator for Health and Adult Social Care Commission for England, which will assume the role of the Mental Health Act

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\(^{112}\) R (Munjaz) v Mersey Care NHS Trust and others [2005] UKHL 58.
Commission in monitoring the Act. The Department is continuing to consider the powers this regulator will have and will look to providing it with a duty to receive information about the use of mental health powers and the treatment of persons subject to those powers. Wherever we provide for this, we will ensure that the use of seclusion will be within the scope of such powers.

Forcible feeding

14. Does the Government consider that it is necessary to provide more effective supervision and review of decisions to forcibly feed a patient than is currently provided by section 63 of the Act?

63. The Department does not consider that it is necessary to provide more effective supervision and review of decisions to forcibly feed a patient than is currently provided by section 63 of the 1983 Act.

64. As outlined in the answer to the Committee’s question 8, although some medical treatment, for example, the forcible feeding of a patient, without consent may reach the threshold of severity to be within the scope of Article 3, there will not be a breach where the treatment is convincingly shown to be a medical necessity. In *Nemvershitzky v Ukraine* the European Court of Human Rights held that:

> “a measure which is of therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading. The same can be said about force-feeding that is aimed at saving the life of a particular detainee who consciously refuses to take food. The Convention organs must nevertheless satisfy themselves that the medical necessity has been convincingly shown to exist”.

65. Again, the Department considers that it is unnecessary to state the medical necessity test in the Act. Where the threshold is reached, clinicians will, in order to comply with Convention Rights, need to consider whether the treatment can convincingly be shown to be a medical necessity. Requiring the “medical necessity” test to be met in cases where the Article 3 threshold was reached would add nothing to the duties imposed by the Human Rights Act 1998.

66. The Department also recognises that most treatment without consent is likely to engage Article 8 and therefore require justification under Article 8(2). As stated in the answer to the Committee’s question 8, 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. Again, the Department’s view, is that adherence to the Act – which in turn implies adherence to good clinical practice – will be sufficient to meet this test.

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113 Application no. 54825/00, Judgement of 5 April 2005 at [94].
67. While section 58 of the Act does provide an additional safeguard of a SOAD in relation to certain treatments, there is no requirement in the Convention for such a second opinion. With respect to the Committee, the key question is actually whether the provisions of the Act which provide for the forcible feeding of patients without consent, with or without a second opinion, are compatible with the Convention. For the reasons stated above, the Department considers that they are.

68. That said, the Department does not rule out considering the question of further safeguards for this type of treatment if needed. However, there is no need for the Department to provide that in the Bill as the Act already contains a regulation making power that could be used to bring this form of treatment within the scope of either section 57 or 58 of the Act (as the case may be).

**Appendix 4: Memorandum dated 12 January, from the Mental Health Alliance**

This has been prepared by the Royal College of Psychiatrists for the Mental Health Alliance.

**Introduction**

In this briefing the Mental Health Alliance raises human rights issues that arise from the Mental Health Act 1983 as it will be amended by the Mental Health Bill 2006 which is currently before parliament.

This is not intended as a legal opinion, although it is informed by the legal knowledge within the Alliance membership. It is also intended only to supplement rather than to duplicate material already provided to the Committee by two members of the Alliance, Mind and Justice. It also takes into account the issues already raised by the Committee in its recent letter to the Minister.

If the Committee were to require further clarification of any of the issues raised we would be pleased to respond further.

In its review of the 2002 Bill the Committee stated

We start from the proposition that mental health patients are a particularly vulnerable group. Their dignity and autonomy, and their related human rights including their liberty and physical integrity, are specifically threatened by a regime of compulsory assessment, treatment and detention. Compared with most other people, they are less likely to be able to take action to protect their own rights. Because of this, they therefore depend heavily on other people to provide proper safeguards, and on legislation to ensure that those safeguards will be in place.

In its Report on the 2002 Mental Health Bill the Committee drew attention to several aspects of the Bill which gave cause to disquiet. All of these issues, with some modification, will apply to the 1983 Act as amended by this Bill. In addition we wish to draw the Committee’s attention to
The scope of compulsory powers

The effect of the amendments to the 1983 Act is to broaden the reach of compulsory powers over people with mental health problems and to expand the discretion of professionals. It weakens the ‘strict controls’ over the exercise of compulsion which were said by Lord Elton, in introducing the Bill in 1982, to be integral to the 1983 Act.\(^\text{114}\)

This result is achieved by the cumulative effect of several individual reforms. The wide definition of mental disorder which currently only applies to compulsory assessment for 28 days is extended by this Bill to cover treatment orders for 6 months and also to patients admitted via the criminal justice system. The exceptions for sexual deviance and immoral or promiscuous conduct are removed. The definition of treatment, is broadened because it covers treatment provided under the direction of professionals other than doctors and psychiatrists (for instance it could consist of vocational training under an occupational therapist). The ‘treatability’ test is removed and replaced with a test of ‘appropriate treatment’ which, according to the Committee’s previous report

“would make it possible for people to be compulsorily detained and cared for when there is nothing that can be done to relieve their disorder. .... a person could be detained for treatment (in the sense of care) even if there is no prospect of any treatment having the effect of improving the patient's condition”.

The Committee expressed its concern about these issues under the 2002 Bill and made recommendations for change. They are equally pertinent to the amended 1983 Act. Very few of the Committee’s recommendations were heeded by the government.\(^\text{115}\)

We wish to draw to the Committee’s attention some consequences of these provisions which, in our view, raise human rights issues. Some are addressed in international standards; whether or not they would result in a breach of the Human Rights Act we do not consider in detail. It would require detailed legal argument on the limits of ‘objective medical evidence’ and an illness of a ‘kind or degree’ to warrant compulsory detention. It would also be necessary to test the limits of the concept of “medical necessity”.

It is possible however that the wide definition of mental disorder combined with the vagueness and breadth of the key concepts (for instance “appropriate”, “for the protection

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\(^{114}\) The Mental Health Act 1959 was a landmark in the development of care for the mentally disordered. It established many important principles. Among them are those which require that where care and treatment in hospital are needed, they are given upon a voluntary basis wherever that is possible and that, in those few cases where compulsion does prove necessary, it must be subject to strict controls. I doubt whether anyone would challenge those principles today; this Bill seeks to amend the 1959 Act but it does not challenge those principles. On the contrary, it seeks to ensure that they are more perfectly implemented (The Parliamentary Under-Secretary of State, Department of Health and Social Security, Lord Elton Mental Health (Amendment)Bill [1 December 1981] Bill [H.L.]).

\(^{115}\) On exclusions “We recommend that an exclusion should be included when a Bill is introduced to Parliament, to prevent mental health professionals becoming the guardians of morality in a way that could lead to a violation of Articles 8 (right to respect for private life) and 10 (right to freedom of expression) of the ECHR."

\(^{116}\) International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social a and Cultural Rights (ICESCR), the standards in the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (the UN Mental Illness Principles);the Council of Europe’s Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (opened to signature at Oviedo on 4 April 1997) (the Biomedicine Convention);Recommendation No. Rec(2004)10 of the Committee of Ministers of the Council of Europe to member States concerning the protection of the human rights and dignity of persons with mental disorder’, adopted on 22 September 2004 under the terms of Article 15(b) of the Statute of the Council of Europe.
of”; “treatment”; “all the circumstances of his case”) lack sufficient certainty to comply with the requirement that loss of liberty must be in accordance with the law.

The effects of changes to professional roles

Under the amended Act the initial detention for 6 months must be based on the opinions of 2 medical practitioners. However thereafter periods of detention of 6 months or 12 months can be authorised by a non-medical practitioner thus potentially removing from the process the ‘objective medical evidence’ of mental disorder that article 5 requires. It is hard to see how a person who is not considered fit to determine the existence of a mental disorder at the outset of the process is nonetheless entitled to decide whether it persists. From a medical point of view it is likely to require a higher level of expertise to diagnose an illness once the person’s condition has stabilised than when s/he is in a state of mental crisis when, while the aetiology of the illness may be uncertain, the disordered state of mind is only too evident.

The following example demonstrates also the effect of the breadth of the concept of treatment.

A person may be detained on the basis of a medical opinion that s/he is suffering from depression. During the course of the 6 month period her condition may improve but it may become apparent that underlying the depression is a borderline personality disorder which makes her “difficult” and has always made it hard for her to sustain good relations with work colleagues. There is undoubtedly some form of therapy, an occupational training programme or rehabilitation that is designed to help such people. It is unlikely that she would be detained in hospital because of the shortage of bed spaces but there is nothing in the Act to prevent it if a clinical supervisor (an occupational therapist or psychologist for instance) decided that this was the best course of action and if her nearest relative did not choose to intervene on her behalf. It is assumed for the sake of this example that she retains full decision making capacity. She could none the less be detained and treated against her will.

As the Joint Committee on Human Rights commented in 2002

“Thus, unlike the position in domestic law before the Human Rights Act 1998 detention initiated lawfully and for a lawful purpose may become unlawful under Article 5 on account of the suitability of the resources which are available for a patient’s treatment, the regime to which the patient is subject, and the need to continue to detain the patient to protect himself or herself, or the public, from danger”.

The treatability test

The new test in the Bill which replaces the ‘treatability’ test states that “medical treatment is available which is appropriate in the patient’s case, taking into account the nature or

\[117\] The treatability test requires that treatment must alleviate or prevent a deterioration of the person’s condition. It applies to 2 of the 4 categories of mental disorder because they are conditions, unlike illnesses, where the condition is a constituent part of the person’s personality (learning disability or personality disorder) and may not respond to treatment.
degree of his mental disorder and all other circumstances of his case”. The new definition of medical treatment includes psychological treatments and the new definition of responsible clinicians includes occupational therapists.

The appropriate treatment clause is so vague that it gives almost unlimited powers to clinicians and too little basis for a legal challenge against a person’s detention. It will prove a fertile ground for disputes between lawyers and clinicians at tribunal hearings. The Code of practice states (emphasis added)

“Medical treatment can only be considered appropriate if it is intended to address the mental disorder(s) from which the patient is suffering… “Intended to address” means that the purpose of the medical treatment is to alleviate, prevent deterioration in or otherwise manage the disorder itself, its symptoms or manifestations or the behaviours arising from it”.

Secondly the test is intended to fall short of providing a therapeutic benefit. This is made clear in the Code

“2A.5. Where appropriate treatment is available no one should be excluded from detention, or discharged, solely because it cannot be shown that it is likely to produce any particular benefit or outcome …. 

2A.6 A patient’s attitude towards proposed treatment is a factor to be taken into account when determining whether the appropriate treatment test is met. But psychological therapies and other treatments which require the patient’s cooperation to be effective are not inappropriate simply because a patient does not wish to engage with them. They will remain available so long as it continues to be clinically appropriate to offer them and they would be provided if the patient agreed to engage. Similarly, the fact that a patient indicates an unwillingness to co-operate with treatment generally, or a specific aspect of treatment, does not, of itself, make such treatment inappropriate.”

The result is a very broad reach for the legislation, a concept of health benefit which is almost meaningless and no requirement that the patient receives any benefit at all beyond that of confinement in a therapeutic environment.

It is inherently unethical to permit people to be detained in hospital or otherwise have their lives controlled because of their ill health or their personality when they are not obtaining any benefit from it. To jettison this principle is to change health legislation into legislation of social control, even if that is not the intention. This would be profoundly discriminatory towards a particular group of people who are already unfairly stigmatised within society and who are therefore easy, even popular, targets for further discrimination.

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118 The Joint Scrutiny Committee on the Mental Health Bill 2004, who reported on an identical clause in that Bill criticised the clause. As the Expert Committee had done before them so the Joint Scrutiny Committee concluded that a proper test of therapeutic benefit was an essential component of the law. The Expert Committee considered the need to show positive clinical measures which were likely to prevent deterioration or secure improvement in the patient’s mental condition and concluded that “a health intervention of likely efficacy” was required. Review of the Mental Health Act 1983, November 1999, para 5.98.
Professor Nigel Eastman, Professor of Law and Ethics in Psychiatry, University of London and Head of Forensic and Personal Disorder Psychiatry, St George's Hospital Medical School, London, stated to the Joint Scrutiny Committee:

“therapeutic benefit to the individual is of crucial importance in terms of protecting the boundary of what is the business of mental health professionals. I am not at all against protecting the public, of course not, but it must be in conjunction with some benefit to the individual that goes beyond simply stopping them offending. If you adopt a definition of treatability, which is simply the reduction of risk or the avoidance of offending, that means that locking somebody up is treating them”.

The Committee made previous statements on this issue\textsuperscript{120}. While it is compatible with jurisprudence under Article 5 for people who have been convicted of a crime to be detained in a therapeutic environment under clinical supervision even if there is no treatment for them the decided cases “set no clear precedent for patients who have had no contact with the criminal justice system”.

“it is questionable whether the non-therapeutic detention of persons without conviction of an offence, on the grounds of “speculation about possible future behaviour and resulting risk to identified persons”, will be compatible with the HRA”.

The tests to ascertain the level of risk justifying compulsion are not reliable\textsuperscript{121}. Using the most accurate risk assessment predictors it would require the detention in hospital of at least 2000 people to prevent a single homicide\textsuperscript{122}.

It is also questionable whether a law permitting indeterminate sentencing for people with a mental disorder who are convicted of a minor offence unrelated to their mental illness or people who are accused but not convicted would be compatible with the HR Act

**Replacement of treatability test by appropriate treatment as the criterion applied by Second Opinion Appointed Doctors (SOADs)**

The Bill changes the current criterion for second medical opinion approval of treatments under s.58 (and also general approval of s.57 treatments) These sections cover the provision for electroconvulsive therapy without consent and medication given without consent beyond 3 months.

\textsuperscript{120} Whatever this Government's intention, the wide definition of 'medical treatment' in the draft Bill would allow people to be detained where the only treatment that could be offered was 'care' under the supervision of an approved clinician. The draft Bill does not, in terms, say that the powers could be used only where professionals believed that they could offer effective treatment in the wider sense of a therapeutic programme with a reasonable chance of mitigating the patient's condition.

\textsuperscript{121} Analysis of 40 homicide enquiries between 1988 and 1997 concluded that in 11 cases (27.5%) violence could have been predicted but in 72% there had been insufficient evidence to alert professionals. The findings state “more homicides could have been prevented by good mental health care which detected relapse earlier (17 cases) than would than be averted by attempts at better risk assessment and management (11 cases).” Munro & Rumsay: 2000. Role of risk assessment in reducing homicides by people with mental illness. British Journal of Psychiatry 176 116-120.

\textsuperscript{122} For instance Szmukler 2003, Risk assessment: 'numbers' and 'values' in Psychiatric Bulletin 27, 205-207 Other studies have quoted a higher figure (for instance Crawford Psychiatric Bulletin (2000)).
At present the SOAD must satisfy himself that “…having regard to the likelihood of its alleviating or preventing a deterioration of his condition, the treatment should be given”. Under the Bill this is changed to “…it is appropriate that the treatment should be given ”. The definition of “appropriate” would be defined (circularly) in the following way: “it is appropriate for treatment to be given to a patient if the treatment is appropriate in his case, taking account the nature and degree of the mental disorder from which he is suffering and all other circumstances of the case”.

This raises particular issues – first that of legal certainty and of proportionality under article 8(2) given that ECT, an invasive treatment with serious physical effects, can be given in the face of the refusal of a patient with capacity to consent to it. The SOAD is himself a public authority and therefore, under current law, would be required to authorise the treatment only if it is in the patient’s best interests and a ‘medical necessity’. The appropriateness test is far broader than that. In our view legislation which raises the prospect of causing confusion or conflicts for practitioners is most undesirable.

**Capacity and treatment without consent. The principle of non discrimination**

We acknowledge that current jurisprudence under the European Convention on Human Rights does not consider that forced treatment of a patient with full capacity breaches the right to physical integrity in article 8 of the Convention. Rather the principle of medical necessity is seen as the determining factor. This is considered in detail in the legal opinion provided to the Committee by Mind. This is despite some recognition of a stricter standard in international standards. They include statements by the World Psychiatric Association and the World Health Organisation.

This situation is a matter of great regret given the extreme harm that can be done to patients through the powerful and potentially toxic chemicals that constitute drug treatment for mental illness. People may live with episodes of mental illness for many years and are likely to develop knowledge of what works best for them when the illness flares up. This may include choosing coping mechanisms that do not give the immediate relief of drug treatments. For some the prospect of long term use of powerful and potentially harmful drugs is deeply unpalatable.

In choosing to cope with unpleasant symptoms of an illness rather than even more unpleasant side effects a mental health patient is not so different from the cancer patient who declines chemotherapy even though he knows it may hasten death. However the compulsory system enables the psychiatrist but not the oncologist to force their opinion on the patient, place him or her under compulsory powers and if resistance continues hold the

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123 The World Psychiatric Association approved at the General Assembly, on August 25, 1996 the following ethical standards that should govern the conduct of psychiatrists worldwide. Article 4 states “When the patient is incapacitated and/or unable to exercise proper judgment because of a mental disorder, the psychiatrists should consult with the family and, if appropriate, seek legal counsel, to safeguard the human dignity and the legal rights of the patient. No treatment should be provided against the patient’s will, unless withholding treatment would endanger the life of the patient and/or those who surround him or her. Treatment must always be in the best interest of the patient”.

124 WHO Mental Health Care Law: Ten Basic Principles WHO/MNH/MND/96.9 These include the right to self determination covering the need for consent to medical treatment. “authority for involuntary hospitalization does not automatically include authority for involuntary treatment, especially if the treatment is invasive).
patient down and forcibly inject them. A recent study demonstrates that in this situation “doctor knows best” is a dangerous falsehood.\textsuperscript{125}

Dr Anthony Zigmond, the Honorary Vice-President of the Royal College of Psychiatrists recently stated to a group of peers in the House of Lords

“How many peers are careful about what they put in their body. Do they avoid junk food or McDonalds perhaps? How would they feel if they were forced to eat such food? Imagine having drugs put in your body. These are the potential side effects of anti-psychotics (I pick this group of drugs because they are the most common to be forced on patients). Parkinsonism, dystonia, akathisia, tardive dyskinesia, hypotension, hypothermia, hyperthermia, neuroleptic malignant syndrome (which may be fatal), drowsiness, apathy, agitation, excitement, insomnia, convulsions, dizziness, headache, gastro-intestinal disturbances, nasal congestion, dry mouth, blurred vision, difficulty with micturition, acute urinary retention, constipation, tachycardia, arrhythmias, (including sudden death), menstrual disturbances, galactorrhoea, gynaecomastia, impotence, weight gain, agranulocytosis or leucopenia, (both of which may be fatal), photosensitization, contact sensitisation, rashes, jaundice, corneal and lens opacities, and pigmentation of the skin, cornea, conjunctiva and retina (which may cause blindness).

A problem in leaving this to psychiatrists, is that for detained patients, there is no true weighing up of harm versus benefit. Doctors do not have to, indeed we are not permitted to, listen to patients with regard to the benefit/adverse effects ratio in relation to medication. If you’re my detained patient, I have to treat your mental disorder before I can discharge you. Whether or not I make you obese or impotent in the process, is largely irrelevant – at that time - to both of us”.

As the Royal College of Psychiatrists maintained in its evidence before the Scrutiny Committee on the 2004 Bill it is profoundly discriminatory for compulsory powers to apply to mentally-ill people in danger of causing harm to themselves unless it is clear that their ability to make decisions about their disorder and treatment is impaired by the mental disorder.

In the previous Report of the Committee the question of discrimination is considered. With reference in particular to Article 26 of the ICCPR which guarantees protection against discrimination on the ground of status. The Committee stated “in principle health, whether mental or physical, would seem to be a type of status and ground of discrimination calling for careful examination and justification”.

“Where a patient is suffering from a condition which seriously impairs his or her mental capacity to choose whether to accept treatment, [our emphasis] there seems to us to be a rational and objective justification for treating that person differently, in relation to decisions about treatment, from someone whose mental capacity for decision-making is not so seriously impaired. This consideration seems to us to justify the liability of mentally disordered patients to non-consensual medical intervention where other patients would not be so liable, avoiding a violation of

\textsuperscript{125} Mind, Evidence to the Joint Scrutiny Committee extract from Report into Withdrawal from Medication, 2005.
ICCPR Article 26. It also seems to us to mean that deprivation of liberty for that purpose is not in principle arbitrary, so avoiding any inevitable violation of ECHR Article 5.1 or ICCPR Article 9.1”.

The Mental Health Alliance agrees with this assessment of the situation of people with mental disorder. It is precisely for that reason that amendments are proposed to align the law to that position. It was a similar conclusion that led the Expert Committee on the 1983 Act to call for new mental health legislation to contain a capacity test and the Joint Scrutiny Committee on the 2004 Bill to endorse that view. The Mental Capacity Act also enshrines the principle of the capacitous patient’s right of choice. This goes so far as to cover an advance refusal of treatment which, subject to some qualifications, must be respected.

Recent research found that a significant minority of detained patients, particularly those who had been detained on a previous occasion retained their capacity\textsuperscript{126}. The authors also found that a capacity test worked with a high level of reliability. Mental disorder no more defines a person than does sexuality define the personality of a homosexual person (to take another group who are subject to prejudice). A person may have many symptom free periods and may also develop an insight into their symptoms.

However the amended 1983 Act does not provide for this situation. Under section 3 of the Act a person with a mental disorder may be detained if it is “necessary for his health or safety or the protection of others” and if it is “appropriate for him to receive medical treatment in hospital”. The consent to treatment of such patients is relevant in that he can be detained only because he does not consent to treatment.

It could be questioned whether the ‘medical necessity’ test is satisfied by such a low threshold for compulsion in circumstances in which the patient retains capacity.

**Advance directives**

The Joint Committee on Human Rights expressed the view in relation to advance decisions

“We have doubts about whether it should be possible to override the wishes of the patient, expressed when capable of making a decision, about treatment.”

There is no provision for advance decisions to be taken into account within the Mental Health Act. By contrast the incapacitous patient who is compliant and placed under the detention regime under the Mental Capacity Act has the right to have an advance decision complied with. The difference of treatment for those under the MHA is in our view unjustified and discriminatory.

**Community treatment orders**

Under the Bill a person may be discharged on to a community treatment order (CTO) by a responsible clinician. The relevant criteria are—

\textsuperscript{126} “Prevalence and predictors of mental incapacity in psychiatric in-patients” Cairns, Maddock, Buchanan,David, Hayward, Richardson, Szmukler and Hotopf British Journal Of P Sychiatry (2005), 187, 379–385.
a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;

b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;

c) subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital;

d) it is necessary for his health or safety or for the protection of other persons that he should be liable to be recalled to hospital for medical treatment; and

e) appropriate medical treatment is available for him.

Conditions shall be imposed on the patient. They may include a condition that the patient reside at a particular place; make himself available at particular times and places for the purposes of medical treatment; receive medical treatment in accordance with the responsible clinician’s directions and abstain from particular conduct. The responsible clinician may, by order in writing, vary or suspend the conditions in the order.

The responsible clinician may also revoke the order and return the patient to a compulsory order under section 3 if he believes that the conditions mentioned in section 3(2) above are satisfied in respect of the patient.

While in most cases the restrictions on liberty will be insufficient to attract the protection of Article 5, Article 8 is engaged by community treatment orders because of the effects of the conditions of an order on the private and family life of the patient. The cumulative effect of the conditions may indeed constitute a considerable interference with a persons’ Article 8 rights and bring article 8(2) into play. There is no right to challenge the conditions imposed. Nor is there a requirement of proportionality built in to the conditions. Both of these factors are problematic. However these issues have been dealt with in the Justice submission to the Committee.

However it is the effect of the power of recall on the capacitous patient’s freedom of choice over medication which, in our view, is most objectionable. The criteria do not include a requirement that the person can only be treated under a CTO (as compared with such a requirement for a section 3 order). It is possible, indeed most likely, that the patient consents to the treatment but that s/he needs to be subject to recall in case of a change of mind. If that were not the case there would be no need for an order at all and the patient would simply need to be discharged as no longer meeting the section 3 detention criteria.

X has a diagnosis of postnatal depression. She is considered to be at risk to her health but she is unwilling to enter hospital because she does not want to be separated from her baby. She is detained under the amended Mental Health Act. After 6 weeks she is ready to be discharged because her condition has greatly improved. However she dislikes the effects of her medication—weight gain, nausea and listlessness and she fears becoming dependent on it. She wants to try gradually to withdraw from medication and use other methods—alternative treatments and therapy to return to health. Her partner who is looking after the baby full time agrees and is prepared to support her and the baby through this period. Her
psychiatrist is concerned that she may relapse and wants her to stay on medication. In order to ensure that happens he only agrees to discharge her if she agrees to be on a CTO. He says he will monitor her condition and help her to withdraw gradually. She reluctantly agrees.

3 months later she has gained in confidence and increasingly returns to a full active life. Unfortunately she suffers increasing side-effects. Huge weight gain and lethargy become an increasing problem, particularly as her child wants more attention. She wishes to stop the medication under the direction of the psychiatrist. Her new community psychiatrist is opposed to her withdrawing from medication. After 2 more months of monitoring herself she decides to give up the medication and fails to attend for treatment as required by her order. She is adamant that she wants to sort this for herself and her partner supports her. The psychiatrist disagrees. He fears her wishing to stop the medication at this time may be due to her depression returning with consequent loss of insight. He believes her partner is agreeing with her as he wishes to be supportive. She is recalled to hospital which she resists angrily particularly as she is upset at being separated from her child. In hospital she is restrained and injected with a tranquilliser. She is placed back on a section 3 order and she continues to take her medication as required. After one month she is again discharged on a CTO. She finds this experience traumatising and humiliating (as is the commonly reported experience of patients). She and her partner are now in a quandary. There is no choice of psychiatrist where she lives and she does not want to return to him.

This patient would appear to have no way of challenging this treatment. Although there is a right of appeal to the Mental Health Tribunal the tribunal can of course only work with the statutory provisions and with these excessively broad powers may find no basis on which to release her. We do not believe that the ability to recall a capacitous patient to hospital and to forcibly treat that patient merely because, under clause 17E s/he “requires medical treatment in hospital” (because s/he cannot be forcibly treated in the community) and there would be a risk of harm to health or safety if recall did not happen, is compatible with Article 8. It may fall well short of a medical necessity and be indeed a punitive measure for the patient failing to follow the advice of the doctor. Breach of a condition is a relevant factor in deciding whether to recall (Clause 17B (6), for instance because they have failed to attend for treatment.

The nearest relative

The Nearest relative provisions have, according to a series of court decisions been held to be incompatible with Article 8 of the European Convention in so far as they give the individual no choice over the appointment of their nearest relative and no mechanism by which the nearest relative can be removed where he/she is unsuitable or the patient otherwise wishes to replace him.127

The Bill proposes to address this by adding the patient to the list of those who can apply to displace the nearest relative. It also inserts a new ground to the reasons for displacement: that the person is “not suitable” to act in this role. Therefore a patient can nominate a

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127 For example, JT v United Kingdom [2000] 1 FLR 909.
nearest relative only through making a court application to the County Court and declaring that the person identified through the hierarchical list as ‘not a suitable person’.

We believe it is unrealistic and unreasonably onerous first, to expect the patient to go to court for the displacement. Access to the court and the procedures that accompany it are daunting to many people, let alone a person with mental illness who is most likely to be unwell and possibly in hospital.

Secondly to expect patients to make a case to a court that their closest relative (the one first on the list) is ‘unsuitable’ is harsh and unreasonable in any circumstance - but in a situation in which they may be at their most vulnerable, and dependent on them to some extent, is simply impractical. It is perfectly legitimate to believe that someone other than the closest relative is better able to give them the support they need through the process even though they may wish to retain a relationship with the person who will be displaced. It is clear that the Government does not intend displacement to take place - except in the most extreme situation perhaps of proven abuse or risk to health. It would not for example cover antipathy between the patient and his/her Nearest relative – and rather ominously the Code of Practice states that a Nearest relative cannot be rendered unsuitable on the basis that another person is more suitable. We believe that the concept of ‘suitability’ is too restrictive and fails to pay sufficient regard to the patient’s wishes.

We understand that the Government is concerned that if a patient were able to chose their representative they might choose someone in a crisis with whom they had no connection or someone who would not act in their best interests. However there are already checks and balances in the law to deal with the nearest relative’s misuse of power - and these could also apply to the named person. The checks include:

- a power to block the nearest relative’s discharge of the patient - if it is likely that the patient would act in a dangerous manner
- a power to displace the nearest relative if he/she is to ill to act or is using their powers unreasonably

We do not consider that the proposals give adequate respect for the patient’s right to private and family life.

It is also likely that the Government is laying themselves open to future embarrassing litigation. For example in the recent case, *R (E) v Bristol City Council* 2005 – the Court held that these provisions should be interpreted in accordance with a patient’s Article 8 ECHR rights so as to take into account her wishes and/or her health and well being. This case considered the circumstances in which an approved social worker is not legally obliged to consult a nearest relative:

“Is the approved social worker really bound to inform /consult the nearest relative of a patient who may intensely dislike a patient and/or would, or might, not act in the patient’s best interests? The answer, in my judgment, is of course not and particularly
so where the patient, as here, is competent and has strongly expressed her wish that her nearest relative…is not informed or consulted.” 128

The Bournewood provisions (Clause 38 and Schedule 6)

The ruling in HL v United Kingdom [2004] requires that deprivations of liberty of people who lack mental capacity should be carried out in accordance with a procedure prescribed by law. Assessing whether there is a deprivation of liberty is a complex matter and the factors to be taken into account include the type, duration, effects and manner of implementation of the measure in question. If there is a deprivation of liberty, this needs to be authorised by a procedure prescribed by law.

The State is under a positive duty to provide effective supervision and review of deprivations of liberty and interferences with the right of sanctity of the person. Someone who is deprived of his or her liberty under the Bournewood proposals will have lesser safeguards than a person deprived of their liberty under the Mental Health Act 1983. For example: a person can be detained in a case of urgency apparently without any safeguards for up to 7 days under the Bournewood proposals whereas they can only be detained following an application under section 4 of the Mental Health Act 1983 with one medical assessment for up to 72 hours, and tribunal rights are much more frequent under the Mental Health Act 1983 than the once in a 12 month review by the Court of Protection envisaged in the proposals. A person might therefore argue discrimination contrary to Article 14 ECHR read in conjunction with Articles 5 and 8 ECHR if they or their relative is detained under Bournewood rather than under the Mental Health Act 1983. It is difficult to see what the objective justification would be for treating Bournewood patients less favourably.

In HL v United Kingdom the Court listed six factors needed to meet the procedure prescribed by law requirement and we are concerned that the Bournewood proposals may fail to satisfy these standards.

1. Fixed procedural rules by which admission and detention of compliant incapacitated persons are conducted.

It is of great concern that the efficacy of the proposed system of supervision depends entirely on the assessment of the care home or hospital as to whether there is a deprivation of liberty and therefore whether the incapacitated person falls within this regulatory system. The regulatory scheme will have to be activated by the hospitals or care homes which are to be regulated by the scheme, which will be financially disadvantaged by the imposition of the scheme in any individual case and which therefore will have strong disincentives to suggest that the person has been deprived of their liberty.

We are also concerned that authorisation for deprivation of liberty in an emergency need not be sought for seven days. The emergency admission procedure under s 4 of the Mental Health Act 1983 authorises detention for up to 72 hours before other assessments are needed to continue deprivation of liberty. We fail to understand why seven days to make

128 Bennet J at para. 28.
an application is seen by the Government as acceptable for people who lack capacity. We suggest that an application should be made as soon as the deprivation of liberty occurs (within 24 hours), and that the full assessments should be completed within 72 hours.

2. **Specification of the reasons and the kind of medical and other assessments and conclusions needed to justify a deprivation of liberty**

The criteria for a deprivation of liberty must in all cases reflect Article 5(1) (e) ECHR which requires that there must be an unsoundness of mind of a nature or degree warranting confinement. The Mental Health Act 1983 requires that the mental disorder must be of a nature or degree which requires detention. We consider that it is likely that the assessment criteria in Schedule 6 paragraph 16 of the Bill will be adequate although they do not specify the need for the disorder to be of that level of seriousness, rather that the potential harm to the patient is serious.

We welcome that as a minimum there must be two assessments: the mental health and the mental incapacity assessment by a doctor, and the best interests assessment by a social worker or Approved Mental Health Professional. However, since it may often be the local authority or the PCT which is funding the placement where the deprivation of liberty is occurring, the question arises of whether they have the requisite degree of independence to be a competent authority.

3. **Specification of the exact purpose of admission and limits in terms of time, treatment or care**

It is of some concern that the criteria for detention under the Bournewood proposals fail to specify the exact purpose of the deprivation of liberty, for example, for assessment or for treatment.

4. **Specific provision requiring a continuing clinical assessment of the persistence of a disorder warranting detention**

Under the Bournewood provisions, the managers of the hospital or care home are given the responsibility for identifying when an assessment is needed and monitoring whether the detention remains necessary. This appears to be a clear conflict of interest. We recommend that an independent body, such as the Mental Health Act Commission, should be given a specific role in monitoring detentions under the Mental Capacity Act 2005.

5. **Nomination of a representative of a patient who could make certain objections and applications on his or her behalf**

This procedural protection is accorded to those committed involuntarily under the Mental Health Act 1983 and we believe is of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities. The Bournewood proposals say that everyone will have someone ‘independent’ of the hospital or care home, and independent is in inverted commas in the document. It is
difficult to see how the representative’s independence will be safeguarded, since they will be recommended by the best interests assessor and appointed by the supervisory body.

Parity with the detention regime under the Mental Health Act

The other question which should be considered is the issue of psychotropic medication given to people who lack capacity and issues such as covert medication. There should be some effective supervision and review of these issues. In Storck v Germany [2005] the Court held that even a slight interference with physical integrity would be a breach of the right or respect form privacy under Article 8(1) ECHR if carried out against the person’s will. The same arguments applied to extend Article 5 ECHR safeguards to compliant incapacitated patients, apply to Article 8 ECHR issues as well. In HL v United Kingdom the court held that compliant incapacitated patients were not to be treated as on a par with consent ing capable patients. This was because the right to liberty in a democratic society is too important for a person to lose the benefit of Convention protection simply because they have given themselves up to detention, especially when they are not capable of consenting to, or disagreeing with, the proposed action. If compliant incapacitated patients cannot be treated as if they were capable consenting patients for the purposes of the right to liberty under Article 5 ECHR, there is a strong argument that the same must be true of the right to sanctity of the person under Article 8 ECHR. This would mean that there should be some supervision and review of medication and other treatments given without consent for mental disorder. This is particularly significant in the scheme proposed here, as the Mental Health Act 1983 will have to be used for non-compliant patients who are detainable, and there must be great concern that inappropriate medication may be used to sedate and render compliant incapacitated patients to avoid Mental Health Act 1983 detention. The question might arise as to whether these inferior safeguards raise issues under Article 14, as combined with Article 5 and Article 8.

Mental Health Alliance

Appendix

Extract from the Royal College of Psychiatrists’ briefing for the Second Reading Debate on the Mental Health Bill

the principles from which we consider that law reform should proceed.

(1) The law should support modern principles and practice of care and treatment for mental health patients
This includes the NHS principles of patient choice and participation and the new ways of working for psychiatrists and other mental health professionals. It also includes the values of human rights and equality.

(2) Informal treatment, care and support should always to be preferred over compulsion when circumstances permit.
Compulsory admission powers which involve the deprivation or restriction of human rights should only be exercised as a last resort. This is indeed stated in the Code of Practice.
This was one of the principles adopted by the Richardson Expert Committee for inclusion on the face of a new Act.\footnote{129}

(3) **The law should seek to reduce stigma and discrimination against people with mental illness. Wherever possible the principles governing mental health care should be the same as those which govern physical health.**

Stigma and discrimination remain the regular experience of people with mental health problems and, despite anti-stigma campaigns by the College and by government, have worsened over the last decade.\footnote{130} While legislation can not cure social problems that are rooted in prejudice a law with a discriminatory impact clearly legitimises and contributes to stigma.

(4) **The law should be practical.**

(5) **The law should be consistent with professional ethics.** Psychiatrists operate in an ethical framework governing all medical practitioners. As NHS consultants we are governed by the Human Rights Act. We also operate within the wider framework of ethical standards of the World Psychiatric Association.\footnote{131} The Hippocratic oath of “first do no harm” should apply in this field of legislation as in any other medical intervention. A law which creates ethical conflicts for psychiatrists is damaging for the profession, for its reputation and for recruitment of new members.

While some patients whom we detain under the Mental Health Act clearly benefit from compulsory care and are grateful for having been protected at a time when their illness made them refuse the help they needed, others look back on their experience of being under compulsion as traumatic and damaging, as leaving a “lingering sense of grievance”.\footnote{132} Large numbers of service users wrote to the Joint Scrutiny Committee on the Mental Health Bill 2004 to express that view.\footnote{133}

As a consequence service users may come to fear and distrust the doctors on whom they rely for help. In the context of the ‘blame’ culture, where every tragedy caused by a patient

\footnotesize
\begin{itemize}
\item \footnote{129} This Bill omits this principle, in relation to community treatment orders.
\item \footnote{130} The Department of Health’s study of public attitudes to people with mental illness found that “levels of fear and intolerance of people with mental illness have tended to increase since 1993” and that “attitudes ...have become less positive between 2000 and 2003” 3 The Social Exclusion Report 2004 found stigma to be the biggest problem people with mental health problems face as a group.
\item \footnote{131} World Psychiatric Association Declaration of Madrid ( 1996) See also the UN Principles for the Protection of persons With Mental Illness and the Improvement of Mental Health Care. 46/119 ( reproduced in Memorandum from Professor Thornicroft, Joint Committee on the Draft Mental Health Bill , Vol II Evidence 668.
\item \footnote{132} “What I needed was an arm around my shoulder not a shot in the arm”, Joint Committee on the Draft Mental Health Bill Vol II Evidence 736 Eric Stark.
\item \footnote{133} “I fully accept that there are some individuals who do need compulsory treatment. However unless one has been through this experience it is quite impossible to express how degrading and terrifying it is Memorandum from Victoria Hanson, Vol II Joint Committee on the Draft Mental Health Bill Evidence 735.
\end{itemize}
can potentially be attributed to a psychiatrist’s misjudgement, psychiatrists often feel required to section patients, perhaps against their better judgement or the best interests of the patient. In its evidence to the Joint Scrutiny Committee on the draft Mental Health Bill the Royal College of Psychiatrists stated:

“Enabling people to feel able to seek help early, to talk about their fears and difficulties, without fearing scorn, humiliation or loss of status, freedom, job and friends is the best way to bring about improvement in their health”.

The Mental Capacity Act has been widely supported by the College. It proceeds truly on a basis of respect for the dignity and autonomy of people who lack or may lack at some time the capacity to make their own decisions, including those with mental illness. It provides structures to protect them at such times. It is compatible with principles stated in Storck v United Kingdom that the State has a responsibility to its vulnerable citizens to protect and empower them.

However in the view of the College the overall effect of this Bill is the opposite – it reinforces stigma and discrimination denies autonomy of patients who are not so different from the other group who fall under the Mental Capacity Act. It is sad but undeniably the case that our patients are seen as different from other human beings and therefore society considers they are entitled to be treated in ways that we would not countenance for ourselves. We consider it our right to drive too fast and take the risk that we cause an accident, drink to excess even if we know from experience that we then become violent to others. We consider that the criminal law is there to prove and punish our excesses. The denial of human rights that mental health law can entail for our patients is consider of utmost seriousness.

Public protection is a part of the ethical code for psychiatrists and a responsibility from which we in no way wish to resile. It is in the light of this that our concern that the law keeps the different goals in balance. Tipped too far towards public protection the law will drive patients from services and increase the danger to the public rather than enhance it.

Appendix 5: Memorandum dated 12 January 2007, from the Council on Tribunals

1. This memorandum is submitted in response to the Committee’s call for evidence on the Mental Health Bill, with particular reference to human rights compatibility issues raised by the Bill.

2. The Council on Tribunals was set up by the Tribunals and Inquiries Act 1958 and now operates under the Tribunals and Inquiries Act 1992. The Council’s main statutory function is to keep under review the constitution and working of the tribunals under its supervision and, from time to time, to report on them. These include the Mental Health Review Tribunals (MHRTs), constituted under section 65 of the Mental Health Act 1983.

3. The Council must be consulted before procedural rules are made for any tribunal under its supervision. The Council must make an Annual Report to the Lord Chancellor and the Scottish Ministers, which is laid before Parliament and the Scottish Parliament. Over the

4. In June 2000 the Council also published a Special Report on the operation of MHRTs to supplement its response to the Government’s consultation on Reform of the Mental Health Act 1983. The key recommendations made in the Report included:

- The new Tribunal to replace the Mental Health Review Tribunals should be headed by a national President, appointed by the Lord Chancellor;
- Every tribunal hearing should be properly supported by a tribunal clerk;
- Proper planning and management information systems should be put in place for the new Tribunal;
- There should be a robust and comprehensive training policy for all tribunal Chairmen and members;
- Good quality legally-aided representation at hearings should be more widely available to mental health patients;
- The need for a review of tribunal accommodation, with a view to securing greater consistency and an improvement in standards.

5. The Council recognises the positive progress that has been made since the publication of its report, for example, in the appointment of a lead Liaison Judge for the MHRT, improved arrangements for training, and most recently the transfer of the MHRT for England in April 2006 to the Tribunals Service under the sponsorship of the Department for Constitutional Affairs.

6. In the paragraphs below, the Council comments on some of the matters to which the Committee is paying particular attention, focusing on those which are most pertinent to the Council’s statutory remit.

Mental Health Review Tribunals for England and Wales

7. The Council’s primary interest lies in how the Bill’s provisions affect the MHRTs, but it also has an interest in how the proposed changes to the definition of mental disorder and the criteria for detention will impact on the operation of the MHRTs. The Council is broadly content with the Bill’s provisions so far as they relate to MHRTs, in particular the creation of a President for each of the Tribunals in England and Wales. However, the Council has serious concerns as to whether the MHRT will be able to cope with the significant increase in its workload, particularly as a result of the new provisions for Community Treatment Orders in the Bill. The Council welcomes the inclusion of a power to reduce the period within which patients must be referred to a MHRT, but would have
liked to see, at least in the Explanatory Notes, some indication of by how much the Government aims to reduce the referral periods and by when.

**Guiding principles and the Code of Practice**

8. In commenting on the Mental Health Bill 2004, the Council supported the proposal to include guiding principles on the face of the legislation, to govern the operation of the new provisions and guide their interpretation. Therefore, whilst it is pleasing to see an expanded explanation of the guiding principles underlying the 1983 Act in the revised draft Code of Practice the Council is disappointed that these principles could not be inserted into the Act itself. At the very least, the Council would wish to see in the statute those which reflect the internationally recognised principles of self-determination and respect for human dignity. A clear statement of principles would also greatly assist Tribunals in carrying out their judicial functions under the Act.

9. The Council welcomes the new chapter 23A in the draft Code of Practice on the MHRT, which provides a source of helpful information and guidance on the MHRT and clarifies a number of issues the Council has raised in the past. In particular, the Council is pleased to see clarification of the role of the Responsible Clinician in attending the hearing, whether as a witness or the nominated representative of the detaining authority.

10. The Council notes that the National Assembly for Wales is considering publishing a separate Code of Practice providing guidance on the operation of the Act to professionals practising in Wales. The Council is concerned that if the two Codes differ significantly, it may be difficult to ensure that the Act is applied consistently in the two jurisdictions. This may cause particular problems where the Code is relied on to establish the principles on which the legislation is based or to remind practitioners of their obligations under the ECHR (see paragraph 12(b) below).

**New single definition of ‘mental disorder’**

11. The new, broadly-drawn definition of ‘mental disorder’ in the Bill, in tandem with the new, wider criteria for compulsory detention, has the potential to draw ever greater numbers of people within the scope of compulsory powers because of the lack of clarity they will create. Such lack of clarity will also make it more difficult for the Tribunals, in exercising their decision making function, to discharge patients from compulsory detention.

**Review of detention by the MHRT**

12. The role of the MHRT is to consider whether the criteria for detention continue to be met in the patient’s case, and the Act directs the Tribunal to discharge a patient where it is not satisfied on this matter. In order to meet the requirements of ECHR Article 5, detention must be based on “objective medical expertise”.134 At present, the Tribunal generally relies on the evidence of the patient’s Responsible Medical Officer (RMO) to confirm that the conditions justifying detention continue to be met. The Council is

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134 Winterwerp v The Netherlands (1979) 2 EHRR 387.
concerned that some provisions in the Bill may require the MHRT to seek additional medical evidence to be satisfied on this point. In particular:

a) The Bill replaces the RMO with the Responsible Clinician (RC) who may not necessarily be a medical practitioner, but could be a psychologist, nurse, social worker or occupational therapist. It may be difficult for some of these professionals acting as RCs to provide the Tribunal with the “objective medical expertise” necessary to satisfy the Tribunal that detention is justified.

b) The Bill introduces a new “appropriate treatment test” into the criteria for detention under section 3 (and the corresponding criteria for renewal and discharge) that appropriate medical treatment must be available to the patient in question. This replaces the current ‘treatability test’ (that treatment in hospital is likely to alleviate or prevent a deterioration in the patient’s condition). Although the Bill provides a basic definition of “appropriate medical treatment”, it is left to the draft Code of Practice (chapter 2A) to remind clinicians of their obligations under ECHR Articles 3 and 8 when providing compulsory treatment under the Act. The Council is therefore concerned that it may be difficult for Tribunals to be satisfied that the ‘appropriate treatment test’ is met in a patient’s case unless further details of the requirements of this test are spelt out in the statute, rather than relying on the Code, which can be departed from by clinicians and NHS Trusts in certain circumstances.135

Community Treatment Orders

13. The Bill contains provisions for new community treatment orders (CTOs), under which a patient may be discharged into the community subject to certain conditions, but who will still be liable to be recalled to hospital, for example, for failure to comply with such conditions. There is a risk that CTOs may be used either as a fallback to discharging patients from detention or, alternatively, as a means of freeing up spaces in hospitals by discharging those who should rightfully be receiving treatment in hospital.

14. CTOs will also require Tribunals to acquire a greater knowledge and awareness of what treatment is available in the community and the judicial decision making process of Tribunals will involve a greater degree of risk assessment in respect of these cases, especially as Tribunals will have the power to recommend that the RC considers placing a patient on a CTO.

15. In the Council’s view the overall impact of CTOs will be to increase significantly the numbers of people who at any given time are subject to compulsory powers, with a consequential increase in the numbers of cases going before Tribunals to be discharged from such orders.

16. The Council has particular concerns that patients only have the right to apply to the tribunal for a CTO to be discharged and have no right to seek a review or variation of any conditions attached to the CTO. Some conditions imposed on patients (for example, that the patient resides at a particular place, or abstains from particular conduct) could amount

135 R v Ashworth Hospital Authority (now Mersey Care NHS Trust) ex parte Munjaz [2005] UKHL 58.
to an interference with ECHR rights under Article 5 and Article 8, for which the Bill provides no effective right of challenge.

The ‘Bournewood’ Proposals

17. The Council’s concerns about the Bournewood proposals relate mainly to the staggering complexity of the proposed processes, both the process of applying for authorisation to deprive a person of their liberty and the procedures for challenging authorisation. In particular, in relation to the latter, an initial challenge or subsequent review of authorisations must first be considered by the supervisory body (usually the relevant Primary Care Trust in England or Local Health Board in Wales or the local authority), which is the same body that granted the authorisation in the first place. The Council is concerned that this review lacks independence and will be carried out without any independent oversight, for example by the Council on Tribunals or other independent monitoring body.

18. Only after the internal review process has been exhausted will there be a right of appeal to the Court of Protection rather than to the Mental Health Review Tribunal, which already has the necessary expertise in dealing with cases involving a deprivation of liberty. The introduction of a two-track appeals process, whereby some cases go to Tribunals and others to the Court of Protection, could create a good deal of confusion.

19. The Council is concerned that the complexity and resulting confusion will make these processes unworkable, leaving vulnerable people who lack capacity to raise concerns on their own behalf without the protection and procedural safeguards demanded by the European Court in *HL v UK* and other cases dealing with deprivation of liberty of people lacking capacity.
**Bills 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**

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