

28 November 2006

## **Mental Health Bill: Lords Second Reading Briefing**

---

### **Background**

#### **The ‘Bournewood Gap’**

The “Bournewood gap” covers people who lack the capacity to give informed consent to the arrangements made for their care, and who are given care in circumstances which amount to a deprivation of liberty under Article 5 of the European Convention on Human Rights (ECHR).

The “gap” is a gap in the law – people in this category are deprived of their liberty without due process or adequate legal remedy. Following a ruling by the European Court of Human Rights (ECtHR) in 2004 in the case of *H.L. v The United Kingdom* (called “the Bournewood judgement”, because it concerned an autistic man who was deprived of his liberty in Bournewood hospital), the government has committed to change the law and close this loophole.

#### **What is “deprivation of liberty”?**

The question of whether or not someone has been deprived of their liberty depends on a range of factors. The ECtHR ruled that “The distinction between a deprivation of, and a restriction upon, liberty is merely one of degree or intensity and not one of nature or substance”. A person is not necessarily deprived of liberty simply by virtue of being in a hospital or care home without having consented, or by virtue of being behind locked doors for part of the day.

Many people who are in hospitals or care homes who lack capacity will therefore not be deprived of their liberty, even if they have never consented to being placed there and have not been sectioned. It depends on the particular circumstances of each case. It is very unclear how many people are currently being deprived of liberty and would be covered by the new proposals.

#### **The government’s proposals**

The government is planning to amend the Mental Capacity Act 2005 as part of the forthcoming Mental Health Bill. They will introduce rules setting out the process which must be followed to authorise the deprivation of liberty of a person who lacks capacity in a hospital or registered care home.

Whenever a hospital or care home identifies that a person who lacks capacity is being deprived of liberty or risks being deprived of liberty, they must apply to the supervisory body (the local authority or primary care trust) for authorisation of deprivation of liberty.

When the supervisory body receives an application for authorisation of deprivation of liberty, they must check:

- If the person is over 18
- If they have a disorder or disability of mind

- If they lack the capacity to object to living in the hospital or care home
- If they are eligible under the rules
- If detention is in their best interests, i.e. necessary in order to protect them from harm, and proportionate to the likelihood and seriousness of that harm

An authorisation may not be given if any of these conditions is not met.

If an authorisation is given, it may last for up to 12 months. The government thinks that in many cases, authorisations will be shorter than this. At the end of the authorisation period, the person must be assessed again to decide whether another authorisation should be given.

If the person is unbefriended, an advocate will be appointed to support and represent them during the assessment process. When an authorisation is granted, the supervisory body must appoint someone to act as the person's representative, to keep in touch with the person, to support them, and to request a review or appeal to the Court of Protection on their behalf where necessary. This will normally be a member of the person's family or a friend. If this is not possible then an advocate will be appointed.

### **The view of the Making Decisions Alliance**

The Making Decisions Alliance welcomes the Government's decision to introduce safeguards for people who lack the capacity to give informed consent to decisions made over their care. However, we have a number of concerns about the detail of the proposals and would like to see the safeguards strengthened to give more protection to these vulnerable people.

Any changes in legislation must be linked in with other policies and standards in health and social care settings so that deprivations of liberty are kept to a minimum. We are seeking confirmation that the Government will ensure that definitions of deprivation of liberty and examples of circumstances which amount to deprivation of liberty are including in the code of practice to the Bill. For example, it would be important to consider:

- the regime under which a person is accommodated, and the extent to which the person has freedom within such constraints;
- 'control' through medication or physical restraint;
- the involvement of the person or their relatives and friends in decisions about admission and the care plan.

We would like the Government to commit to publishing a draft version of the section of the code of practice relating to Bournewood as soon as possible, and certainly before the passing of the legislation. The code of practice should clarify under what circumstances an individual would come under either the Mental Health Act or the Mental Capacity Act.

There should be greater parity with the safeguards in the Mental Health Act 1983. Without extra safeguards, people who lack the capacity to give informed consent would be being treated less favourably than other groups. The Making Decisions Alliance would like to see the following key safeguards in place:

1. Authorisations should not exceed six months before an automatic review of a case is triggered, in line with patients detained under the Mental Health Act.

2. Appeals should be heard by the Mental Health Tribunal, not the Court of Protection.
3. Any individual who may be deprived of their liberty under these provisions should have the right to an independent advocate, including those who are befriended.
4. Medication, ECT and other serious treatments should be approved by an independent clinician through a second opinion procedure.
5. People detained under these provisions should have the right to free aftercare services.
6. The patient's representative should be appointed at the beginning of the assessment process, not after an authorisation of deprivation of liberty has been granted.
7. Independent third parties such as relatives, friends or advocacy groups should be able to trigger an assessment for authorisation of deprivation of liberty if they have reason to believe that someone is being deprived of their liberty.
8. When an authorisation is not approved, the supervisory body should make recommendations on how a person's health and social care needs can be met in their best interests without depriving that person of their liberty.

### **1. Length of Authorisation**

The maximum length of authorisation of one year is considered to be a 'long-stop' measure which will affect relatively few people as there will be opportunities to ask for a review at any time. There will, however, be cases where an individual or their carer may not have the confidence or knowledge of the system to feel able to instigate a review of their authorisation. For these people, twelve months is far too long to wait for a review of their situation if they are being deprived of their liberty and this is not in their best interests.

### **2. Appeals Process**

The Court of Protection is not a suitable body to hear appeals because it lacks expertise in authorising detentions and does not have sufficient resources to deal with the increase in workload. The Mental Health Review Tribunal has experience of dealing with the legality of detention of people with mental disorders and of reviewing the cases of people who lack capacity. The Tribunal should be the body which hears appeals against authorisations under these provisions. Tribunal staff would need very little further training to equip them for this role.

We believe that all appeals and reviews must be supported by non means tested legal aid.

### **3. Advocacy**

Everyone deprived of their liberty under the Mental Capacity Act should have access to an independent mental capacity advocate from the point of assessment onwards. It should not matter whether they have friends acting on their behalf, as a friend does not replace a trained advocate who understands the system. A person needs such an advocate to be able to properly express their wishes and exercise their rights under the Act.

### **4. Right to a second opinion**

Medication, ECT and other serious treatments should be approved by an independent clinician through a second opinion procedure. Under the Mental Health Act there is a statutory second medical opinion procedure for medication beyond three months and for ECT. The same safeguard should be given to people treated under the Bournemouth provisions. The second opinion doctor should be a specialist in the same field as the treatment proposed.

## **5. Aftercare**

People who are detained in a hospital or care home under the Bournewood provisions to be given the same rights to after-care services as a patient who is detained under the Mental Health Act. These services should be provided free of charge as the person has not had a choice over whether to receive the initial treatment and detention.

## **6. Patient's representative**

The patient's representative – likely to be a family member, friend or someone who knows the patient well – will be in a good position to advise on the patient's wishes and feelings, and on their best interests. They should be appointed before the Best Interests Assessment is carried out, so that they can inform the authorisation process – not, as is currently envisaged, after the process is finished.

## **7. Third Party request**

If someone has reason to believe that another person is being deprived of their liberty, then they should have the right to ask the appropriate body to look into this, and to make sure that that person receives the appropriate safeguards. At the moment, only the managers of the hospital or care home in which a person may be being deprived of their liberty have the right to ask for an authorisation. We are concerned that managers may not always be best placed to know when deprivation of liberty may be taking place. In many cases, it is a person's relatives or friends who are the first to become aware of potential problems with their care regime. Deprivation of liberty is a serious matter, and the law should be drawn to make it as simple and rapid as possible to identify it and decide whether it is justified. Making this change would also enable independent third parties to "blow the whistle" on poor practice which amounts to unauthorised deprivation of liberty.

## **8. Supervisory body recommendations**

If a supervisory body refuses to authorise a deprivation of liberty it is incumbent upon hospital and care home managers to review their regimes to ensure that a deprivation of liberty will no longer occur. For example, they may need to examine the extent to which the person has freedom to move around within a facility or to leave the facility without hindrance. The onus is on the supervisory body to ensure that such changes are made.

## **The Making Decisions Alliance**

The Making Decisions Alliance (MDA) is a consortium of 40 charities set up to campaign for new legislation on mental capacity and to support the implementation of the Mental Capacity Act.

The Making Decisions Alliance brings together a wide range of organisations and groups, working with people who may, for range of different reasons, have difficulty in making or communicating decisions. The Alliance members are: Action on Elder Abuse, Age Concern England, Alzheimers Concern Ealing, Alzheimer's Society, Beth Johnson Foundation, Carers UK, Cloverleaf Advocacy, Community Living, Consumer Forum, Centre Policy on Ageing, The Down's Syndrome Association, Foundation for People with Learning Disabilities, Help The Aged, Horsham Gateway Club, Kent Autistic Trust, Leonard Cheshire, Manic Depression Fellowship, Mencap, The Mental Health Foundation, Mind, Motor Neurone Disease Association, North Staffordshire Users Group, The National Autistic Society, Parents Autism Campaign for Education, Patient Concern, POPAN, The Oaklea Trust, The Relatives and Residents Association, Respond, Rethink, Scope, Sense, Skills for People, The Stroke Association, St Clements Patients Council, Turning Point, United Response.

**Contact Details:** Emily Frith, Public Affairs Officer, Turning Point, 020 7553 5222