Mental Health Bill

JUSTICE Briefing for House of Lords Second Reading

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Introduction

1. Founded in 1957, JUSTICE is a UK-based human rights and law reform organisation. Its mission is to advance justice, human rights and the rule of law. It is the British section of the International Commission of Jurists.

2. JUSTICE is also a member of the Mental Health Alliance, an umbrella group of mental health organizations and other groups concerned with the reform of the 1983 Mental Health Act.

3. We fully endorse the Alliance's briefing on this Bill. The purpose of this separate briefing is simply to highlight what we regard as the most pressing human rights aspects of the Bill.

Summary

4. JUSTICE recognises that the 1983 Act contains significant gaps. Nonetheless, it is essential that fresh mental health legislation should be fully compliant with human rights standards. Sadly, this is not something that can be said of the Bill in its current form.

5. Indeed, given the many previous attempts to reform the law in this area, we are nonplussed by the continuing failure of the Department of Health to bring forward mental health legislation that manages to achieve even minimal compatibility with relevant international standards. In particular, many of the deficiencies noted in the 2005 report of the Joint Committee on the Draft Mental Health Bill remain extant in the current Bill.

6. Thus, although the Bill contains several welcome changes to the 1983 Act, this briefing identifies a number of significant flaws in its provisions, flaws that threaten the basic rights of those suffering from mental illness. These include:

    - A vague and sweeping definition of 'mental disorder' (clauses 1-3);

    - An 'appropriate treatment' test that permits the use of preventative detention and coercive treatment without any requirement to show therapeutic benefit, seriousness or even basic necessity (clauses 4-7);

    - The lack of adequate safeguards to prevent Community Treatment Orders being made in ways that may significantly interfere with a patient's fundamental rights (clauses 25-29);

    - The lack of a clear definition governing the deprivation of liberty of compliant patients who do not possess mental capacity to consent to treatment (clauses 38-39).

Definition of mental disorder (clauses 1-3)

7. The new definition suffers from two fundamental problems: it extends the provisions of mental health legislation to new groups of people, and it fails to state with sufficient precision and certainty to whom it will apply.

Drugs and alcohol

8. Clause 1(3) of the Bill provides that dependence on alcohol or drugs does not fall within the definition of mental disorder. However, the Draft Code of Practice states that this does not exclude *'other mental disorders relating to the use of alcohol or drugs*', for example uncomplicated acute intoxication (IB.7).

9. The WHO Classification of Mental and Behavioural Disorders (ICD-10) describes acute uncomplicated intoxication as '*a transient condition following the administration of alcohol or other psychoactive substance, resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psychophysiological functions and responses*'.[1]

10. The Bill therefore provides for powers of detention to be used in relation to people who are temporarily inebriated. While the Code of Practice ('the Code') states that such a condition will '*only rarely justify the use of powers under the Act*', the potential for abuse is obvious. There is a particular problem with reliance on the Code to limit what are otherwise substantial increases in the width of powers under the Act since the Code itself must only be treated as guidance and may be departed from with good reason.[2]

Sexual deviancy

11. The Bill removes the previous exclusions for promiscuity, immoral conduct, and sexual deviancy. As a result, any recognised psychiatric disorders concerning sexual behaviour may be included in its scope.

12. The Draft Code of Practice states that sexual orientation does not by itself indicate the presence or absence of mental disorder (IB.5). Homosexuality is no longer classified as a psychiatric disorder in the UK: it is therefore exceptionally unlikely that it would fall under the new definition of mental disorder in any event. However, a variety of other lawful sexual behaviours are still judged to be psychiatric disorders, including transsexualism ('gender identity disorder'), masochism, and fetishism.

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[1] http://www.who.int/substance_abuse/terminology/ICD10ClinicalDiagnosis.pdf

[2] See the decision of the House of Lords in *R (Munjaz) v Mersey Care NHS Trust and others* [2005] UKHL 58.

13. The Explanatory Notes to the Bill state that it is intended that certain behaviours (specifically fetishism and paedophilia) be brought within the scope of mental health legislation for the first time.[3]

14. It is in our view entirely inappropriate that all sexual preferences and behaviours classified as psychiatric disorders should be brought within the purview of mental health legislation, particularly where that legislation provides for detention and compulsory treatment.

15. The Department of Health's note on the definition of mental disorder in the Bill states that the exclusion for sexual deviancy has been removed because *'it has sometimes resulted in patients who need compulsory treatment for mental disorder being excluded because their disorder manifests itself in sexual deviancy or offending*'. No doubt this is primarily an opaque reference to paedophilia.

16. There is no obvious reason why, if this is the basis of the change in position with respect to sexual deviancy, a specific exception could not be made for paedophilia, rather than widening the scope of mental health legislation to include other sexual behaviours such as those mentioned. The extension of powers of detention and compulsory treatment to individuals with sexual preferences which can be expressed without infringing the rights of other people or committing a criminal offence is, in our view, a fundamentally misconceived and seriously retrograde step.

Epilepsy and other brain disorders

17. The Draft Code of Practice states that disorders or disabilities of the brain are not included in the term 'mental disorder' (IB.6). There is no attempt to define a disorder of the brain, or to distinguish it from a disorder of the mind. Its intent may be to exclude conditions such as epilepsy or Huntington's disease from the legislation. In its current form however, the exclusion is hopelessly vague.

18. Clarity is required in the provisions of the Bill itself so that there is no doubt that conditions such as those mentioned are excluded from the provisions of the legislation.

Appropriate treatment (clauses 4-7)

19. The Bill introduces a new criterion for detention - availability of appropriate treatment - and removes the requirement in the 1983 Act that treatment (for psychopathic disorders or mental

[3] Explanatory Notes, para 32.

impairment) is likely to alleviate or prevent a deterioration in the condition of the individual. The Department of Health briefing sheet states that the *'appropriate treatment test will be better* [than the treatability test] *because it calls for an holistic assessment of whether appropriate treatment is available, not focused only on the likely outcome of treatment'.*

20. The 'appropriate treatment' test applies throughout the Bill, including in respect of treatment under s.57 and s.58 of the 1983 Act (psychosurgery, long term medication and ECT).

21. As noted in response to the previous draft Bills, the concept of 'appropriate treatment' is wholly uncertain, and therefore unsuitable in provisions governing the use of coercive powers to override individual autonomy. The European Court of Human Rights has repeatedly emphasised the need for clear rules governing compulsory treatment powers in order to avoid arbitrariness.[4]

22. In previous submissions in respect of the proposed changes to mental health legislation, we have cited Principle 11(6)(c) of the *UN Principles for the protection of persons with mental illness and the improvement of mental health care*, which requires that 'an independent authority is satisfied that the proposed plan of treatment is in the best interests of the patient's health needs*'* prior to any compulsory treatment. We regard this as a more balanced test for the imposition of compulsory treatment than the proposed 'appropriate treatment' test.

23. By removing the requirement that treatment is likely to benefit the individual's mental condition, the Bill appears to allow for the compulsory treatment of individuals in cases where that treatment is expected to have little or no positive effect on the individual's mental disorder, or where detention is merely preventative. In view of the broad definition of treatment, a regime of supervised care which has no effect on the individual's mental disorder could be sanctioned by the new provisions.

24. It is difficult to see how such activity could be regarded as 'treatment' in the ordinary sense of the word. If the objective of the proposed legislation is to enable *treatment* of individuals with mental disorders, not merely to *detain* them, any interpretation which permits detention in the absence of potentially beneficial treatment would, in our view, fail to respect the requirement that measures designed to meet the legislative objective are rationally connected to it, and would thus be judged disproportionate under human rights legislation.[5]

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[4] For example *HL v United Kingdom* (2004) 40 EHRR 761, *Winterwerp v Netherlands* (1979) 2 EHRR 387.

[5] *R (Daly) v Secretary of State for the Home Department* [2001] 2 AC 532 at para. 27.

25. If in fact the objective of the legislation is simply to enable the detention of individuals with mental health problems, we take the view that the current proposals are excessive, insufficiently certain and an unwarranted interference with rights to liberty and autonomy.

26. To comply with requirements of Article 5 of the European Convention on Human Rights, the provisions must be sufficiently precise to enable an individual to foresee the consequences for himself. The Bill allows for detention even where there has been nothing other than the fact of the mental disorder itself to trigger this response, for example committing or attempting to commit a criminal offence. In this respect, its provisions can be distinguished from those considered in cases concerning restricted patients.[6]

27. The European Court of Human Rights has regularly noted that the detention of an individual is such a serious measure that it is only justified where other, less severe measures have been considered and found to be insufficient to safeguard the individual or public interest. In order to avoid arbitrariness, the deprivation of liberty must not only be executed in conformity with national law, but also necessary in the circumstances.[7] In our view, it is questionable whether preventive detention in the absence of reliable, convincing evidence of imminent danger to members of the public could be said to be necessary.

28. The Bill as it stands provides no guidance as to the circumstances in which such preventive detention might be required, nor does it provide additional safeguards and opportunities for review for individuals who have been detained in this manner, as compared with individuals who are receiving treatment for their condition.

29. We further note that the criteria for admission for treatment do not restrict detention to cases in which the individual's health needs are significant. In its current form, the Bill allows detention and compulsory treatment for any mental disorder, regardless of the seriousness of its effects. The reference to the 'nature and degree' of the condition does not impose any limit or provide any guidance as to the severity of illness required before detention may be permitted. Again, the proportionality of such an approach is questionable. While detention may be justified to enable the treatment of a disorder posing a severe or substantial risk to the health or safety of an individual, or the safety of others, it is a drastic measure in less serious cases. This is of particular concern in view of the wide range of psychiatric disorders that will fall within the new definition of mental disorder.

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[6] For example *Ashingdane v United Kingdom* (1985) 7 E HRR 528 and *Anderson v Scottish Ministers* [2001] UKPC D5, [2003] 2 AC 602

[7] See for example *Witold Litwa v Poland* (2000) 33 EHRR 1267.

Professional roles

The shift in definition from 'Responsible Medical Officer' to 'Responsible Clinician' (clauses 8-16)

30. The stated intention of the Government (see, for instance, its briefing paper on professional roles published to accompany the draft Bill)[8] is to open up the position of Responsible Medical Officer ('RMO'),[9] a position which carries with it very significant responsibilities under the MHA 1983. At present, the position is almost invariably held by a consultant psychiatrist who is approved under s.12 MHA 1983.

31. The Government wishes to open the position of RMO to 'mental health professionals with the appropriate training and competencies, including chartered psychologists, nurses, social workers and occupational therapists, in addition to doctors'.[10] As a safeguard, professionals must be trained and approved by the Secretary of State as 'approved clinicians'.[11]

32. JUSTICE accepts that there have previously been problems with the number of suitably trained psychiatrists available to act as RMOs. In principle, it agrees that one important way in which this problem can be solved is to widen the pool of persons potentially able to fulfill the role currently fulfilled by an RMO. We also acknowledge that professionals from disciplines other than psychiatry have potentially important skills to bring to bear upon the care and treatment of patients. However, it is vitally important to bear in mind the fact that RMOs are intimately involved in the deprivation of liberty and the infliction of treatments that constitute interferences – often serious interferences – with the human rights of patients. To this end, we believe that, should these clauses be accepted, a commensurate commitment must be made to the provision of proper training, regulation and professional support of a potentially large new cohort of people from very different disciplines so that they have the same understanding of issues concerning the human rights of patients. JUSTICE would urge very strongly that these clauses are not given effect until such point as sufficient time has passed to allow such provision has been made and a capable workforce has been trained.

33. As a secondary point in relation to approved clinicians, JUSTICE also notes with concern the amendments at clause 11 of the Bill to Part 4 of the MHA 1983, which deals with consent to treatment. The relevant sections of Part 4 as amended such that the role of the RMO will be fulfilled by 'the appropriate clinician in charge of the treatment'. In other words, it appears that

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[8] http://www.dh.gov.uk/assetRoot/04/14/05/11/04140511.pdf.

[9] Defined in s.34 of the Act as it currently stands as 'the registered medical practitioner in charge of the treatment of the patient'.

[10] Ibid.

[11] S.145(1) of the MHA 1983 as amended by clause 35(1) of this Bill.

under the revised scheme, important decisions concerning consent and review of treatment (including treatment against the will of the patient) will be made by professionals with responsibility for particular treatments, rather than responsibility for the individual patient. We believe that the Government needs to provide a sound justification for this change in policy which, as it stands, risks substantially reducing the protections available to vulnerable patients, and allowing for patients to receive treatments which are not necessary and proportionate as required under the European Convention on Human Rights.

The shift in definition from 'Approved Social Worker' to 'Approved Mental Health Professional' (clauses 17-20)

34. We have similar concerns regarding the proposed shift in definition from 'Approved Social Worker' ('ASW') to 'Approved Mental Health Professional' ('AMHP'). We have one further comment to make with regard to AMHPs, in respect of the proposed extension of the powers now exercised by ASWs to nurses and other professionals employed by the relevant health (rather than social services) authority. At present, ASWs usually have the protection of a different line management structure when they disagree with clinicians about whether to use the Act in an individual case. If the role currently occupied by an ASW is occupied by a professional employed by the health authority, then an important practical safeguard against the inappropriate treatment of patients will have been removed. We note that the draft amended Code is alive to the potential pitfalls of the new regime,[12] but we urge that very serious consideration is given to strengthening the division of responsibilities between professionals so as to ensure that different voices can be brought to bear in the interests of the protection of the rights of patients.

35. We also recommend that the Codes of Practice produced under s.62 Care Standards Act 2000 (which set down the conduct expected of social workers) be amended to outline the practice expected of an AMHP. Clause 19 amends s.62 CSA 2000 such that the Codes *may* lay down such practice, but we recommend that the Codes should be amended to provide specific, and detailed, standards to be expected of professionals directly engaged in the deprivation of liberty.

The patient's nearest relative (clauses 21-24)

36. These clauses make some important amendments to the provisions relating to the nearest relative within the MHA 1983. We note that the amendments proposed to s.29 MHA 1983 by clause 21 go some considerable way towards giving patients a wider say in whom should act

[12] See, e.g. paragraph 2.11(b) in respect of assessment: "[e]xcept in exceptional circumstance the AMHP and the doctors making the assessment should not be in a line management relationship."

as nearest relative.[13] In particular, we welcome the fact that: (1) patients will be able to apply to displace a nearest relative; and (2) to nominate in such an application a person to act as nearest relative: (see new s.29(1A) and s.29(2)(za)). While new s.29(1A) appears on its face to allow the patient to nominate anyone that they choose in any application they bring, we believe that it should be made explicit in that new section that the patient has an unfettered right to advance any name that they wish to act as their nearest relative.

37. Moreover, we recommend that clause 21(3) (inserting new s.29(1A)) should be amended to provide that on any application for displacement (whether by the patient or otherwise) particular weight is given to the patient's wishes as to identity of the nearest relative, so far as to those wishes can be ascertained.

38. In principle, we believe that clause 21(5), introducing a new ground of suitability upon which a nearest relative can be displaced, is a sensible and useful amendment to s.29(3). However, we are concerned that the breadth of the ground may allow for inappropriate considerations being used to justify removal of a nearest relative. We note that nearest relatives frequently have a tense relationship with those detaining and treating patients, and we have serious concerns that applications may be made to remove a nearest relative on the basis of suitability, when, in essence, the detaining/treating authority is making the application on the basis that they are 'difficult customers'. In the circumstances, we would urge strongly that clause 21(5) be amended so as to provide sufficient protection to nearest relatives falling into this category.[14] One way in which this could be done would be to outline considerations that must be taken into account when determining whether a nearest relative is a suitable person to act as such.

39. A similar concern exists in relation to clause 22(6), which would have the effect of amending s.29(4) MHA 1983 to allow, in effect, the nearest relative to be displaced permanently. JUSTICE appreciates and acknowledges that there are circumstances in which a person the subject of a s.29 application is clearly inappropriate, such that it would be proportionate to displace them permanently. However, we also have serious concerns that nearest relatives who are acting vigorously in defence of a patient's rights may end up being permanently deprived of their statutory function.[15] The threat of such a permanent displacement could well

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[13] And hence to remedying the incompatibility between the nearest relative provisions in the Act and the right to respect for family and private life under Article 8 of the European Convention on Human Rights.

[14] This is all the more important if the former nearest relative displaced under new s.29(3)(e) MHA 1983 is to have their right of access to the county court to have the order discharged under s.30 MHA 1983 restricted: the effect of new s.30(1A), introduced by clause 22(3) of this Bill. They would also be unable to make an application to the MHRT under s.66 MHA 1983: see clause 23.

[15] Especially given that, as noted above, a nearest relative displaced under new s.29(3)(e) could not apply to have the order discharged expect with the leave of the court.

act as a potent discouragement to the defence of patients' rights. The displacement itself may be unnecessary and disproportionate, not least because a patient may require the protections afforded by a nearest relative for his whole life. It may then be better to make provision for the appointment of another, non-institutional nearest relative, similar to an Independent Mental Capacity Advocate under the Mental Capacity Act 2005, rather than leave such a patient 'unbefriended'.

Community treatment orders (clauses 25-29)

Problems with the breadth of the category of patients who can be made subject to CTOs

40. The provisions for the making of community treatment as set out in the Bill replace the current provisions for after care under supervision. JUSTICE welcomes the fact that Community Treatment Orders ('CTOs') may only be made in respect of patients who have been subject to detention in hospital for treatment. However JUSTICE considers that CTOs should be restricted to a defined patient group who have had multiple admissions (commonly called revolving door patients), the patient to group for whom they have been said to be devised. This submission is based upon the premise that a CTO is a significant interference with a patient's rights to liberty and respect for private life under Article 8 of the European Convention on Human Rights. Such an interference should only be made when it is necessary and proportionate, and where there is no other less restrictive way of treating the patient in the community. Leaving the way open for the use of CTOs for a wider group as the Bill will allow or encourage the use of more invasive and restrictive measures for patients in the community who otherwise would not have been subject to detention

The ambit of CTOs

41. We note the very wide ambit of the conditions that can be imposed on a patient under a CTO by the responsible clinician. Such conditions pose a very real threat of a significant interference into a patient's private life on discharge from hospital. We have serious concerns at the lack of guidance in the Bill to direct the responsible clinicians to consider exercising their powers in line with public law principles and the patient's convention rights under the Human Rights Act 1988 and the European Convention on Human Rights. Again, the limited effect of the Code means that it cannot be sufficient to provide protection to patients in this regard.[16] In particular JUSTICE consider that the responsible clinician should be directed to do the following:

[16] See the decision of the House of Lords in *R (Munjaz)* at n2 above.

(i) Have regard to the individual's right to liberty and respect for private life when specifying the conditions the patient is subject to under the community treatment order.

(ii) Consider whether the conditions are strictly necessary and are the least restrictive means of achieving the result in question.

(iii) Consider whether the conditions serve a therapeutic purpose and will improve the patient's mental health. (As the Bill is currently drafted there is no requirement for the conditions to be connected in any way to the care and treatment that the patient is receiving, nor for the conditions to relate to the patient's mental illness).

(iv) Consider whether the conditions and the CTO are in the patient's best interests.

(v) Consider at the outset, how long it is likely that the conditions and the CTO will be required.

42. In our view, if a clinical supervisor considers that a CTO should be made, then the matter should come before the Mental Health Review Tribunal which will hear evidence and come to a determination as to whether a CTO is justified, and if so, what conditions are justified, taking into account all the matters set out above.

The making of a CTO

43. Further concerns arise as a result of the process by which the community treatment order is made. In particular:

(i) There is no requirement upon the responsible clinician to discuss the making of a CTO with the patient, nor is there a requirement to consult the patient on the conditions to be put in place either at the time that they are set, or if they are varied. This is surprising where the Bill provides that the patient under a CTO must consent to the treatment to be given, and that similar requirements exist in relation to after-care under supervision which CTOs are intended to replace.

(ii) There is no requirement upon the responsible clinician to discuss the making of a CTO or the setting of the conditions with the nearest relative. The nearest relative has no powers to object to the making of the CTO, but can of course apply to discharge the patient from it. It is surprising therefore that the nearest relative's views are not canvassed.

(iii) There is no requirement upon the responsible clinician to discuss the making of a CTO or the setting of the conditions with any person who will be or is likely to be a carer for the

patient while out in the community. This is surprising where the workability of the conditions is critical to the success of the CTO.

(iv) There is no requirement to explain orally to the patient what the conditions being imposed are, and what the consequences of breaching those conditions are. As one of the consequences could be the recall of the patient to hospital it is of utmost importance it is clearly vital that the patient knows and understands the significance of the CTO.

(v) There is no requirement for the clinician who will be responsible for the patient in the community to be consulted about the conditions. Nor is there any requirement to consult with those professionals providing services to the patient in the community to ascertain whether they have any views about the conditions (such as the effectiveness of a particular treatment if the patient is compelled to undergo it, or the effect on the therapeutic relationship of the practitioner policing compliance with conditions).

Recall and consent to treatment of patients subject to CTOs

44. If a patient is recalled within either one month of the CTO being made or within three months from when treatment was first given to the patient then section 58 treatment can be given without consent or a certificate. There seems to be no justification for treating recalled CTO patients differently from those detained in hospital under the Act and allowing treatment to be given when it may not fulfill the requirements of necessity and proportionality under the European Convention on Human Rights.

Review of CTOs by Mental Health Review Tribunals

45. As set out above it is our view that the Mental Health Review Tribunal ('MHRT') should be making the decision as to whether a CTO should be made, and determining the ambit of it.

46. However, we are also struck by the fact that the MHRT has *no power* to review the conditions imposed on a CTO. Instead, the power of the MHRT is limited to discharging a patient from a CTO. We are deeply concerned that the imposition of conditions could in some cases amount to a deprivation of a patient's liberty (if for example there were conditions that a patient had to reside in a certain institution, and was subject to an extensive curfew or supervision). In such cases the patent inability of the MHRT to review the conditions would amount to a breach of the patient's Article 5 ECHR rights.

Mental Health Review Tribunals (clauses 30-31)

47. We welcome the proposed amendment to s.68 to break the link between renewal of detention under s.20 and subsequent referral to the Mental Health Review Tribunal ('MHRT'), as we believe strongly that the subsequent referrals must be made on a regular basis where patients do not themselves bring applications. At present, it often takes up to four years before a patient's case is considered by the MHRT if the patient does not apply, because a renewal only happens once a year and the referral cannot take place until the detention is next renewed. Breaking the link will mean that the only requirement for subsequent referrals is that the MHRT has not considered the patient's case in three years. We therefore welcome these proposals.

48. We also welcome the proposed introduction of s.68A to reduce the time periods for such subsequent referrals. But we would make the simple point that the practical import of these changes will be minimal without adequate investment in the MHRT system.

The Bournewood gap (clauses 38-39)

Definition of 'deprivation of liberty'

49. Although we welcome measures to address the situation of compliant patients who lack capacity to consent to treatment (the so-called 'Bournewood gap'), there is a grave lack of clarity about what amounts to a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights and, in consequence, the Bill. It is necessary for 'deprivation of liberty' to be clearly defined so that:

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

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

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

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

Given the limited status of the Code under the MHA 1983 i.e. merely guidance, it is submitted that there should be a definition of deprivation of liberty in the Bill and it should not be left to the Code.

50. Currently, the question of whether a man who is accommodated in a nursing home is deprived of his liberty is the subject of proceedings in the Family Division of the High Court,[17] with judgment expected before the end of term. Two days of Court time were expended solely on the issue of whether there was a deprivation of liberty in the case, although the individual's situation is relatively typical of incapable persons accommodated in residential and nursing care. It is vital that this difficulty is avoided in the future by a clear and easily-applicable definition in the Bill.

The decision of the supervisory body

51. It appears from the Bill that the supervisory body exercises no discretion when it authorises detention, but it merely looks to see whether the relevant criteria are met in a "tick box" exercise (Schedule A1, paragraph 50(1)). JUSTICE has the following concerns about this proposal:

    (a) it does not allow for any evaluation of the complex issues that are highly likely to arise from time to time about a patient's capacity or best interests, and provides no means for their resolution at that level of decision-making;

    (b) since a 'failure' to fulfil the criteria on this binomial basis may leave an incapable person without the care or protection they require, or lead to an unwarranted interference in the rights of the individual, it is submitted that a discretionary power should be given to the supervisory body either to make decisions in contested cases, or to engage in a dialogue with those preparing the assessments as to how the arrangements for an incapable individual might be modified so that they would be in his best interests and deprivation of liberty might be lawfully authorised.

Meaningful right of appeal

52. If the right to apply to the Court of Protection for the determination of issues arising out of an authorisation of deprivation of liberty is to be real and effective then there must be non-means tested public funding for patient applicants as there is for those who are detained under the MHA 1983.

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[17] The case of *E v Surrey County Council.*

Other matters

53. A significant omission from the current Bill are the provisions for mental health advocacy that were contained in the 2004 draft Mental Health Bill. We can see no good reason why this was not carried forward to the present bill, and we believe that the (suitably funded) provision of such a service is an essential pre-requisite for the effective protection of vulnerable patients.

54. We further urge that s.20 is amended so that it is made clear that any report provided by the (now) responsible clinician must be considered by the hospital managers in order to renew the authority for detention. As it stands, and as interpreted by the Court of Appeal in *R v Warlingham Park Hospital Managers, ex p B*,[18] s.20(8) appears to make the lawfulness of a renewed detention contingent solely upon the completion of the requisite form by the (now) responsible clinician and its dispatch into the hospital mailing system. We have very serious doubts as to whether this is compatible with the right to liberty under Article 5(1) of the European Convention on Human Rights. In any event, we consider that it sits uneasily with the system of protection provided for patients elsewhere within the MHA 1983. We would urge that the Government take advantage of this Bill to rectify this anomaly.

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[18] Reported in *The Independent*, 25 July 1994.