Liberty’s Response to the Department of Health consultation on the draft Mental Health Bill

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Liberty (The National Council for Civil Liberties) is one of the UK’s leading civil liberties and human rights organisations. Liberty works to promote human rights and protect civil liberties through a combination of test case litigation, lobbying, campaigning and research. It is the largest organisation of its kind in Europe and is democratically run.
**Introduction**

1. Liberty (the National Council for Civil Liberties) makes these representations to the Department of Health following publication of the Draft Mental Health Bill Cm 5538-I and the Consultation Document Cm 5538 –III inviting views upon certain aspects of the proposed new legislation.

2. Liberty welcomes the opportunity to respond but notes, as it was compelled to note during the initial round of consultation upon the 1983 Act before publication of the Draft Bill, that the consultation period is in its view too short given the breadth and the importance of the subject.

3. Before the final draft of the Mental Health Bill Liberty made a number of representations as to the proposed content of that Bill. Whilst it welcomes the expressed intention to enact a measure more compliant with the obligations of the ECHR, Liberty is disappointed to note that a number of the matters that go to the heart of civil liberties have not been satisfactorily addressed in the current Draft Bill.

4. The representations made in this paper begin with a consideration of the main points Liberty wishes to address, and concludes with further significant areas, among which are some of the points on which views have been specifically requested by the Consultation Document¹.

5. Liberty has annexed to this paper a copy of the submission it made to the Expert Committee chaired by Professor Genevra Richardson in 1999. We believe that there are matters addressed therein that still remain to be dealt with in manner consistent with the Government’s obligations to patients and potential patients of the system.

6. The current main areas for Liberty’s particular concern are the following:

   ♦ The definition of mental disorder
The Definition of Mental Disorder

7. Liberty is concerned to note that the Bill has chosen a broad and unqualified definition of the main criterion for compulsory detention. The term “mental disorder”, standing alone replaces the more complex definitions of the 1983 Act, which was generally accepted to be outdated for various good reasons.

8. The concern arises out of the fact that there is no statutory definition of the phrase mental disorder save for the following broad statement in clause 2(6) “Mental disorder means any disability or disorder of mind or brain which results in an impairment or disturbance of mental functioning…”. There are no protections in the form of exclusions for those suffering from, for example, alcohol or drug dependency. In fact the definition is drawn so broadly that minor disorders such as mild depressions or learning disabilities would fall into the definition in clause 2(6). Liberty is very concerned that there are no protections from the abuse of power on the face of the statute. The Explanatory Notes to the Bill explain that further materials and diagnostic criteria will be referred to in the Code of Practice. However, Liberty notes with concern that the Code of Practice has no statutory force.

9. We believe the criteria by reference to which a person may be deprived of his or her liberty should be set out in, at the least, secondary legislation. It is clear from the face of Article 5 and from the earliest Strasbourg cases that

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1 CM5538III
2 See below
3 In Winterwerp v The Netherlands (1979) 2 EHRR 387, 402-403 para 39 - 45 part of the reasoning included the proposition that the law must be sufficiently accessible to the individual and sufficiently precise for him to for see the consequences for himself, in order to be lawful.
detention must be “according to the law”; that law must be readily ascertainable and precise. Liberty queries whether that can properly be said of the current Bill as structured. As drafted the Act lays itself open to abuse and for the criteria for detention to be changed without the democratic safeguards of legislation.

10. The reason for the change of format is said\(^4\) to be the fact that Clinicians have misunderstood the old Act, not applying the Act to those with mental disorder overlaid with, for example, substance abuse. The remedy lies in education, or in more precise drafting. It does not lie in replacing the protections of the old Act with general, undefined terms, which are open to abuse.

**Dangerous people with Severe Personality Disorder**

11. Liberty recognises that the Government has expressed\(^5\) its intention to include within the scope of the new Act those with untreatable psychopathic disorder, sometimes referred to as dangerous people with severe personality disorder or DSPDs. That is to say, that it intends to change the definition of treatablity as to effectively remove it as a criterion for admission for treatment for this class of person. It is accepted that the treatablity criterion does not find a clear place in the Strasbourg jurisprudence as it has developed in the Strasbourg case law. We also recognise that the challenge mounted in the Scottish jurisdiction\(^6\) to provisions having similar effect, arguing principles of ECHR law, failed in the Privy Council on a devolution issue appeal. We nonetheless contend that the compulsory detention within a hospital (and thus, therapeutic) regime, of those who can receive no therapeutic benefit from that regime is wrong.

12. Liberty believes there are cogent arguments against the Privy Council’s conclusion that it is neither arbitrary nor disproportionate to detain a person in hospital who cannot be treated. Detention in the hospital system without treatment is mere containment. In *Ashingdane v United Kingdom (1985) 7 EHRR 528* the court accepted there should be some relationship between the

\(^4\) In Mental Health Bill, Consultation Document Cm 5538 III
\(^5\) Draft Mental Health Bill Department of Health 2002 Annexe A paragraph 4
place of detention and the reasons for detention under Article 5(1)(e): there must exist suitable conditions or treatment to justify the detention. It is suggested that hospital detention is unsuitable for a person who cannot benefit from treatment. Irrespective of the potential benefits to public safety of containment of such persons, it is inappropriate for any such person to be, effectively, imprisoned within the hospital regime. It is also an inappropriate use of hospitals and National Health Service resources. There are shortages of properly trained health professionals and secure beds in the NHS.

13. Liberty understands that the number of persons within the definition of dangerous personality disorder is around only 300 – 600 in England and Wales. We contend that the disproportionate publicity attaching to the comparatively small number of incidents caused by this minute segment of the population has unduly influenced policy. Liberty acknowledges that the public interest in safety must also be an important consideration. However, in this instance, it is suggested that the balance between the interests of the public and those of the individual is wrong.

14. Hospital is an inappropriate venue for the containment of offenders who cannot be treated, and even more inappropriate for potential offenders who cannot be treated.

**The Code of Practice**

15. There were cogent submissions made regarding the Code of Practice to the Expert Committee to the effect that the Code should have statutory force. The Committee decided, on balance, after careful consideration, that the Code should not have statutory force. It urged, however, that there should be a statutory presumption of compliance expressed in the Draft Bill. There is none.

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6. *Karl Anderson and Ors v The Scottish Ministers and Ors PC ( 31st July 2000) [2001] UKPC D5*
7. See also *Guzzardi v Italy 3 EHRR 367*
8. Government Consultation Paper Managing Dangerous People with Severe Personality Disorder [ref]
9. in Report of the Expert Committee; review of the Mental Health Act 1983, November 1999 (the "Richardson Report")
10. Richardson report paragraph 2.30
16. Liberty is concerned at these omissions. Indeed, it is our contention that the Code must have statutory force. The Bill has expressly been drafted with the purpose of fulfilling the government’s obligations under the ECHR. This is presumably not least because the circumstances and treatment of the mentally disordered expose them to a risk of breaches of their human rights (Keenan v UK (2001) 33 ECHR 38 at paras 110 and 112, X v UK Appn. No. 6840/74 followed by the DHSS Review of Special Hospitals Seclusion Procedures). The Code’s express purpose is to set down the principles that underlie the Bill, and give guidance to those discharging functions under the Bill. It is plainly at the Bill’s heart, and following a recommendation of the Expert Committee, reference to it is placed in clause 1 of the Bill.

17. The Code’s ambit includes the care and treatment of persons subject to the Bill, for instance, their seclusion and restraint, or their compulsory treatment – all areas in which their fundamental human rights are engaged. However, as stated above, the Bill as currently drafted does not impose any obligation on those who compulsorily detain or treat the mentally disordered under the Bill to comply with the Code, or contain any presumption of compliance: despite the fact that it is intended as a safeguard against breaches of their human rights.

18. The same deficiency in the present Act has recently been exposed in the case of R (Munjaz) v Ashworth Hospital and others (unreported, 5 July 2002, Sullivan J). In essence, the UK government claims to safeguard the human rights of those subject to the present Act and the Bill by a Code which detaining authorities and professionals may ignore at their discretion. This code cannot be relied upon by patients in legal proceedings because it has no greater force than merely non-statutory Guidance.

19. Liberty understands a number of the considerations regarded by the Richardson Report as essential, to the construction of a humanitarian and modern mental health statute, are relegated to this non-statutory document.
Thus reference to consensual care, autonomy, reciprocity, respect for diversity etc\textsuperscript{11} will only be made in the Code.

20. It is suggested that the unsatisfactory position of the Code reflects the character of the Draft Bill, which is wholly different from the character of the legislation proposed by the Expert Committee. In essence, the patient focused Richardson Report is being replaced by a bill where presumed public safety considerations are dominant.\textsuperscript{12}

21. Liberty submits that the only way in which the Bill’s avowed intention to fulfil obligations to individuals, particularly under Articles 2, 3, 5, 6 and 8 ECHR, is to give the Code statutory force either under the Bill or by the making of a Direction by the Secretary of State.

**The Incapacitated Patient**

22. The proposal that incapable patients should benefit from statutory safeguards is plainly necessary. However, Liberty is concerned that the positive potential of this part of the Bill is undermined by the absence of a statutory definition of incapacity. If it is proposed that the Code should supply the definition, the comments made above in relation to the Code are repeated. Liberty submits that the definition put forward by the Law Commission (in Who Decides? \textsuperscript{13}) should be adopted and included in the Bill to promote certainty in the care and treatment of this group of patients newly included within the statutory framework.

23. Parliament should further consider whether, having made legislative provision in respect of this aspect of incapable adult’s lives, it should enact the Mental Incapacity Bill so that decisions may be made about other areas such as social care, housing and all medical treatment, not just for mental disorder.

\textsuperscript{11}see further the critique of the Green Paper by Jill Peay in “Reform of the Mental Act 1983: Squandering an Opportunity”

\textsuperscript{12}See further in this connection the comments upon DSPDs above

\textsuperscript{13}CM 8303
**Compulsory Treatment in the Community**

24. Liberty wishes to encourage a cautious approach to the delivery of compulsory medical treatment in the community. We are pleased to see that there are no provisions which allow the compulsory treatment of a person in their own home. Liberty is nonetheless concerned that compelling the capacitated to accept medication with the threat of confinement on failure (clause 117) is likely to discourage co-operation; and undermine if not destroy the therapeutic relationship in the community. This approach runs the risk of alienating and isolating the patients it is intended to serve, since collaborative relationships are generally considered to be the most beneficial. An additional element of coercion in the relationship between carers and patients will not assist the provision of care, or, ultimately, the protection of the public.

25. It has been suggested\(^{14}\) that compulsory treatment in the community should be coupled with the provision of intensive community support services. If adequate care is absent the powers are open to abuse. Liberty supports the suggestion that assertive outreach is a necessity if the proposals are to work to the benefit of patients in the community, and draws attention to the significant negative response it understands to have been received from professionals. However, we also recognise that there is also informed support for the principle\(^{15}\) of such compulsion if adequately supported within the community.

26. Liberty wishes to emphasise the necessity for a suitable location for the administration of any treatment that was not carried out in a hospital setting; an issue allied to the provision of sufficient community support generally for those discharged from hospital care.

\(^{14}\)by The Sainsbury Centre for Mental Health, among others

\(^{15}\)National Schizophrenia Fellowship
The Scope of New Review Tribunals

27. There is provision in the Bill for a single member to sit and determine some matters brought to the Tribunal. While it may be appropriate for some matters to be dealt with by a Single Member, it is suggested that fairness requires that such Single Member sittings should take place only with the consent of the patient concerned, and that he should be entitled to request a full sitting of the Tribunal.

28. While the creation of a right of appeal to a specialist body is welcomed by Liberty, it is concerned that this right is limited to appeal on a point of law. This has two adverse consequences:

a. The limitation on the right of appeal undermines the positive effect of the creation of the right and the appeal body, namely that of determination by an expert body with specific experience of the area. Many issues before Mental Health Tribunals will turn upon difficult clinical questions of diagnosis, treatment and care. To deal with these issues, there should be a right of appeal, with leave of the chairman or the Tribunal.

b. This will involve preliminary consideration of cases that are likely to require adjudication by a higher court. In recent years a number of vital issues in the area of mental health (particularly since the coming into force of the ECHR) that have required adjudication by the House of Lords and Court of Appeal. Such decisions, e.g. Bournewood, have had consequences for very many patients. A requirement that such issues must first be determined by the Appeal Tribunal is undesirable, resulting in the prolonging of potentially unlawful detention or treatment of many. Leapfrog provisions exist in other statutes where delay is to be avoided in order to protect both individual human rights and the public interest.\textsuperscript{16}

\textsuperscript{16} Compare the Immigration Act materials
c. Liberty is further concerned that the right of appeal may only be exercised by the chair of the Mental Health Tribunal, and that there is apparently no mechanism for challenging this refusal of appeal save by judicial review of his decision.

Data Sharing

29. Although some information sharing may be necessary for public protection, Liberty is concerned that information should only be shared with individuals or public authorities when it is necessary to do so. It is vital that there is clear government guidance on this issue since there are currently a wide variety of local and inter agency practices which lack consistency.

30. Particular care should be exercised in considering whether victims, or relatives of victims, of mentally disordered patients should be informed of their discharge, or progress towards discharge. The giving of such information often comes close to providing information about the medical condition or treatment of the patient to others when no other individuals would have their medical confidentiality broken in this way. Liberty believes that extreme caution should be exercised when passing out information to ensure that patient confidentiality is protected to as great an extent as possible. Further, any guidance on the provision of information to victims or their relatives should require those considering the giving of information to have regard to the effect of the giving of information on the mental state of the patient, and to the risk that he may be subject to reprisals or other negative consequences.

Alison Foster QC
Fenella Morris

Chambers of Nigel Pleming QC
39, Essex Street,
London WC2R 3AT