

Re-considering the Mental Health Bill: The view of the Parliamentary Human Rights Committee

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1. Introduction

The Mental Health Bill has finally seen the light of day.² Because the Government has changed tack, it proposes, not to abolish the Mental Health Act 1983 ('MHA 1983'), but to amend it.

The new Bill has a lengthy antecedence: an expert report;³ a Green paper;⁴ a White Paper;⁵ and two draft Bills.⁶ It was introduced into House of Lords on 16 November 2006, and has finally finished being debated there.⁷ On 6 March 2007, the Bill was sent to the House of Commons.

Lately, the Bill has been scrutinised by the Parliamentary Joint Committee on Human Rights ('JCHR').⁸

The JCHR decided to consider the Mental Health Bill because it raises "significant human rights issues". The Committee also sought further information from the Government and received evidence from groups such as the Mental Health Alliance and the Council on Tribunals.⁹

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2 Mental Health Bill 2006, HL Bill 1, 54/2 www.publications.parliament.uk/pa/ld200607/ldbills/001/2007001.pdf

3 Department of Health, November 1999, *Review of the Mental Health Act 1983: Report of the Expert Committee* www.dh.gov.uk/assetRoot/04/06/26/14/04062614.pdf

4 Department of Health, November 1999, *Reform of the Mental Health Act 1983: Proposals for Consultation*, Cm 4480 www.dh.gov.uk/assetRoot/04/08/57/76/04085776.pdf

5 Department of Health, December 2000, *Reforming the Mental Health Act: Part I – The new legal framework*, Cm 5016

www.dh.gov.uk/assetRoot/04/05/89/14/04058914.pdf
Department of Health, December 2000, *Reforming the Mental Health Act: Part II High risk patients*, Cm 5016-

[II www.dh.gov.uk/assetRoot/04/05/89/15/04058915.pdf](http://www.dh.gov.uk/assetRoot/04/05/89/15/04058915.pdf)

6 Department of Health, June 2002, *Draft Mental Health Bill*, Cm 5538

www.dh.gov.uk/assetRoot/04/07/47/22/04074722.pdf
Department of Health, September 2004, *Draft Mental Health Bill*, Cm 6305

www.dh.gov.uk/assetRoot/04/08/89/14/04088914.pdf

7 Reports of the Parliamentary debates may be found at http://www.publications.parliament.uk/pa/pabills/200607/mental_health.htm

8 Joint Committee on Human Rights, *Legislative Scrutiny: Mental Health Bill, Fourth Report of Session 2006-07*, HL Paper 40, HC 288, 4 February 2007 ('JCHR Report')

<http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/40/4002.htm>

9 JCHR Report, Appendices 1–5

This is not, of course, the first time the Government's proposals have been subjected to Parliamentary scrutiny. The first draft Bill was itself the subject of a JCHR report,¹⁰ and the second draft Bill had a committee of its own.¹¹ Like those, the JCHR's new report is critical of the Bill, which it says creates nine human rights compatibility issues and omits two means to enhance or promote human rights.¹²

2. An unsound mind

The first question the JCHR considers is what constitutes an 'unsound mind'.¹³

This is important because 'unsoundness of mind' is one ground upon which a person might be deprived of liberty under Article 5 of the ECHR.¹⁴

Although the European Court of Human Rights ('ECtHR') has steadfastly refused to define the term 'unsoundness of mind',¹⁵ we know that:

- it must be construed narrowly;¹⁶
- if the exception is to be made out, there must be a "true mental disorder";
- the disorder in question must be "of a kind or degree warranting compulsory confinement";
- this must be established by "objective medical expertise"; and
- a patient's confinement on grounds of mental disorder will remain valid only for as long as the disorder persists.¹⁷

The Committee is satisfied that current and proposed MHA 1983 admission procedures fulfil these requirements.¹⁸

The Mental Health Bill will apply to those who are suffering from 'mental disorder', a term that it defines in a new way. Instead of the four-limbed definition that is the keystone of the un-amended MHA 1983, 'mental disorder' will be, simply, "any disorder or disability of mind."¹⁹

The Government believes this definition to be compatible with the ECHR conception of 'unsoundness of mind', but JUSTICE, the all-party law reform and human rights organisation, regards it as "too broad and sweeping".²⁰ The JCHR does not state which of these views it prefers. Its particular concerns are about sexual deviancy.

10 Joint Committee on Human Rights, November 2002, Draft Mental Health Bill, HL Paper 181, HC 1294 www.publications.parliament.uk/pa/jt/200102/jtselect/jtrights/181/181.pdf

11 Joint Committee on the Draft Mental Health Bill, Session 2004-2005, Draft Mental Health Bill, Vol I, HL Paper 79-I, HC 95-I; Vol II, HL Paper 79-II, HC 95-II; Vol III, HL Paper 79-III, HC 95-III www.publications.parliament.uk/pa/jt/jtment.htm. See, David Hewitt, To improve, not bury, the draft Mental Health Bill, *New Law Journal*, vol 155, no 7172, 15 April 2005, p 561. See also: Department of Health, July 2005, Government response to the report of the Joint Committee on the draft Mental Health Bill 2004, Cm 6624 www.dh.gov.uk/assetRoot/04/11/52/68/04115268.pdf;

David Hewitt, *Mind games*, *Solicitors Journal*, vol 149 no 32, 12 August 2005, p 966

12 JCHR Report, para 5

13 *Ibid*, Report, paras 6-16

14 ECHR, Art 5(1)(e)

15 *Winterwerp v Netherlands* (1979) 2 EHRR 387 at para 37

16 *Litwa v Poland* (2001) 33 EHRR 53

17 *Winterwerp v Netherlands* (1979) 2 EHRR 387

18 JCHR Report, para 16

19 Mental Health Bill 2006, cl 1(2)

20 JCHR Report, para 7

Trans-sexualism

At the moment, a person may not be deemed suffering from mental disorder “by reason only of [...] sexual deviancy”.²¹ But what does that mean? Who are the deviants now?

It would seem to be common ground that ‘paedophiles’ should be capable of being detained under MHA 1983. The Government certainly doesn’t take issue with the suggestion.²²

The problem, according to the JCHR, is that instead of retaining the ‘sexual deviancy’ exception but ensuring that paedophiles can’t claim its protection, the Government has decided to abolish the exception altogether. This, the Committee fears, might allow an amended MHA 1983 to be applied to trans-sexuals, and also to masochists and fetishists.²³

The Government says that sexual fetishism and sexual masochism *should* be capable of being regarded as ‘mental disorder’, and of being addressed under MHA 1983, at least “where they reach a level of clinical significance.”²⁴ However, the Government “does not see” how trans-sexualism could reasonably be classed as ‘sexual deviancy’ and suggests that it will not, therefore, be affected by the Mental Health Bill.²⁵ The JCHR is not so sure. It suggests that principles of non-discrimination and proportionality be inserted into MHA 1983.²⁶

Drunkenness

At the moment, a person may not be dealt with as suffering from mental disorder “by reason only of [...] dependency on alcohol or drugs.”²⁷

At one time, the Government had proposed abandoning this exception, stating, for example,

“We intend that mentally disordered people should not be excluded from compulsion where it is necessary in their case simply because they are [...] alcohol dependent [...]”²⁸

This decision was widely criticised, not least by the Parliamentary committee that scrutinised the draft Mental Health Bill of 2004.²⁹

The Government has changed its mind, and the relevant exception will say, “dependence on alcohol or drugs is not considered to be a disorder or disability of the mind.”³⁰ But this might not be the full story.

Alongside the new Bill, the Government has published a draft Code of Practice.³¹ Explaining the new version of the old exception, it says:

“[MHA 1983] does not exclude other mental disorders relating to the use of alcohol or drugs. *Some such disorders, for example uncomplicated acute intoxication, may only rarely justify the use of powers under the Act, whilst others, for example withdrawal state with delirium or associated psychotic disorder may justify use more often, provided the other criteria are met.*”³²

21 MHA 1983, s 1(3)

22 JCHR Report, para 10 and Appendix 3

23 Ibid, para 11

24 Ibid, para 11 and Appendix 3, para 3

25 Ibid, Appendix 3, para 5

26 Ibid, paras 14 & 15

27 MHA 1983, s 1(3)

28 Department of Health, September 2004, *Improving Mental Health Law: Towards a new Mental Health Act*, para

3.20 www.dh.gov.uk/assetRoot/04/08/89/17/04088917.pdf

29 Joint Committee on the Draft Mental Health Bill, *op cit*, para 104
www.publications.parliament.uk/pa/jt200405/jtselect/stment/79/79.pdf

30 Mental Health Bill 2006, cl 3

31 Department of Health, November 2006, *Draft Illustrative Code of Practice*
www.dh.gov.uk/assetRoot/04/14/07/68/04140768.pdf

32 Ibid, para 1B.8 [emphasis added]

The Committee believes the effect of this is clear. It says the draft Code “creates the possibility that Mental Health Act powers may be used in relation to drunk people.”³³

3. Replacing the treatability test

Next, the JCHR examines the Government’s plan to replace the ‘treatability test’.³⁴

The treatability test

According to the four-limbed definition referred to above, ‘mental disorder’ comprises mental illness, mental impairment, severe mental impairment and psychopathic disorder.³⁵

Where a patient is suffering from mental illness or severe mental impairment, the test will apply only when detention is being renewed, so that at first, s/he will be detainable even if it is not fulfilled.³⁶ However, no patient with mental impairment or psychopathic disorder may be detained unless s/he is ‘treatable’ from the outset.³⁷ This, of course, is the ‘treatability test’.

The available appropriate treatment test

The Government has on several occasions given its reasons for replacing the treatability test.³⁸ It told the JCHR:

“The intention is (*inter alia*) to remove the 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.”³⁹

The new test would make it possible to use MHA 1983 where “medical treatment which is appropriate to the patient’s mental disorder and all other circumstances of their case is available.”⁴⁰

On the face of it, this would diminish the treatability test. In order to justify compulsion, it would no longer be necessary to show that treatment would improve or at least prevent a worsening of a patient’s mental state; s/he would be capable of being brought within MHA 1983 merely if there was ‘appropriate’ treatment that was ‘available’ to him/her.

Previous versions of this test have been heavily criticised. In 2004, for example, the Parliamentary scrutiny committee said that compulsion should only be possible if it would bring ‘therapeutic benefit’ to the patient concerned.⁴¹

Yet, the law does not require therapeutic benefit – or, for that matter, treatability.

The lawfulness of the new test

The JCHR accepts that the abolition of the treatability test does not engage the ECHR.⁴² This is because Article 5(1)(e) neither entitles a patient to treatment appropriate to his/her condition nor requires that

33 JCHR Report, para 9

34 *Ibid*, paras 17-20

35 MHA 1983, ss 1 & 3

36 MHA 1983, ss 3(2) & 20(4)(b)

37 MHA 1983, s 3(2)(b)

38 See, David Hewitt, *A suitable case for treatment? New*

Law Journal, vol 156 no 7230, 23 June 2006, pp 1008-1009

39 JCHR Report, para 18 & Appendix 1, para 8

40 Mental Health Bill 2006, cl 4

41 Joint Committee on the Draft Mental Health Bill, *op cit*, paras 140 & 148

42 JCHR Report, Appendix 1, para 8

s/he be ‘treatable’ in order to be detained.⁴³ Indeed, the ECtHR has gone as far as to say that people of unsound mind might be detained:

- merely because of public safety concerns;⁴⁴
- because “they have to be considered as occasionally dangerous for public safety”;⁴⁵ or
- “because of considerations dictated by social policy.”⁴⁶

This shows how weak the ECHR is, and it suggests that the Government might be wrong to see the treatability test as a bar to detention.⁴⁷

The Committee ends its discussion of this point on a note of caution. Its attention was drawn to Council of Europe Recommendation No (2004) 10, which was published after the last of the cases on which the ECHR treatment jurisprudence now stands.

Recommendation 17(1) (iii) states that the ‘involuntary placement’ of someone with mental disorder will only be permitted if, *inter alia*, “the placement includes a therapeutic purpose”,⁴⁸ a term that, we are told, “includes prevention, diagnosis, control or cure of the disorder, and rehabilitation.”⁴⁹

The Recommendation does not, however, say that detention must be contingent on treatment. It doesn’t mention ‘treatment’ at all. Indeed, it seems to permit involuntary placement simply on the grounds that it will prevent, control or cure the person’s mental disorder, or simply allow it to be diagnosed.

Even if the definition of ‘therapeutic purpose’ were to include ‘treatment’, it is unlikely that it would be any stronger. The definition of ‘treatment’ adopted elsewhere in the Recommendation is vague:

“[A]n intervention (physical or psychological) on a person with mental disorder that, taking into account the person’s social dimension, has a therapeutic purpose in relation to that mental disorder. Treatment may include measures to improve the social dimension of a person’s life.”⁵⁰

It seems, therefore, that the Recommendation does not go so far as to require that a person be treatable before s/he is detained, and that the restriction it imposes is no greater than is already imposed by the ECHR and the cases decided under it.

4. Renewal of detention

The JCHR is concerned that the renewal of a patient’s detention under the amended MHA 1983 might breach the ECHR. There are two reasons for this.⁵¹

43 *Winterwerp v Netherlands* (1979) 2 EHRR 387; *Hutchison Reid v United Kingdom*, Application no 50272/99, Judgment of 20 February 2003. See also, *Koniarska v United Kingdom*, Application no 33670/96, Decision of 12 October 2000, unreported

44 *Luberti v Italy*, 6 EHRR 440, 449, para 28

45 *Guzzardi v Italy* (1980) 3 EHRR 333, 366, para 98

46 *Litwa v Poland*, Application no 26629/95, Judgment of 4 April 2000, para 60

47 See, David Hewitt, *Treatability tests*, *Solicitors Journal*, vol 146 no 37, 4 October 2002, pp 886-887

48 Council of Europe, Committee of Ministers, Recommendation (2004) 10, Concerning the protection of the human rights and dignity of persons with mental disorder, adopted on 22 September 2004, Art 17(1) (iii)

49 *Ibid*, Art 2(3)

50 *Ibid*

51 JCHR Report, paras 21-26 & 27-29

Objective medical expertise

As we have seen, detention will only be lawful under Article 5(1)(e) of the ECHR if its subject is shown to be of ‘unsound mind’ by objective medical expertise.⁵²

The JCHR accepts that the procedures for a patient’s initial detention under MHA 1983 will continue to fulfil this requirement.⁵³ It takes a different view, however, with regard to the *renewal* of a patient’s detention.⁵⁴

Once MHA 1983 has been amended, a patient’s detention – or, as we must learn to call it, *compulsion* – will be renewed by the successor to the Responsible Medical Officer (‘RMO’), the Responsible Clinician (‘RC’).⁵⁵ Crucially, the RC will not need to be medically qualified and might in fact be a nurse, a psychologist, an occupational therapist or a social worker.⁵⁶

The Government considers this to be consistent with the ECHR. It says that ‘objective medical expertise’

“means relevant medical expertise, and not necessarily that of a registered medical practitioner;”⁵⁷

and that in *Winterwerp*, the phrase

“was used in the wider sense and the [ECtHR] was not seeking to lay down which sort of qualifications available in a national system would be acceptable and which would not.”⁵⁸

The JCHR does not accept this analysis, and it relies instead on the *Varbanov* case.⁵⁹

Quoting at length from the judgment of the ECtHR, the Committee concludes,

“[T]he opinion of a medical expert who is a psychiatrist is necessary for a lawful detention on grounds of unsoundness of mind.”⁶⁰

As we have seen, detention might be lawful under Article 5(1)(e) merely because it is in the interests of public safety or social policy.⁶¹ If that is so, why is it necessary for any such detention to be justified by objective medical expertise? This might logically be so where the reason relied upon is ‘unsoundness of mind’, but:

- (a) does reliance upon that ground exclude reliance on broader, public safety or social policy grounds subsequently (for example at renewal)?
- (b) even in the case of someone suffering from unsound mind, is it not possible to eschew the ‘unsoundness of mind’ ground and claim instead that his/her detention is lawful on those broader grounds?

In either case, objective medical expertise would add nothing to the issue of whether detention was justified, which would instead turn on questions of safety or public policy.

52 *Winterwerp v Netherlands* (1979) 2 EHRR 387

53 MHA 1983, s 12(2)

54 JCHR Report, paras 21-29

55 Mental Health Bill 2006, cl 8(4)(a)

56 Mental Health Bill 2006, cl 8(9) & (10) and Explanatory Notes, n 52; JCHR Report, para 22

57 JCHR Report, para 23 and Appendix 1, para 9

58 *Ibid*, Appendix 3, para 7

59 *Varbanov v Bulgaria*, Application no 31365/96, Decision of 5 October 2000; JCHR Report, para 26

60 JCHR Report, para 26

61 *Luberti v Italy*, 6 EHRR 440, 449, para 28; *Guzzardi v Italy* (1980) 3 EHRR 333, 366, para 98; *Litwa v Poland*, App No 26629/95, 4 April 2000, para 60

Who may renew?

A patient's detention under section 3 of MHA 1983 will be renewed once the appropriate report is furnished by his/her RMO to the hospital managers,⁶² and the managers need not consider the report for it to have that effect.⁶³

The JCHR notes the ECHR requirement – first stated in the *Winterwerp* case – that in order to be “in accordance with a procedure prescribed by law” and so comply with Article 5,

“any measure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary.”⁶⁴

The Committee notes that as far as MHA 1983 is concerned, the ‘appropriate authority’ that detains non-offender patients is not the RMO, but the hospital managers. It worries that because the managers need only receive, and need not approve, a report by the RMO, the renewal process might breach the ECHR.⁶⁵

The Government's response to this concern was two-fold. First, it said that the ECHR does not require that a patient's detention be renewed, merely that it be kept under review, and that it is the RC, not the managers, that performs this function.⁶⁶

The second limb of the response was perhaps surprising. The Government said that renewal by someone other than the managers is consistent with the ECHR because:

- (a) once a patient has been admitted to hospital under MHA 1983, responsibility for his/her case passes to the RMO; and
- (b) at that point, the hospital managers cease to be the detaining authority.⁶⁷

The Committee says it finds this argument “unconvincing”, and it adds, “It is not apparent to us how and by what process the responsible clinician becomes the competent authority for Convention purposes.”⁶⁸

It might be added that MHA 1983 gives the managers a number of functions that can only be exercised or performed after a patient has been detained, at a time when, on the Government's assumed analysis, responsibility has shifted to the RMO. These powers and duties are neither granted to nor imposed upon the RMO.

5. The nearest relative

The JCHR next considers the proposals to address the nearest relative problem.⁶⁹

It is accepted that in the case of a detained patient, the mechanism for identifying his/her nearest relative breaches Article 8 of the ECHR. That is because it is inflexible, and also because it allows a patient neither to select his/her nearest relative nor to remove one that is unsuited to the role.

62 MHA 1983, s 20(3)

63 *R v Warlingham Park Hospital Managers, ex parte B* (1994) 22 BMLR 1

64 *Winterwerp v Netherlands* (1979) 2 EHRR 387 at para 45

65 Although this possibility was brought to the Committee's attention in a briefing from JUSTICE, it would appear to derive from the work of Professor Fennell. See, for example, Phil Fennell, *Medical Law* [1995] All England

Law Reports: Annual Review, pp 354-396 at pp 383-384. Professor Fennell was the Committee's specialist adviser. See also: *Koendjibiaire v The Netherlands* (1990) 13 EHRR 820; *Keus v The Netherlands* (1990) 13 EHRR 701

66 JCHR Report, para 29 & Appendix 3, para 19

67 *Ibid*, para 22

68 *Ibid*, para 29

69 *Ibid*, paras 30–37

Following adverse proceedings in the ECtHR,⁷⁰ the Government promised to make the necessary reforms. It proposes that MHA 1983 make it possible:

- (a) for a patient to seek displacement of his/her nearest relative;⁷¹
- (b) for displacement to be ordered on a further ground: the nearest relative is not a 'suitable' person to act as such;⁷²
- (c) for a patient to nominate his/her own nearest relative;⁷³ and
- (d) for the appointment of a replacement nearest relative to be of indefinite duration.⁷⁴

These proposals are a good less radical than those contained in the draft Mental Health Bills of 2002 and 2004.⁷⁵ Nevertheless, with one caveat, the JCHR says that they appear to satisfy the promise the Government made to the ECtHR.⁷⁶

The caveat is, however, a significant one. It concerns the notion of 'suitability', which the Committee was concerned might be used to justify displacing a nearest who is simply a 'difficult customer' and has a tense relationship with the authorities.⁷⁷ The Government said this was not its intention:

"It is vital [...] 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. [We do] not wish to restrict this role by allowing for the displacement of a nearest relative for acting independently in this way."⁷⁸

"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."⁷⁹

"It is [our] 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."⁸⁰

The JCHR is not reassured by this explanation, and it concludes that the concept of suitability is "potentially too broad".⁸¹

But what also concerns the JCHR is that a patient might fall out with his/her nearest relative but still be unable to displace him/her. The Committee feels that the Government has paid insufficient attention to this possibility, which, it says, demonstrates that the concept of 'suitability' is not only too broad,

"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."⁸²

70 *JT v United Kingdom*, Application no 26494/95, Judgment of 30 March 2000; (2000) 1 FLR 909; *FC v United Kingdom*, Application no 37344/97, Decision of 7 September 1999. See also *R (M) v Secretary of State for Health* [2003] EWHC 1094 (Admin)

71 Mental Health Bill 2006, cl 21(4)

72 Mental Health Bill 2006, cl 21(5)(b)

73 Mental Health Bill 2006, cl 21(3)

74 Mental Health Bill 2006, cl 22(7)

75 Department of Health, Draft Mental Health Bill, Cm 5538, 2002, cl 148-158; Department of Health, Draft Mental Health Bill, Cm 6305, cl 232-246. See, David Hewitt, *Relative progress?* *New Law Journal*, vol 157, no

7257, 26 January 2007, pp 126-127. This issue is further explored in, David Hewitt, *The Nearest Relative Handbook*, 2007, Jessica Kingsley Publishing, ch 1

76 JCHR Report, para 33

77 *Ibid*

78 *Ibid*, Appendix 3, para 23

79 *Ibid*, para 24

80 *Ibid*, Appendix 3, para 25. See also, HL Deb 17 Jan 2007, col 672, Lord Hunt of King's Heath

81 *Ibid*, para 37

82 *Ibid*. The Government's position is set out at HL Deb 17 Jan 2007, col 672

Even if circumstances do not permit a nearest relative to be displaced, it is possible that they will lead an Approved Social Worker to conclude that it would be ‘impracticable’ to consult him/her before making an application for the patient’s detention under section 3 of MHA 1983.

This possibility arises, of course, out of the case of *E*,⁸³ which, the JCHR tells us, establishes that:

“the Approved Social Worker’s duty to consult the nearest relative about compulsory admission if appropriate and practicable does not apply if the patient objects to that person being consulted as the nearest relative.”⁸⁴

This is surely to over-state the effect of the *E* case. There will, mercifully, be few cases in which the potential consequences of consulting a nearest relative will be as grave for the patient as they were said to be there. Yet, it is only where the facts are comparable that the judgment will be relevant and the duty to consult might be waived. In any case, although the judgment might excuse an ASW from the duty of consultation, it cannot be used to deprive a nearest relative of his/her other rights under MHA 1983. The case of *E* does not provide a comprehensive solution to the problems identified by the ECtHR (and acknowledged by the Government).

6. Community treatment

Making a community order

One of the most significant features of the Mental Health Bill is the Community Treatment Order (‘CTO’), a device that would extend compulsion from hospital into the community.⁸⁵ A patient might be made subject to a CTO if s/he was detained under MHA 1983, under either section 3 or Part III.⁸⁶

Although the CTO might be viewed as a strengthened version of Supervised Discharge, the Bill does not conceive of it as such, preferring to see it as a species of leave.

The Bill abolishes Supervised Discharge and provides that in a case where s/he might grant a patient leave of absence for more than seven consecutive days, the RC must first consider a CTO.⁸⁷

This confirms a common suspicion: under the un-amended Mental Health Act, leave of absence – and particularly long leave of absence – has increasingly come to be used as a form of community compulsion.⁸⁸

One feature of the CTO that has caused particular concern is the possibility that it might have attached to it conditions, whose breach would lead to a patient’s being recalled to hospital and, possibly, re-detained.⁸⁹

Any such conditions would usually relate to the patient’s residence, medical assessment and acceptance of medical treatment.⁹⁰ However, and perhaps ominously, the Mental Health Bill says that a CTO might include “a condition that the patient abstain from particular conduct”.⁹¹ There is a concern that such a condition need not relate to the patient’s mental disorder or treatment.

83 *R (E) v Bristol City Council* [2005] EWHC 74 (Admin)

84 JCHR Report, para 37

85 Mental Health Bill 2006, cl 25-29

86 Mental Health Bill 2006, cl 25(2)

87 Mental Health Bill 2006, cl 26(2)

88 *R (DR) v Mersey Care NHS Trust* [2002] EWHC 1810 (Admin); David Hewitt, *There is no magic in a bed – The renewal of detention during a period of leave*, *Journal*

of Mental Health Law, August 2003, pp 87-101; *R (CS) v Mental Health Review Tribunal* [2004] EWHC 2958 (Admin). See also, David Hewitt, *An inconvenient mirror: Do we already have the next Mental Health Act?* *Journal of Mental Health Law*, November 2005, pp 138-149

89 Mental Health Bill, cl 25

90 Mental Health Bill, cl 25(2)

91 Mental Health Bill, cl 25

The Government has rebutted that concern. So, for example, the draft Code of Practice states that a conduct 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.”⁹²

Nevertheless, the draft Code goes on to state:

“The above is not an exhaustive list of conditions which may be applied – there may be others depending on the patient’s individual circumstances.”⁹³

Concern has been voiced that the CTO might turn out to be a ‘mental health ASBO’. Those fears have been officially expressed, both by the Parliamentary committee that scrutinised the 2004 Mental Health Bill⁹⁴ and during the debates that have attended the present, substantive Bill.⁹⁵

For its part, the JCHR notes those fears.⁹⁶ They are hardly allayed by the Government’s latest word on the subject. In a letter to the Committee, the Right Honourable Rosie Winterton wrote:

“[I]t 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.* [...] [T]he 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.”⁹⁷

Although it is intriguing that a patient might be able to veto the conditions of his/her CTO, it is perhaps dispiriting that those conditions will be capable of being imposed solely for public protection.

Still concerned about a possible breach of Article 8, the JCHR suggests that each CTO be authorised by the hospital managers, and that this process be enshrined in the Act and not simply left to a Code of Practice.⁹⁸

Reviewing the conditions of community treatment

The JCHR is concerned that a CTO might also breach the right to liberty under Article 5 of the ECHR, “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.”⁹⁹

The Government said:

- (a) that a RC could only impose conditions on a patient’s CTO with the consent of the Approved Mental Health Professional (‘AMHP’), and that both the RC and the AMHP would be a ‘public authority’ for the purposes of the Human Rights Act 1998 and so obliged to act compatibly with the ECHR;¹⁰⁰ and

92 MHA 1983 *Draft Code of Practice*, para 12A.23 [emphasis added]

93 *Ibid*

94 *Joint Committee on the Draft Mental Health Bill, 2005*, *op cit*, para 194; *HL Deb*, 17 January 2007, cols 707-8

95 *HL Deb*, 17 January 2007, cols 707-8

96 *JCHR Report*, para 48

97 *Ibid*, Appendix 3, para 32 [emphasis added]

98 *Ibid*, paras 49-51

99 *Ibid*, paras 53 & 54

100 *Ibid*, Appendix 3, para 131

- (b) that “it would [not] 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.”¹⁰¹

The Committee is not reassured by these suggestions. It recommends:

- (a) that if it is not to be permissible to impose CTO conditions that amount to a deprivation of liberty, an express statement to that effect be enshrined in the statute, and not just in the Code of Practice; and
- (b) that a patient should be entitled to apply to a MHRT for a review of the conditions of a CTO.¹⁰²

This is not an order

The JCHR makes a further, telling comment, which perhaps speaks to our deepest fears about the motive behind the current Mental Health Bill and the Bills and pronouncements that preceded it. The Committee says:

“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.”¹⁰³

7. Compulsory treatment

The Committee is concerned that the new SOAD test won't comply with the ECHR.¹⁰⁴

At the moment, of course, a SOAD may authorise the compulsory treatment of an incapable patient, or of a capable patient who refuses to accept it, where, “having regard to the likelihood of its alleviating or preventing a deterioration” of the patient's condition, such treatment “ought to be given”.¹⁰⁵

As far as the new test is concerned:

- (a) it will be that “it is appropriate for the treatment to be given”;¹⁰⁶
- (b) treatment will be ‘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”;¹⁰⁷ and
- (c) we are told that ‘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.”¹⁰⁸

The problem, as far as the JCHR sees it, is that although the first of these stipulations will appear in MHA 1983, the second and third will not: they will be confined to the Code of Practice.

The Government sees little difference between the old and the new tests,¹⁰⁹ and the draft Code says that “scrupulous adherence” to the latter will ensure compliance with the ECHR.¹¹⁰ The JCHR, however, points out that there is little in the Act to require such scrupulousness. The Code of Practice is not

101 *Ibid*, para 57 and Appendix 3, para 38

102 *Ibid*, para 58

103 *Ibid*, para 42

104 *Ibid*, paras 59-66

105 MHA 1983, s 58(3)(b)

106 *Mental Health Bill 2006*, cl 6(2)

107 MHA 1983, *Draft Illustrative Code of Practice*, para 2A.4

108 *Ibid*

109 *JCHR Report*, para 59

110 MHA 1983, *Draft Illustrative Code of Practice*, para 15.2e

absolutely binding and practitioners may depart from it where they have cogent reason for doing so.¹¹¹

The Committee notes that the full requirements of the ECHR, may be found, not just in Articles 3 and 8, but also in the cases they have generated,¹¹² and it recommends that those requirements be set out in the Act itself, and not just in the Code of Practice.¹¹³

The Committee also suggests that it might now breach Article 8 of the ECHR to permit a patient to be treated compulsorily for three months before a second opinion need be obtained.¹¹⁴ A similar suggestion was made in the course of the Parliamentary debates.¹¹⁵

8. Forcible feeding

The JCHR notes that in some circumstances, forcible feeding may be given under section 63 of MHA 1983 without the need for consent or a second opinion.¹¹⁶ This, it suggests, might constitute “a significant and potentially traumatic invasion of physical integrity” and so breach Articles 3 and 8 of the ECHR.

Basing itself on the relatively recent decision in the *Storck* case,¹¹⁷ the Committee says that the state has a positive obligation to secure Article 8 rights for its citizens, that this obligation “requires effective supervision and review of decisions to treat against an individual’s will” and, perhaps contentiously,

“that the direction of the responsible clinician, even if that person is a medical practitioner, is not sufficient to provide such supervision and review.”¹¹⁸

This suggestion is not entirely contingent upon *Storck*: the state’s positive obligation under Article 8 have been recognised for some time.¹¹⁹ Neither, of course, does it constitute a criticism of the new Bill; it might have been made at any time since the 1983 Act was first introduced. That said, and unless the Government decides to heed the Committee’s warning (as it seems highly unlikely to do), it will surely provide useful ammunition to patients in the course of future legal proceedings.

9. Bournemouth

The Committee also considers the Government’s proposals to close the ‘*Bournemouth* gap’.¹²⁰ They hinge on the notion of a ‘deprivation of liberty’: if s/he is deprived of liberty, an incapable patient will be eligible for certain safeguards; if s/he isn’t, s/he won’t. The safeguards will include a requirement that anyone depriving – or proposing to deprive – an incapable patient of liberty obtain authorisation for doing so.

The Government does not consider it necessary to define ‘deprivation of liberty’ in the Act itself, preferring to provide mere guidance in another code of practice.¹²¹

The JCHR, however, is not impressed by such an approach. It says that “deprivation of liberty is a less

111 JCHR Report, para 60

112 See, for example, *R (N) v Dr M and others* [2002] EWCA Civ 1789

113 JCHR Report, para 65

114 *Ibid*, para 66

115 *HL Deb*, 15 Jan 2007, cols 490-496

116 JCHR Report, paras 67-69

117 *Storck v Germany*, Application no 61603/00, Decision of 16 June 2005

118 JCHR Report, para 69

119 See, for example, *X and Y v The Netherlands* (1986) 8 EHRR 235; *Hatton and others v United Kingdom*, Application no 36022/97, Judgment of 8 July 2004

120 JCHR Report, paras 70-91. See *Mental Health Bill 2006*, cl 38

121 Department of Health, *The Bournemouth framework: Draft Illustrative Code of Practice*, December 2006, paras 19-28 – <http://www.dh.gov.uk/assetRoot/04/14/17/64/04141764.pdf>; JCHR Report, Appendix 3, para 52

flexible and elusive concept than might be thought” from the guidance;¹²² and it suggests that confining the essential detail of ‘deprivation of liberty’ to a code might mean that the new framework cannot constitute a procedure prescribed by law and will therefore breach the ECHR. As before, therefore, the Committee suggests that this key detail be placed on the fact of the Act.

When discussing the notion of a deprivation of liberty, the Committee invokes the recent case of *JE*,¹²³ in which, it says, Munby J held that:

“[T]he 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.”¹²⁴

But this might be slightly to mis-state the *ratio* in *JE*, and also to over-state the importance of the case. The words of Munby J may be taken to mean nothing more than that the circumstances of the case were *among those* in which a person would be held to have been deprived of liberty; they need not imply that it would *only* be in those circumstances that such a deprivation would be made out.

Such a reading would be consistent with the Government’s draft guidance, which says that an act that prevents a person from leaving when s/he has made a meaningful attempt to do so might “contribute” to a deprivation of liberty.¹²⁵ It would also appear to be inconsistent with the decision of the ECtHR in the *Bournemouth* case itself.¹²⁶

The Committee has, however, prompted the Government to concede that an authority granted in respect of a ‘*Bournemouth* patient’ will not carry the power actually to *convey* him/her to the place in which s/he is to be deprived of liberty.¹²⁷

The Committee does not like this state-of-affairs. It recommends that, as in MHA 1983, the authority to detain should include the power to convey into detention, for

“[I]f 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 them, moreover, that person is deprived of liberty from the point of removal from their home.”¹²⁸

The Committee also expresses its concern about the complexity of the new framework, which it says might breach Article 5(1) of the ECHR because it is not

“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.”¹²⁹

In the course of the Parliamentary debate, the Government confirmed that, subject to a means-test, a person might have to pay for the accommodation in which s/he was deprived of liberty.¹³⁰ The Committee feels this state-of-affairs might breach Articles 5 and 6 of the ECHR, and also Article 14 (which is the prohibition of discrimination).¹³¹

122 JCHR Report, para 86

123 *JE and DE v Surrey County Council* [2006] EWHC 3459 (Fam)

124 JCHR Report, para 86

125 Department of Health, *The Bournemouth framework: Draft Illustrative Code of Practice*, December 2006, para 25

126 *That said, Munby J does provide a very helpful summary of the authorities on this point*

127 JCHR Report, para 88 & Appendix 3, para 56

128 *Ibid*, para 89

129 *Ibid*, para 90

130 *HL Deb*, 17 January 2007, col 764

131 JCHR Report, para 91

10. Other issues

The Committee also considers what, from a human rights perspective, appear significant omissions from the Bill. The first of these is also related to the new *Bournewood* framework.

Treatment under the Bournewood proposals

The Committee is concerned that although the new framework will allow incapable patients to have their liberty taken away, it is silent as to the treatment that might be imposed on them.¹³²

The Government says it will be possible to treat such patients under the Mental Capacity Act 2005 ('MCA 2005'), or even the common law,¹³³ but the Committee is not so sure. It notes that the principal effect of MCA 2005 is to "provide a retrospective defence for a person who gives treatment which they reasonably believe to be in a patient's best interests."¹³⁴ In *Storck*, however, when commenting on similar or stronger measures available in German law, the ECtHR said, "such retrospective measures alone are not sufficient to provide appropriate protection of the physical integrity of individuals".¹³⁵

Drawing on the baleful example provided by the investigation into learning disability services in Merton and Sutton,¹³⁶ the JCHR concludes: "effective supervision and review requires more than the common law or the Mental Capacity Act currently provide."¹³⁷ The Committee says that in the case of treatment given to '*Bournewood* patients', that review should come *via* a second opinion system or an inspectorate such as the Mental Health Act Commission ('MHAC').¹³⁸

Seclusion

The Committee says that the second significant omission from the Mental Health Bill is anything about seclusion.¹³⁹

We know that seclusion is lawful,¹⁴⁰ but it is regulated, not by MHA 1983 or even by secondary legislation, but by guidance in the MHA 1983 Code of Practice. The House of Lords has confirmed that practitioners and services may depart from that guidance if they have "cogent reason" to do so.¹⁴¹

The problem is Article 8(2) of the ECHR, which requires that any interference with the right to respect for one's privacy be, *inter alia*, in accordance with the law in the sense that its consequences are predictable. The Committee believes this means that the relevant regulatory mechanism must be contained in statute, and not a mere code.¹⁴²

If a code were sufficient, the only adjudication on the question of whether a departure was 'cogent' – and therefore lawful – would come retrospectively. As before, the JCHR suggests that retrospective supervision and review will not be enough to amount to Article 8(2) predictability.¹⁴³

132 *Ibid*, paras 93-101

133 *Ibid*, para 101

134 *Ibid*

135 *Storck v Germany*, Application no 61603/00, Judgement of 16 June 2005

136 Healthcare Commission, January 2007, *Investigation into the service for people with learning disabilities provided by Sutton and Merton Primary Care Trust* – http://www.healthcarecommission.org.uk/_db/_documents/Sutton_and_Merton_inv_Main_Tag.pdf

137 JCHR Report, para 101

138 *Ibid*

139 *Ibid*, paras 102-110

140 *R (Munjaz) v Mersey Care NHS Trust; R(S) v Airedale NHS Trust* [2003] EWCA Civ 1036. See, David Hewitt, *A secluded view*, *New Law Journal*, Vol 153, No 7090, 25 July 2003, p 1133

141 *R (Munjaz) v Mersey Care NHS Trust and others* [2005] UKHL 58. See, David Hewitt, *Dancing on pinheads*, *New Law Journal*, vol 155, no 7199, 4 November 2005, pp 1658 & 1659

142 JCHR Report, para 106

143 *Ibid*, para 107; *Storck v Germany*, Application no 61603/00, Judgement of 16 June 2005, para 150

The Committee seems to favour a system of regulation by statute (or at least statutory instrument).¹⁴⁴ This would accord with recommendations made by MHAC,¹⁴⁵ and also by the last JCHR.¹⁴⁶ It was a system that at one time, the Government seemed to favour as well,¹⁴⁷ but which it has now disavowed.

The Committee believes that safeguards should be inserted into MHA 1983

“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.”¹⁴⁸

11. Conclusion

The new report of the Joint Human Rights Committee is not the easiest of reads. It is discursive and, at times, elliptical. Sometimes, its discussions are not pursued to a point and there is a vague sense of tailing off; of thoughts being, perhaps, withdrawn.

What is crystal clear, however, is that many of the issues raised by the JCHR are of wider concern. A majority of the defeats inflicted on the Government during the Mental Health Bill's passage through the House of Lords is prefigured in this report.

And the Joint Committee has performed another service, whose true value might only become clear long after the Mental Health Act has been amended. It has wrung from the Government a number of concessions that will serve as guidance – if not hostages to fortune – in days to come.

¹⁴⁴ JCHR Report, para 107

¹⁴⁵ MHAC, *Eleventh Biennial Report, 2003-2005: In place of fear*, London, 2006, para 4.237 & 4.238

¹⁴⁶ JCHR, *Third Report of Session 2004-2005, Deaths in custody*, HL Paper 15-1 HC 137-1, para 245

¹⁴⁷ MHAC, 2006, *op cit*, para 4.237

¹⁴⁸ JCHR Report, para 110