Response to the consultation on the Draft Mental Health Act 1983 Code of Practice

This submission is written by Professor Phil Fennell and Dr Lucy Series. Phil Fennell is a professor of law at the Centre for Health and Social Care Law at Cardiff University. He has written many books and articles on mental health law. Most recently he co-authored with Professor Bartlett, Gostin, McHale, and Mackay Principles of Mental Health Law and Practice (2010) Oxford University Press, and with Penny Letts and Jonathan Wilson he wrote a guide to the operation of Mental Health Tribunals in England and Wales (Mental Health Tribunals, Law Society) which was published in April 2013. The second edition of his own book, Mental Health Law and Practice was published by Jordans in 2011. Phil served as specialist legal adviser to the Joint Parliamentary Scrutiny Committee on the Mental Health Bill 2004, and to the Joint Committee on Human Rights on the Mental Health Bill 2006, which became the Mental Health Act 2007. Dr Series wrote her doctoral thesis on the Mental Capacity Act 2005 (MCA), part of which focused on access to justice under the MCA and the deprivation of liberty safeguards. She has published several articles on the MCA. Professor Fennell and Dr Series, in conjunction with Professor Luke Clements and Dr Julie Doughty at Cardiff Law School, are currently working on a research project about welfare cases in the Court of Protection, funded by the Nuffield Foundation.

Paragraphs 13.50 and 13.51 oversimplify the legal position on using the Mental Capacity Act 2005 to deliver electro-convulsive therapy (ECT)

We wish to comment on paragraphs 13.50 and 13.51 of the Draft Code, which are about giving electro-convulsive therapy (ECT) to people who may lack mental capacity. Our contention is that Paragraph 13.51 represents an inaccurate and incomplete summary of the legal position in relation to ECt given to patients who lack capacity to consent to it.

Para 13.50 of the Draft Code states that:

> 'ECT cannot be given to an individual who has the capacity to consent to that treatment but refuses to do so. Under the Act, ECT can only be given to individuals who lack capacity if approved by a second opinion appointed doctor (SOAD).

This paragraph, although brief, summarizes the legal position of patients who lack the capacity to understand the nature, purpose and likely effects of ECT and are detained under the 1983 Act. Section 58A, which establishes the safeguard of SOAD approval for a person who lacks capacity, also applies to informal (non-sectioned) patients who are under 18.

The Draft Code then goes on to state at para 13.51:

> 'Currently, there is no requirement for an independent medical opinion about the appropriateness of ECT being given to a person who lacks capacity to consent to that

treatment. Such treatment could in principle be given on the basis of section 5 of the MCA.'

We contend that the interpretation in paragraph 13.51 is confusing, is wrong as a matter of English law, and contravenes the European Convention on Human Rights. First of all there is a requirement under s 58A for an independent medical opinion about the appropriateness of ECT being given to a person who lacks capacity to consent to that treatment if the patient is detained under the Mental Health Act 1983. Second, the statement offers a general and sweeping permission without apparently taking into account the effect of Articles 5 and 8 of the European Convention on Human Rights (ECHR), or suggesting what safeguards might apply in relation to treatment purportedly given under section 5 of the MCA.

Article 8 ECHR – the right to private life

In *X* v *Finland* [1] the European Court of Human Rights reaffirmed 'that a medical intervention in defiance of the subject's will gives rise to an interference with respect for his or her private life, and in particular his or her right to physical integrity'[2] The key phrase here is 'against the subject's will.' A patient may be resisting the treatment but may be deemed to lack capacity. The treatment is still being given against that person's will. The treatment in *X* v *Finland* was psychotropic medication. The ruling also applies to ECT, which is a physical intervention surrounded by controversial arguments about its efficacy and long term side effects.

In *X* v *Finland* the Court then went on to consider the requirement that in order to be justifiable under Article 8(2) the interference must be "in accordance with the law." This 'requires firstly that the impugned measure should have some basis in domestic law; it also refers to the quality of the law in question, requiring that it should be accessible to the person concerned, who must moreover be able to foresee its consequences for him, and compatible with the rule of law.'[3] In the context of forced administration of medicine, the court held that the domestic law must provide some protection for the individual against arbitrary interference with his or her rights under Article 8. [4] The Court held that the forced administration of medication represents a serious interference with a person's physical integrity, and must accordingly be based on a "law" that guarantees proper safeguards against arbitrariness. In this case the court found that such safeguards were missing as:[5]

[1] Judgment of 3 July 2012
http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-111938
[2] Ibid., para 212.
[3] *Ibid*., para. 215.
[4] *Ibid.*, para. 217.
[5] *Ibid*., para. 221.

> 'the decision-making was solely in the hands of the doctors treating the patient, who could take even quite radical measures regardless of the applicant's wishes. Moreover, their decision-making was free from any kind of immediate judicial scrutiny: the applicant did not have any remedy available whereby she could require a court to rule on the lawfulness, including proportionality, of the forced administration of medication, or to have it discontinued.'

If patients lacking capacity to consent to ECT are detained under the Mental Health Act, before ECT can be given they must have a second opinion from a SOAD to verify that this is so, and to determine whether it is appropriate for the treatment to be given. This is so regardless of whether the patient is resisting. Hence the decision-making is not 'solely in the hands of the doctors treating the patient.' If the SOAD acts unlawfully, which would include any breaches of Article 8 rights, the decision will be open to judicial review. It is a moot point whether this would be found to amount to 'an available remedy whereby a patient could require a court to rule on the lawfulness, including proportionality, of the forced administration of medication, or to have it discontinued.' Whatever the potential shortcomings of this process, at least in *X* v *Finland* terms there is a system designed to provide *some* protection for the individual against arbitrary interference with his or her rights under Article 8, and the law is accessible and sufficiently clear in its effects that a person may be able to foresee its consequences for him.[6]

Safeguards under the Mental Capacity Act 2005

If a patient were subject to DOLS or is an informal patient, whether or not electro-convulsive therapy may be given under sections 5 and 6 MCA immediately prompts the question of what safeguards are available to a patient under the MCA. The nature and availability of the safeguards here is far from clear and accessible. It would be hard for a person to be able to foresee the consequences of the law for him. The MCA applies extra safeguards to 'serious medical treatment.' If a person with no-one other than a paid carer to consult is to be given a serious medical treatment, they are entitled to the support of an Independent Mental Capacity Advocate (IMCA) [7], who can feed their views in to the best interests assessment, seek a second opinion on the person's behalf[8], and could prompt the case to be brought before the Court of Protection.

ECT may constitute 'serious medical treatment' within the meaning of the MCA. The Mental Capacity Act Code (para 10.45) includes ECT on its list of examples of medical treatments that might be considered serious, concluding the relevant paragraph with the statement that:

[6] *Ibid.*, para 215.
[7] s37 MCA
[8] s6(d) The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 SI 2006/1832

> 'These are illustrative examples only, and whether these or other procedures are considered serious medical treatment in any given case, will depend on the circumstances and the consequences for the patient.

This is repeated in para 7 of the Court of Protection Practice Direction 9E on Applications Relating to Serious Medical Treatment which states that 'Whether or not a procedure is regarded as serious medical treatment will depend on the circumstances and the consequences for the patient.'[9] The appearance of ECT on the list in the MCA Code makes it clear that if ECT is to be given to a patient who has no one other than a paid carer to consult, an IMCA is necessary.

Although ECT is in the MCA Code illustrative list of serious treatments, it does not feature in the list in paragraph 5 of Practice Direction 9E of specific treatments which should be brought to court, or in paragraph 6 of other potential examples of serious treatments. However, there are other circumstances where the case should be brought to court. Paragraph 3 of the Practice Direction defines serious medical treatment as treatment which involves providing, withdrawing or withholding treatment in circumstances where:

> (a) in a case where a single treatment is being proposed, there is a fine balance between its benefits to P and the burdens and risks it is likely to entail for him;
>
> (b) in a case where there is a choice of treatments, a decision as to which one to use is finely balanced; or
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> (c) the treatment, procedure or investigation proposed would be likely to involve serious consequences for P.

In these cases, and in cases where P or P's relative or carer objects to the treatment, or where P is to be subject to more than transient physical restraint, the case should be brought to court. [10]

It is not clear whether ECT is to be viewed as a serious treatment. Opinion is divided as to the balance between benefit and risk, with many doctors believing that, properly administered, ECT is less risky than anti-depressant medication, but others reporting serious

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[9] Part 9 of the Court of Protection Rules 2007 and Practice Direction 9E
APPLICATIONS RELATING TO SERIOUS MEDICAL TREATMENT
http://webarchive.nationalarchives.gov.uk/20110218200720/http:/www.hmcourts-service.gov.uk/cms/files/09E_-_Serious_Medical_Treatment_PD.pdf

[10] *NHS Trust 1 and NHS Trust 2* v *FG* [2014] EWCOP 30, para 103. See also: Rose, D., Fleischmann, P., Wykes, T., Leese, M. and Bindman, J. (2003) 'Patients' perspectives on electroconvulsive therapy: systematic review', *BMJ,* 326(7403), 1363, §20-24

side effects[11]. Again these sorts of widely held beliefs may go to the question of serious consequences, defined in paragraph 4 of the Practice Direction, which states that:

> "Serious consequences" are those which could have a serious impact on P, either from the effects of the treatment, procedure or investigation itself or its wider implications. This may include treatments, procedures or investigations which:
> (a) cause, or may cause, serious and prolonged pain, distress or side effects;
> (b) have potentially major consequences for P; or
> (c) have a serious impact on P's future life choices.

ECT is a treatment which may cause serious and prolonged side effects in terms of short term memory loss. The invasive nature of the method of delivery is also relevant to its seriousness. By any measure ECT is a controversial treatment. In legal terms this is evidenced by the very existence of the safeguards in s 58A of the Mental Health Act 1983, which prohibit the treatment from being given to a capable patient who refuses, even if that patient is subject to detention under section. If the patient lacks capacity, a second opinion must be obtained to authorise the treatment.

There are strong indications in the European Court of Human Rights case law and in some of the CoP case law that ECT, like any other serious interference with physical or psychological integrity, given without consent under the Mental Capacity Act should be subject to effective safeguards.

Article 5 – the right to liberty

There is also the vexed debate of whether, in order safely to give a course of ECT in hospital a person may be deprived of their liberty if one applies the 'acid test', under the *Cheshire West* ruling.[12] In *Cheshire West* the Supreme Court held that a person is deprived of their liberty if they 'are under continuous supervision and control and are not free to leave', even if the person is not objecting to their confinement. In *a National Health Service Trust 1 and a National Health Service Trust 2* v *FG* [13] Keehan J held that an application to the CoP ought to be made if there is a real risk that P will suffer a deprivation of her liberty which, absent a Court order which has the effect of authorising it, would otherwise be unlawful (i.e. not authorised under either the MHA, or s4B of or Schedule A1 to the MCA). The deprivation of liberty safeguards under the MCA have fewer safeguards for ECT than the MHA, and care should be taken not to encourage healthcare practitioners to use the deprivation of liberty safeguards in preference to the MHA so that people lose the benefit of these safeguards.

[11] Rose, D., Fleischmann, P., Wykes, T., Leese, M. and Bindman, J. (2003) 'Patients' perspectives on electroconvulsive therapy: systematic review', *BMJ,* 326(7403), 1363.
[12] *P v Cheshire West and Chester Council and another; P and Q v Surrey County Council* [2014] UKSC 19
[13] *Ibid*., para 103

For all the above reasons we suggest that paragraph 13.51 represents an oversimplification of the position in that it suggests ECT can be given under s 5, without alerting practitioners to the fact that other safeguards may apply such as the duty to engage an IMCA and potentially also the duty to seek authority from the CoP. Consideration needs to be given to the applicability of the additional safeguards we have mentioned above. In conclusion we might suggest that the second opinion system under s 58A should be extended to patients given ECT under the Mental Capacity Act. At the moment, those detained under the Mental Health Act 1983 have more immediate access to safeguards than their counterparts who are subject to Deprivations of Liberty under the Mental Capacity Act or are subject to DOLs. We suggest here that additional safeguards apply under the MCA, on the basis that if not applied, the UK risks breach of Article 8. Hence paragraph 13.51 is an inaccurate and incomplete statement of the legal position.

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