UK National Preventive Mechanism
c/o HM Inspectorate of Prisons
Victory House
6th Floor
30-34 Kingsway
London WC2B 6EX

Tel: 020 3681 2800
E-mail: Louise.Finer@hmiprisons.gsi.gov.uk

Malcolm Evans
UN Subcommittee on Prevention of Torture
Office of the High Commissioner for Human Rights
Palais Wilson
52, rue des Paquis
CH-1201 Geneva

04 July 2017

Dear Malcolm,

Re: Approach of the SPT regarding the rights of persons institutionalized and treated medically without informed consent

I am writing on behalf of the UK National Preventive Mechanism (NPM), to share our reflections on the recently published SPT document on the rights of persons institutionalized and treated medically without informed consent (CAT/OP/27/2). My colleagues welcomed the opportunity to speak with you about this last year.

The UK NPM and its members are committed to ensuring that those detained are subject to the highest standards of care and that the development of new standards about what constitutes ill-treatment are implemented throughout detention regimes in the UK.

For this reason, we would find it helpful to know more about the genesis of this new SPT document. Obviously it would be helpful to have any material from other jurisdictions and treaty bodies that have provided the basis for the new standards you set out because if we need to recommend any changes to procedures and policies of the institutions that detain or administer treatment we need to make those on the basis of well-founded recommendations. For any changes to be proposed and eventually adopted in the UK, will need to be informed by expert analysis, consultation and internationally-respected authority. They will also need to be underpinned by consensus (or a developing consensus) across UN treaty bodies and, for us in Europe, with the considered support of the CPT and/or the European Court of Human Rights.

In light of your document we have looked across the different legal systems in the UK to assess whether there is compliance with the new SPT document. Fortunately we believe that, overall,

the UK systems are in compliance and set this out as follows. However we have also set out below some doubts we have about the standards in the SPT document.

1. Requirements for judicial authority of detention and 'close and constant review' (paragraph 5)

"5. Involuntary confinement of any person is a form of arbitrary detention unless it is ordered by a competent and independent judicial authority through due process, which must include close and constant review. States should develop and make available alternatives to confinement, such as community-based treatment programmes, which are particularly appropriate for avoiding hospitalization and for providing care for persons upon their discharge from hospitals."

The document appears to assume that all mental health systems require judicial authority in advance for hospitalisation without consent. Most areas of UK mental health systems rely on medical authorisation for hospitalisation without consent which is followed by a system of judicial review.

In England and Wales, the Mental Health Act 1983 and in Northern Ireland, the Mental Health (Northern Ireland) Order 1986 (the Order), provide a process based on certification by independent professionals for most detention. This relies upon independent multi-disciplinary assessment which provides safeguards against arbitrary detention and complies with the jurisprudence of the European Court of Human Rights. In Scotland, the Mental Health (Care and Treatment) (Scotland) Act 2003 does provide for prior judicial authorisation of long term detention, but patients may still be detained without prior judicial authority for several weeks. We accept that significant delays before a medical authorisation can be reviewed by a judge are problematic but, subject to that, our assessment is that the UK's system is in compliance with the paragraph set out above. Furthermore, we do not know of any entirely judicial procedures that provide better safeguards, particularly for urgent situations.

The SPT document states that it expects to find "close and constant review" of involuntary confinement. We accept that there is a duty of detaining authorities (ie in UK law and by the hospital) to keep all detentions in hospital under review and end them when no longer lawful or justified, and for the law to be clear in requiring this. This is already provided by the law in the UK such as that established in England and Wales under the Mental Health Act 1983. Under this legislation, the onus falls on the psychiatrist in charge of a patient's treatment to keep the necessity for detention under review and end it when the conditions for detention no longer apply, and the patient and relatives have rights of appeal to detaining managers and, periodically, to a separate judicial tribunal with the power of release.

2. Requirement for judicial review of restraint (paragraph 9)

9. Restraints, physical or pharmacological, are forms of deprivation of liberty and, subject to all safeguards and procedures applicable to the latter, should be considered only as measures of last resort for safety reasons. The State must take into account, however, that there is an inherently high potential for abuse of such restraints and as such these must be applied, if at all, within a strict framework that sets out the criteria and duration for their use, as well as procedures related to supervision, monitoring, review and appeal. Restraints must never be used for the convenience of staff, next of

kin or others. Any restraint has to be recorded precisely and be subject to administrative accountability, including independent complaint mechanisms and judicial review.

Paragraph 9 sets out the requirement that any restraints, physical or pharmacological, must be "subject to administrative accountability, including through independent complaint mechanisms and judicial review". In the UK we have both civil and criminal law to cover assault, supplemented by practice guidance and inspection regimes, and would be happy to explore whether more might need to be done to meet this standard.

However we are not clear how the SPT would define pharmacological restraint, which could include any medication that has a sedative effective, medication that is given principally for its sedative effect, or any chemical that results in changes in the detainee's behaviour.

3. Solitary confinement (paragraph 10)

10. Solitary confinement must never be used. It segregates persons with serious or acute illness and leaves them without constant attention and access to medical service. It should be differentiated from medical isolation. Medical isolation requires daily monitoring with the presence of trained medical staff and must not deprive the person of contact with others provided that proper precautions are taken. Any isolation has to be made for the shortest possible period of time, recorded precisely and be subject to administrative accountability, including independent complaint mechanisms and judicial review.

We suggest that where medical isolation is designed to have a real therapeutic purpose, is justified on the basis of expert medical opinion and involves frequent review and access to medical services it is not a violation of any of the UN's human rights treaties. As an NPM we acknowledge that in some other instances it may be necessary to isolate patients temporarily to protect themselves or others, but that this must only be used to contain severely disturbed behaviour which is likely to cause harm to others and with appropriate safeguards in place. In practice this may not only be justified but is part of the duty on the state to protect any individuals detained (including from other patients). We would consider any instances of isolation or medical isolation to amount to solitary confinement if detainees were confined alone for more than 22 hours a day with minimal or no meaningful contact with others. The UK NPM has recently published comprehensive guidance on monitoring isolation in detention which we hope will be of use to the SPT in further refining these principles.[1]

However, because the SPT does not define the difference between solitary confinement and medical isolation, but does call for a differentiation to be made and for the former never to be used, we would be grateful for your help in defining the precise nature of this difference, if it diverges from our understanding above.

[1] See http://www.nationalpreventivemechanism.org.uk/wp-content/uploads/2017/02/NPM-Isolation-Guidance-FINAL.pdf

4. Involuntary confinement including the right to administer medication without informed consent (paragraph 7)

7. If involuntary confinement seems to be appropriate and proportional on a legal basis, this should never directly include the formal right for medication to be administered without informed consent.

In England and Wales and Northern Ireland, mental health law authorises treatment for mental disorder without informed consent as a consequence of detention (Mental Health Act 1983, s.63;) and the Mental Health (Northern Ireland) Order 1986). This excludes ECT and other treatments that are listed by regulation (and which can only be imposed on a patient without capacity following a second opinion) or neurosurgery for mental disorder (which can only be given with certified valid consent). However the decision to detain does not, in itself, justify the imposition of any specific treatment without consent. Treatment must be subsequently authorised by doctors on the basis of their expert opinion. Arbitrary compulsory treatment would be unlawful and an assault and subject to legal sanction. There are some differences in the Scottish system, where under Community Treatment Orders compulsory treatment is not automatically authorised.

In any case, after two (in Scotland) or three (in England and Wales) months have elapsed since initial treatment, medication cannot continue to be imposed on a patient who is capable of giving consent but refuses to do so, or on an incapable patient, unless there is an independent second opinion.

5. Emergency care and treatment without informed consent (paragraph 17)

17. Only in the situation of emergency care may the decision about any necessary intervention be made by the medical professional alone.

The SPT document states that medical treatment without informed consent should be subject to review as soon as practicable, and that only in situations of emergency care may a decision about such treatment be made by the medical professional alone.

We are concerned that the criteria of 'emergency' could be used in too many cases, and that the effective threshold for an 'emergency' might merely be based on where clinicians thought that it was in the best interests of a patient to have no delay in commencing treatment.

As drafted, this proposal does not differ significantly in its likely practical effect from the situation in much of the UK set out above, where there is an initial period in which medication for mental disorder can be given without formality on the sole authority of one medical professional (that is not to say that such an initial period should be as long as three months from the start of treatment). We would be interested to know if there are examples from other countries that provide a model of how an alternative and better system might work.

6. Right to refuse medical treatment (paragraphs 13, 14, and 18)

13. Every person deprived of liberty who requires medical treatment should be fully informed about the diagnostic reasons for recommending a particular medical treatment and about existing alternatives, and given the opportunity to decline or receive the suggested treatment or other form of intervention.

14. Exceptionally it may be necessary to medically treat a person deprived of liberty without her or his consent if the person concerned is not able to:

(a) Understand the information given concerning the characteristics of the threat to her or his life or personal integrity, or its consequences;

(b) Understand the information about the medical treatment proposed, including its purpose, its means, its direct effects and its possible side effects; and

(c) Communicate effectively with others.

18. An expert decision regarding psychiatric disease cannot in itself override the right to refuse medical treatment.

We note that paragraphs 14 and 18 only allow compulsory treatment to be given to patients who lack legal capacity to give consent in exceptional circumstances, and that the right to refuse medical treatment should override an expert decision regarding the proper treatment of the psychiatric illness if the person is of "unsound mind" but has legal capacity. Arguably all legislation in the UK except the yet to be implemented Mental Capacity Act (Northern Ireland) 2016 fail to meet this expectation. The Mental Health Act 1983 in particular contains a power to impose medical treatment for mental disorder in the face of a refusal of consent by a patient with legal capacity who is compulsorily detained in hospital for treatment. In the case of medication for mental disorder, the law provides that this may initially be on the sole authority of the treating physician, but includes the safeguard that thereafter only following certification by an independent physician expert. Similarly, the Mental Health (Care and Treatment) (Scotland) Act 2003 states that if there is authority for a doctor to give treatment, it can be given to a patient with legal capacity against their wishes (except for specified treatments such as ECT and neurosurgery for mental disorder).

Treatment without consent is obviously a significant interference with a person's integrity and, absent medical authorisation based on good science and the best interests of the patient, would be a violation of the Convention Against Torture (and Article 3 of the ECHR). It must also be acknowledged that once a person is detained the public interest justification for the detention – the prevention of self-harm or harm to others – significantly reduces. The difficulty however is that without treatment the person's stay in compulsory detention will be significantly longer – in some cases for the foreseeable future because the risk which the basis of the detention remains unaltered.

Given the effectiveness of modern drugs in alleviating many psychiatric illnesses and the support for such compulsory treatments by many of those whose symptoms have disappeared as a result of such treatments, perhaps a better way of improving safeguards for patients would be to require judicial authorisation in such circumstances rather than outright prohibition. We believe that the scientific evidence of the positive effect of the drugs would probably result in

the majority of cases being authorised by judges. Nevertheless such a process would provide an important safeguard and would make treatments like ECT, where there is less scientific consensus would be focused only on those (fewer) patients where it is more likely to be justified. In addition, the judicial authorisation process would surely require an assessment of the proportionality of the compulsory treatment and a balance between the effectiveness of the drug and an assessment of the effects of the illness on the patient. It would also allow a clearer right for the patient to make representations and call alternative expert testimony.

European Court of Human Rights case law clearly permits involuntary treatment for mental health problems if certain strict conditions are fulfilled.[2] The UN Special Rapporteur on Torture has stopped short of calling for a prohibition of involuntary treatment, stating that "instances of treatment without informed consent should be investigated".[3] The CRPD Committee stated that "forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law, and an infringement of the rights to personal integrity; freedom from torture; and freedom from violence, exploitation and abuse".[4] The CRPD Committee call on States parties to "abolish policies and legislative provisions that allow or perpetrate forced treatment". We therefore see a number of different standards being set by different human rights bodies, which obviously creates some confusion.

We hope that our comments and questions will be helpful to the SPT and considered in any future reviews of this document. We would be interested to start a dialogue with your Committee about our assessment of the current UK procedures and we would of course welcome any feedback on the points raised in this letter.

Kind regards,

John Wadham
Chair
UK National Preventive Mechanism

[2] ECHR: Herczegfalvy v. Austria - 10533/83 [1992] ECHR 83 (24 September 1992)
[3] Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, 1 February 2013. A/HRC/22/53, para. 85
[4] CRPD General Comment 1 (2014), para 42