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Ms Catalina Devandas-Aguilar
Special Rapporteur on the rights of persons with disabilities

OHCHR
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Dear Special Rapporteur,

Thank you for your letter dated 6 April 2018 (OL GBR 3/2018) in response to our correspondence of 17 August 2017 (UA GBR 2/2017).

You have raised further concerns about the UK's legal framework around legal capacity, detention and treatment and its compatibility with the UN Convention on the Rights of Persons with Disabilities. I would like to reiterate that the UK takes disability rights extremely seriously and ensures that the relevant legislative mechanisms are in place to protect and implement these. This letter provides further information on these matters.

1. The UK's mental health legislation and its compatibility with the UN Convention on the Rights of Persons with Disabilities

The Mental Capacity Act 2005 empowers people to make decisions for themselves wherever possible and protects those who may be unable to do so. The Act defines a standard of mental capacity that applies to everyone and recognises that persons with disabilities have mental capacity in all areas of life. The second principle of the Act states that every effort must be taken to encourage and support the person to make the decision for themselves. The underlying philosophy of the Act is to ensure that any decisions made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves is made in their best interests. This involves taking into account the person's past and present wishes and feelings and any beliefs and values, as well as any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves. The Act provides for Independent Mental Capacity Advocates whose role is to represent and support persons in the cases of provision of serious medical treatment by the National Health Service or accommodation by the National Health Service or local authorities. Court of Protection Rules, which are made under the Act and govern the procedure in the Court of Protection, have been amended to require judges to determine how best to secure the involvement of the individual in proceedings.

In 2015, the UK Government formed the National Mental Capacity Forum to promote and raise greater awareness of the Act. In February 2017, the forum held an Action Day – the theme of which was "Supporting decision making". The Action Day was attended by 140 stakeholders who ranged from health and social care, together with those from other sectors (for example, finance, legal, police, housing). The Forum held another Action Day in March 2018, again on the theme of "Supported Decision Making". The Forum continually promotes supported decision making and through its close association with the Social Care Institute for Excellence now hosts extensive materials on the subject which can be accessed both by the public and professionals. The National Institute for Health and Care Excellence is also working on guidelines for supporting decision making.

The Mental Capacity Act provides for Lasting Powers of Attorney and Advance Decisions which give an individual the ability to plan in advance. This is seen by many as an important form of support, whereby an individual can state their will and preferences which should be followed at a time when they may not be in a position to communicate their wishes to others. There are currently 2.3 million registered Lasting Powers of Attorney. There are no details of the numbers of Advance Decisions as these do not require registration.

The UK Government has worked closely with the Social Care Institute for Excellence to produce materials and training on the Mental Capacity Act for social care professionals. This training contributes to the care professionals "Continuing Professional Development" accreditation. In addition, the Care Quality Commission – the independent regulator of health and adult social care in England - monitors the use and awareness of the Act in care homes.

In England, the UK Government has worked with the Social Care Institute for Excellence to produce training materials on the Deprivation of Liberty Safeguards and the UN Convention on the Rights of Persons with Disabilities. We are aware that there are criticisms of the Deprivation of Liberty Safeguards (DoLS) and in light of these, the UK Government asked the Law Commission to investigate and make recommendations on the process. The report was published in March 2017 and the Government responded to it in March 2018[1]. The Government response agrees that the current DoLS system should be replaced as a matter of urgency and concludes that legislation will be brought forward when Parliamentary time allows.

Compatibility with Articles 12, 14, 15 and 25 of the CRPD

- **Article 14:** The justification for the detention under the Act is based on more than simply the existence of a disability and there are a range of safeguards in place to protect against the "unlawful or arbitrary" deprivation of liberty. We note that Article 14(b) does not prohibit detention of people with mental disorders where

[1] https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2018-03-14/HCWS542/

that is in accordance with law and justified by the risk that the mental disorder poses to the person or to other people.

Detention under the Act is not merely based on "the existence of disability" because:

1. It is risked based; detention and other compulsory measures are only permitted where they are justified by the risk posed by a person's mental disorder. Simply having a mental disorder is not sufficient justification. Two people with similar mental disorders may present very different levels of risk - the risk will vary according to:
(i) the patient's own attitude to the disorder, their willingness to seek and accept treatment, and their ability to cope with the consequences of their disorder;
(ii) the patient's personal circumstances – for example, whether their living situation puts them at risk of exploitation or puts others at risk of violence or other damage by the patient; and
(iii) the availability of other effective methods of managing the risk.

2. Disability and risk are not synonymous. It applies to all mental disorders whether or not they could be considered to be disabilities.

- **Articles 12.2, 17, 19 and 25:** the Act is compliant as it treats all detained patients, and those who are released into the community after detention, in the same way. Detention is based on risk to the person/other people, rather than disability.

2. The Independent Review of the Mental Health Act 1983

The Independent Review published its interim report on 1 May 2018, and its final report is expected in autumn 2018.

The interim report contains a commitment that the review will fully consider the implications of the UN Convention on the Rights of Persons with Disabilities, and in particular the “legal, ethical and political issues arising out of the statements of the Committee on the Rights of Persons with Disabilities”.

The Government looks forward to receiving and considering the final report of the review, and it has made Professor Sir Simon Wessely, the chair of the Review, aware of your correspondence of 6th April.

3. Involuntary mental health practice and compatibility with the UN Convention against Torture

The Mental Health Act sets out a number of safeguards for situations where treatment can be given to a patient who does not consent. Where a patient does not agree with treatment that is proposed they are able to request a second opinion to discuss the treatment through their own GP or a consultant psychiatrist. They can also raise concerns directly with the Care Quality Commission, who as the regulator of care quality, monitors the use of the Mental Health Act and inspects providers to assess the quality, and also the safety of the care provided. This route of complaint for people who do not agree with their treatment has been emphasised in the Mental

Health Act Code of Practice. People who do not agree with their treatment can also speak to an Independent Mental Health Advocate.

The Code of Practice sets out guiding principles, one of which is the importance of patients being involved in their care as much as possible. Where a patient is being treated without their consent, mental health providers must tell the patient, their carer, family and the independent mental health advocate where appropriate.

Mental health providers must also ensure that patients understand and can consent to treatment where possible, they are required to make information available to patients in a format and language that they understand.

As this will also form part of the Mental Health Act review being undertaken we look forward to receiving any recommendations that arise in these areas.

Background on the Mental Health Act

The main purpose of the Mental Health Act 1983 (the Act) is to allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment they need for their own health or safety, or for the protection of other people. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients. The Act has been amended by the Mental Health Act 2007.

Under the Act, a person suffering from a mental disorder of a nature or degree which makes hospitalisation appropriate may be detained and treated (or be made subject to certain other restrictions) without his or her consent where that is justified by the risk that the mental disorder poses to him or her or to other people and appropriate medical treatment is available. Safeguards ensure that any such deprivation of liberty is not arbitrary and complies with the law (including Article 5 of the ECHR as set out in the Human Rights Act 1998). Those making decisions under the Act must have regard to a Code of Practice that sets out guiding principles. The principles are:

(i) a requirement to always use the least restrictive option and maximise independence – this means that a person should not be detained where it is possible to treat them safely without detention;
(ii) empowerment and involvement – this means that patients should be fully involved in decisions about their care, support and treatment;
(iii) respect and dignity;
(iv) purpose and effectiveness – this means that decisions about care and treatment should be appropriate to the patient and promote recovery; and
(iv) efficiency and equity – this means that mental healthcare services should be of high quality and should be given equal priority to physical health and social care services.

Section 1 of the Act defines mental disorder as “any disability or disorder of mind”. This straightforward definition applies throughout the Act. Section 1 continues to

make clear that a person with a learning disability shall not be considered by reason of that disability to be suffering from a mental disorder for the purposes of admission for treatment or for community treatment orders unless that learning disability is associated with abnormally aggressive or seriously irresponsible conduct.
The Act defines medical treatment for mental disorder as "medical treatment which is for the purpose of alleviating or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations". Medical treatment includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care. The Act does not regulate medical treatment for physical health problems.
Part 2 of the Act sets out the civil procedures under which people can be detained in hospital for assessment or treatment of mental disorder. Detention under these procedures normally requires a formal application by either an Approved Mental Health Professional (AMHP) or the patient's nearest relative, as described in the Act. An application is founded on two medical recommendations made by two qualified medical practitioners, one of whom must be approved for the purpose under the Act. Different procedures apply in the case of emergencies.
A person can be detained for treatment under section 3 only if all the following criteria apply:

- the person is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital;
- it is necessary for the health or safety of the person or for the protection of other persons that they should receive such treatment and it cannot be provided unless the patient is detained under this section; and
- appropriate medical treatment is available for him/her.
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The statutory Code of Practice, which must be followed by persons making detention decisions, makes clear at paragraph 14.7 that before it is decided that admission to hospital is necessary, consideration must be given to whether there are alternative means of providing the care and treatment that the patient requires. This includes consideration of alternative forms of care and treatment. The guiding principles explained above make clear that the least restrictive option must be chosen.

<u>Safeguards</u>

Individuals have the right to have their case reviewed by an independent and impartial Tribunal, who can order the discharge of a patient.

A patient can apply to a Tribunal during the first six months of his or her detention, once during the second six months and then once during each period of one year thereafter (ss.66(1)(b) and (2)(b)). A patient's nearest relative can also discharge a patient, and if that is prohibited, a patient's nearest relative can apply to the Tribunal for discharge (s.25(1)).

Further, if a patient does not apply in the first six months of detention, the hospital managers are under a duty to refer the patient's case to the Tribunal, and after that, must also refer when a period of three years has elapsed since a Tribunal last considered the patient's case (section 68).

Patients also have the right to receive support from statutory Independent Mental Health Advocates, who would help take a case to a Tribunal if the patient wishes. Hospitals where patients are detained, like all other hospitals, are monitored or inspected by the Care Quality Commission (CQC) in England.

Legal grounds for treatment

Medication after the first three months of its first administration requires the patient's consent or the agreement of an independent medical practitioner (s.58). However, hospitals are required to involve patients as far as possible in planning and reviewing care and treatment, in accordance with the Code of Practice principle of empowerment and involvement, so that patients are fully involved in decisions about their care, support and treatment.

This is important because at the point of having had medication for three months, the patient must give consent again to continue the treatment, or an independent medical practitioner must review decisions about the care the patient is receiving.

I hope that this letter addresses your concerns and provides additional reassurance on these important issues.

Yours sincerely,

JULIAN BRAITHWAITE