

**RESPONSE TO THE GREEN PAPER ON THE REFORM OF THE MENTAL
HEALTH ACT 1983**

1. JUSTICE is a human rights and law reform organisation with particular experience in criminal justice and the interface with broad mental health issues. We have taken cases to the ECtHR on behalf of discretionary life prisoners, resulting in the provisions in the Criminal Justice Act 1991 introducing discretionary lifer panels, themselves modelled on mental health review tribunals. We have also done policy work in this area, and in this capacity we commented on the recent government proposals on managing dangerous people with severe personality disorders. A copy of our submission is enclosed. JUSTICE is currently training lawyers and government departments in human rights in preparation for the implementation of the Human Rights Act. We are grateful to Caroline Neenan for her assistance in preparing this response.

2. We have sought to deal with those consultation points that are relevant to our work and experience. We make the general point at the outset that the green paper refers in the criminal justice section to public safety being paramount, and to the purpose of orders being for the protection of others. While accepting that public protection is an essential part of the equation we draw attention to the necessity for appropriate and effective treatment for the individual as a necessary counterbalance. These points are made fully in our response to the consultation paper on dangerous people with severe personality disorders, where we discuss the human rights and ethical implications of a system that does not acknowledge this imperative.

Consultation Point A:

3. The articulation of principles underlying a piece of legislation are always a valuable aid to interpretation. It is the most effective way to ensure that the decision-making authorities (in the broadest sense) address their minds to the

factors which should be considered as part of the decision-making process. Obviously the inclusion of principles in the statute itself, as opposed to the accompanying code of practice, gives them greater weight.

4. In addition to the domestic precedents which employ guiding principles to excellent effect: the Family Law Act 1996 and the Children Act 1989; there is also a commonwealth precedent for the inclusion of such principles in Mental Health legislation:

"It is the intention of Parliament that the provisions of this Act are to be interpreted and that every function, discretion and jurisdiction conferred or imposed by this Act is, as far as practicable, to be performed or exercised so that:

(a) persons who are mentally ill or who are mentally disordered receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given; and

(b) in providing for the care and treatment of persons who are mentally ill or who are mentally disordered, any restriction of the liberty of patients and other persons who are mentally ill or disordered any interference with their rights, dignity and self-respect are kept to the minimum necessary in the circumstances"

(Section 4 of the New South Wales Mental Health Act 1990).

5. It is important that any guiding principles are not inconsistent with other statutory provisions and have practical effect. The Government's proposed principles as set out in paragraph 4 are welcomed. The following framework, based on the Australian model, is proposed:

"It is the intention of Parliament that the provisions of this Act are to be interpreted and that every function, discretion and jurisdiction conferred or imposed by this Act is, as far as practicable, to be performed or exercised so that:

(a) informal care and treatment are always considered before recourse to compulsory powers;

(b) any interference with the rights, dignity and self-respect of a person who is mentally ill are kept to the minimum necessary in the circumstances, taking into account the safety of the individual patient and members of the public;

(c) where compulsory powers are used, care and treatment should be located in the least restrictive setting consistent with the patient's best interests and safety and the safety of the public;

(d) patients are involved in the process of developing and reviewing their own care and treatment plans."

6. Sub-section (b) above is intended to ensure that the importance of recognising and enhancing patient autonomy is clear.
7. The principle of proportionality is employed, which, simply stated, means that any interference should be the minimum necessary to achieve the desired result. The use of proportionality goes some way towards removing the inconsistency inherent in promoting the right to self determination in the context of a statute which permits the compulsion of individuals.
8. Sub-section (b) encourages the decision-making authorities to address their minds to principles such as patient autonomy and non-discrimination, when determining whether a compulsory treatment order is appropriate. It is therefore explicitly acknowledged that although every effort must be made to

promote patient autonomy that there may come a point at which the interests of the public must be permitted to override the absence of consent.

9. The concept of "rights, dignity and self-respect" should be elaborated on in the Code of Practice. This concept encompasses "respect for diversity" as defined in the Report of the Expert Committee; "equality"; "effective communication" and "the provision of information".
10. It should also be made clear in the Code of Practice that the care plan must meet the patient's individual needs and be sensitive to their gender, sexuality, culture, ethnicity and religion. Compulsion should not be used disproportionately against black or ethnic members of the community. "Information" should include diagnosis and prognosis; reasons for proposed treatments; risks involved in the treatment, and in not proceeding with it; effects and side-effects of medication and other treatments; alternatives to medication; the range of services available; rights, particularly with regard to the right to refuse treatment. Such information should be made available in appropriate language and style.
11. The principles of respect for carers and evidence-based practice should be included in the Code of Practice, provided that there is an express presumption in the statute in favour of compliance with the Code of Practice.
12. With regard to the principle of reciprocity, it is accepted that if new statutory duties are to be imposed upon health authorities and social services elsewhere in the Act, it is unnecessary to duplicate them here. The importance of such duties is emphasised in the light of the difficulties highlighted in *R v Mental Health Review Tribunal and Others, ex parte Hall* [1999] 4 All ER 883.

Consultation Point B

A statutory definition of mental disorder is necessary. Such a definition should endeavour to reduce the stigma attached to mental illness by society in general.

13. The difficulties with defining mental disorder have been acknowledged by the European Court of Human Rights in *Winterwerp v Netherlands* (1979) 2 EHRR 387: "the Convention does not state what is to be understood by the words 'persons of unsound mind'. This term is not one that can be given a definitive interpretation...it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitudes to mental illness change, in particular so that a greater understanding of the problems of mental patients is becoming more widespread". This is subject to the proviso that a person cannot be detained simply because his views or behaviour deviate from the norms prevailing in a particular society (at para. 37) (a similar notion to "prohibited reasoning": *R v St George's Healthcare NHS Trust, ex parte S* [1998] 3 All ER 673). For these reasons, a broader statutory definition is to be preferred with further guidance being given in the accompanying Code of Practice.

14. It is important that substance abusers should not be allowed to slip through the net and that it is made clear in the Code of Practice that where there is evidence of a dual disorder, such substance abusers fall within the ambit of the legislation.

15. The situation with regard to learning disabilities is rather more problematic. People with learning disabilities should not be considered to have a mental disorder, except in the case of a person with a dual disorder. The burdens which come with learning impairment should not be increased. However, in the absence of legislative proposals designed specifically to deal with learning disabilities, it appears that there may be situations in which people with learning disabilities alone and no mental disorder may have to enter into long term compulsory care and treatment in order to acquire the necessary

safeguards (which are not available under common law). It should therefore be made clear in the Code of Practice that in the short term learning disabilities are included within the definition of mental disorder.

Consultation Points D and E

16. Article 5(1)(e) of the Convention authorises the detention by lawful order of persons of unsound mind. As far as time limits are concerned, the guiding principle is contained in Article 5(4):

"Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided *speedily* by a court and his release ordered if the detention is not lawful" [Emphasis added].

17. Contracting States must organise their legal systems so as to enable the courts to comply with the various requirements of the Convention. It is incumbent on the judicial authorities to make the necessary administrative arrangements to ensure that urgent matters are dealt with speedily, and this is particularly necessary when the individual's personal liberty is at stake ***E v Norway*** (1994) 17 EHRR 30 at para. 66. In ***E v Norway*** the ECHR considered eight weeks was too long for the applicant to wait for a decision on the lawfulness of his custody (para. 67). The ECHR considered 16 days to be permissible in ***Christinet v Switzerland*** (1979) 17 DR 35 at 57.

18. With regard to the sufficiency of a period of 24 hours for gatekeeping assessment, this obviously is dependent to a large extent upon the availability of the appropriate medical personnel, which in turn relates to allocation of funds. The guiding principle must be that the period should be as short as is reasonably possible. The most recent judicial statements on the allocation of resources are to be found in the judgment of the Court of Appeal in ***North West Lancs. HA v A, D & G*** [1999] Lloyd's Med Reports 399 at 408: "It is

natural that each [health] authority, in establishing its own priorities, will give greater priority to life-threatening and other grave illnesses than to others less demanding of medical intervention". In this case Convention rights were not asserted. Although the Court of Appeal recognised that the precise allocation and weighting of priorities is clearly a matter of judgment for each authority, in matters concerning the liberty of the person that the courts may closely scrutinise the allocation of funding.

19. The key factor under Article 5(4) is the determination of whether detention is lawful by a court. In *X v UK* (1979-1980) 2 EHRR 404 at para. 42 the ECHR stated that it was prepared to regard the Mental Health Review Tribunal as a body with appropriate "court-like" attributes (providing certain guarantees were met) for the purposes of Article 5(4). It is clear that the proposed independent reviewer would not qualify as a "court". It is therefore preferable that the available resources be deployed so that patients have access to the tribunal at the earliest possible opportunity i.e. between day 7 and day 21.

Consultation Point F

21. The suggestion of having a single lawyer member tribunal for uncontested cases does give us some cause for concern. Tribunals have an inquisitorial function, and a lawyer may not be sufficiently aware of medical matters to know when and whether to pursue further inquiries should they be necessary.

Consultation Point G

22. The notion of capacity is not one of the minimum conditions set out by the ECtHR in *Winterwerp*:

- (i) (except in cases of emergency) the person to be detained must reliably be shown to be of unsound mind (a true mental disorder must be established on the basis of objective medical expertise); and
- (ii) the relevant mental disorder must be of a kind or a degree warranting compulsory confinement;

- (iii) the validity of continued confinement must depend upon the persistence of such a disorder (para. 39).

23. In situations such as this the ECHR deploys the doctrine of the margin of appreciation, leaving sensitive policy decision to the government of the relevant signatory state. With the impending entry into force of the Human Rights Act 1998, the Government must address the question of the relevance of capacity. It is essential that capacity is dealt with in the new Mental Health Act itself. The right to self-determination is a fundamental human right (Article 1 of the International Covenant on Civil and Political Rights: "All peoples have the right to self-determination"). The Government has indicated clearly that it is of the view that the wishes of a person may be overridden where there is a serious risk of harm to others. This principle is accepted. However, the Government is urged to apply the higher standard of "a substantial risk of serious harm" where the risk relates solely to the health of the individual in question. This higher threshold is appropriate as the individual's right to determine his own destiny must be respected. To employ a lower threshold in these circumstances would constitute an unjustifiable encroachment on the rights of the individual.

Consultation Point J

24. A single power to order assessment and treatment would appear to meet sentencing needs of the criminal courts. The key factor is that offenders who are suffering from mental disorders should be treated in hospitals as prisons are ill-equipped to meet their needs. However, the length of the assessment period must not exceed the period for which the offender could be lawfully detained in prison. In cases where the likely sentence will be in excess of 12 months, subject to the views of experienced practitioners, it appears that 12 months should be adequate for an assessment to be made of the offender and his likely attitude treatment.

Consultation Point L

25. The arrangements for transferring prisoners to hospital for compulsory care and treatment for mental disorder should be altered as suggested by the Committee: the Secretary of State, or the Governor acting as his delegate, should be empowered to direct the transfer to hospital of a prisoner who, on the evidence of three professionals, he has reasonable grounds to believe meets the requirements for compulsory assessment. The decision to impose long-term compulsion would then rest with the tribunal upon an application by the offender's clinical supervisor.

26. This alteration should enable a thorough assessment of the offender's condition to be carried out in an appropriate environment. It is preferable for the decision re compulsory treatment to be placed automatically in the hands of the tribunal, a "court-like" body with appropriate procedural safeguards, as opposed to the decision being taken at first instance by the executive.

27. The proposal to give the Home Secretary the power to transfer patients back to custody in magistrates' court proceedings would not appear to be necessary, given that very few of these cases will involve serious harm to others.

Consultation Point M

28. Police powers to remove people who appear to be in need of medical treatment from public places (pursuant to section 136 of the Mental Health Act 1983) should be extended to cover cases where the person concerned is found by the police when they have legitimately entered private property.

29. Detention by the police is not based upon prior objective medical expertise. Indeed, the purpose of the detention is to enable the person to be medically examined. The period of detention is sufficiently short to constitute an emergency measure and should therefore fall within the *Winterwerp* "emergency" exception. The period of detention should not be longer than 24

hours as police stations are not adequately equipped to deal with people in need of medical attention.

30. However, it should be emphasised in the Code of Practice that such a power should be used in a non-discriminatory manner.

Consultation Point N

31. The preferred option is that the police should be given the power to remand an alleged offender into hospital and, given the authorisation of the necessary professionals, into compulsory treatment. Local police stations do not have the space nor the facilities to cope adequately with people needing urgent medical assessment and treatment. Police officers do not have the necessary training. The proposal that the gate-keeping assessment should be carried out at the station with a duty that the relevant authorities should respond promptly seems likely to lead to a backlog of mentally distressed people being kept in inappropriate conditions for lengthy periods. As the choice between the two options appears to be dictated by the insufficiency of resources, as such the Government should carefully consider making the funding necessary for option two available.

Consultation Points O and P

32. In *Herczegfalvy v Austria* (1993) 15 EHRR 137 the ECHR considered force feeding and the administration of neuroleptics in the context of Article 3 (prevention torture and inhuman and degrading treatment) at para. 82:

"The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and

mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3, the requirements of which permit of no derogation.

The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist".

33. The same principles apply to the administration of ECT, depot medication, polypharmacy and doses above BNF where the patient cannot consent: a medical necessity must be convincingly shown to exist. The Committee's recommendation that in the case of patients without capacity, ECT should not be administered without either the express approval of the tribunal through its medical member or by a panel of approved independent doctors should be accepted.

34. The ECtHR has not considered the situation where the patient can consent. In accordance with the right to self-determination, the use of ECT (and the other treatments listed above) must be banned without fully informed consent. All of the current information concerning the benefits and risks of the procedure must be made available to the patient.

35. With regard to force feeding, as domestic law currently stands a prisoner, of sound mind and understanding (i.e. has the capacity to decide), has the right to self-determination which prevails over any countervailing interest of the state. As a result, in *Home Secretary v Robb* [1995] 1 All ER 677 Thorpe J held that the Home Office, prison officials and the physicians and nursing

staff responsible for a prisoner who went on a hunger strike could lawfully observe and abide by his refusal to receive nutrition for as long as he retained the capacity to refuse the same. However, the situation is different if section 63 of the Act is in play and force feeding is considered to be a "treatment" for mental illness *B v Croydon Area Health Authority* [1995] 1 All ER 677. The law should be changed so that patients who retain capacity but have, for example, personality disorders should not be denied the right of autonomy enjoyed by other adults.

Consultation Point R

36. Prior to the issue of the formal compulsory order the administration of treatment without consent should be limited to emergency measures in cases of (suspected) incapacity. With regard to patients who appear to retain capacity, there should be no treatment without consent if the treatment in question is one to which special safeguards apply, as discussed above. As far as other treatments are concerned, it must be demonstrated convincingly that "medical necessity" for any emergency intervention exists (cf test in *Herczegfalvy*).

Consultation Point T

37. Article 8 provides that:

"1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this rights except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, 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".

38. A challenge under Article 8 to the current system of providing information to the "nearest relative" as defined in section 26 of the Act is likely to succeed. A "nearest relative" is defined as one of eight varieties of kinship. This may result in the patient's same-sex partner not being informed, or indeed someone who the patient has never met or with whom he does not have a close relationship receiving private details. Before a person is admitted for treatment an approved social worker must consult and seek the approval of the nearest relative (section 11(4) of the Act) and after making an admission he must endeavour to inform the nearest relative (section 11(3) of the Act). It is only upon compulsory admission to hospital that the patient has a right to object to a nearest relative receiving information about his rights (section 132(4) of the Act).

39. The guiding principle must be that a person with mental health problems should have the right to decide who should receive information. He should be entitled to nominate an individual. If an individual lacks capacity, any direction made in advance should be respected.

40. With regard to the disclosure of information to other agencies, reference should be made to Article 8(2). Any disclosure without consent must be necessary in the interests of public safety, for the prevention of disorder or crime, or for the protection of health or morals.

Consultation Point U

41. The right to be given information about the detention and the release of offenders should be extended to cover the victims and families of restricted patients who have committed serious violent or sexual offences. Similar principles should apply to the way this is dealt with.

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