

“Bournewood” Consultation

The approach to be taken in response to the judgment of the European Court of Human Rights in the “Bournewood” case

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1 Purpose of Document

- 1.1 This document seeks your views on the issues raised by, and consequent options for public policy arising from, the judgment of the European Court of Human Rights (ECtHR), published on 5th October 2004, in the case of H.L. v. the United Kingdom (the “Bournewood” judgment - so called because H.L.’s care and treatment took place in Bournewood Hospital).
- 1.2 The Government and the National Assembly for Wales accept that, in the light of the judgment, additional procedural safeguards are required for those incapacitated patients who are not subject to mental health legislation, but whose treatment nonetheless involves a deprivation of liberty. We have committed ourselves to bringing forward proposals for new safeguards as soon as possible, after first consulting widely with interested parties, including representative groups, the NHS and local authorities.
- 1.3 The purpose of this document is to carry out that consultation. You have until 17th June to let us have your comments. The consultation covers England and Wales and, in the light of the responses received, we will determine the approach we intend to adopt in relation to people who fall into the “Bournewood gap” – ie, whose circumstances are broadly comparable with H.L.’s (paragraphs 2.1 to 2.3 below briefly describe H.L.’s circumstances). Whatever approach is adopted will involve changes to the law in order to effect an appropriate policy solution.
- 1.4 Specific questions on which views are sought are highlighted in bold text within this document and are listed at Annex A. These questions address the main issues to be resolved through this consultation process. You should not however feel constrained to limit your comments just to these questions. The aim is, given the complexity of the matter, to find the best way to help people determine whether in practice a person is at risk of being deprived of his or her liberty and to ensure that there are suitable safeguards available to persons who are deprived of liberty.
- 1.5 Because the issues addressed in this document are relevant to people with learning disabilities, a version of it is being produced in a form which they will find easier to understand.

2 Introduction: the Bournemouth Judgment

- 2.1 H.L., a man who lacked the capacity to consent or object to medical treatment, was admitted under the common law doctrine of necessity for treatment in Bournemouth Hospital following an instance of self-harming behaviour.
- 2.2 The approach taken in H.L.’s case complied with the Code of Practice drawn up under the Mental Health Act 1983 (the “1983 Act”), which states that (paragraph 2.8) if at the time of admission a patient is mentally incapable of consent but does not object to entering hospital and receiving care or treatment, admission should be informal.
- 2.3 In its judgment the ECtHR concluded that H.L. was deprived of his liberty contrary to Article 5(1) of the European Convention on Human Rights (ECHR) because his admission was not “in accordance with a procedure prescribed by law”; and was contrary to Article 5(4) of the ECHR because he was unable “to take proceedings by which the lawfulness of his detention shall be decided speedily by a court”. Details of the judgment, and of its impact on public policy, are at Annex B.
- 2.4 The implications of the ECtHR’s judgment are significant because (like H.L.) many patients who lack capacity and are “of unsound mind”¹ have previously been informally admitted to hospital for treatment under the common law doctrine of necessity. Following the ECtHR’s judgment, the continued implementation of that well-established policy and practice is clearly unlawful if deprivation of liberty arises², unless ECHR-compliant safeguards are provided.
- 2.5 The implications of the judgment also potentially extend to people of unsound mind who lack capacity but do not require hospital treatment. Such people might, for example, be living in non-hospital settings such as care homes in circumstances that might be considered to amount to deprivation of liberty in ECHR terms. It is also important to bear in mind that the condition of patients who are admitted to hospital or a care home informally or voluntarily may deteriorate and their circumstances change to the extent that they become deprived of their liberty.
- 2.6 The Government and the National Assembly for Wales have each issued interim advice³ to the NHS and local authorities on the implications of the Bournemouth judgment, pending the development of proposals for new procedural safeguards for the protection of those people falling within the “Bournemouth gap”.

1 see para 7 of Annex B

2 see paras 12–13 of Annex B

3 version for England available at <http://www.dh.gov.uk/assetRoot/04/09/79/92/04097992.pdf>; the version for Wales is available from Health.Enquiries@wales.gsi.gov.uk quoting reference WHC (2005) 005

3 The Population Affected

- 3.1 Information about the number of people formally detained in England under the 1983 Act is available from the Department of Health's Annual Statistical Bulletin, and similar information is published by the National Assembly for Wales. In England, for example, there were 26,235 formal admissions under the Act during 2003-04 with a further 19,500 formal detentions following admission. At 31st March 2004 14,000 patients were detained in hospital under the Act.
- 3.2 There is little reliable information about the groups of people who potentially come within the scope of the Bournemouth judgment, whether in hospitals or in other settings such as care homes. These may include people with dementia or psychiatric problems which cannot be treated.
- 3.3 In 1998, when the Court of Appeal gave a similar (though not identical) judgment, the Mental Health Act Commission (MHAC) undertook a survey which implied that at any one time there were some 22,000 compliant incapacitated hospital in-patients in England and Wales who would instead have to be detained formally under the 1983 Act and that each year there would be around 48,000 more formal admissions under the 1983 Act.
- 3.4 In 2003-04 there were 78,000 permanent admissions of older people to care homes. Research suggests that two thirds of that number might have had a cognitive impairment. In the same year there were 7,000 admissions of younger adults to care homes, of whom nearly two thirds had mental health problems or learning disabilities. Overall there might therefore be around 50,000 permanent admissions to care homes who could be affected by the Bournemouth judgment. If temporary admissions were included, the potential population would be even greater.
- 3.5 How realistic are those estimates? What might be a reasonable estimate of the number of temporary admissions to care homes, and how many of them might be at risk of falling into the "Bournemouth gap"?
- 3.6 Provision of appropriate safeguards for these people will generate extra expense. If 10,000 extra people (either in hospitals or care homes) each year were given a second medical assessment at the time of admission the cost nationally would approach £2 million. If, for example, one in five of that number resulted in a court or tribunal hearing, the extra cost each year would be around £4 million, implying that the costs of providing the safeguards would be at least £6 million overall. If 100,000 people fell within the "Bournemouth gap", the cost would be £60 million.

- 3.7 There would also be additional demand for scarce professional skills. How much additional clinical time would be required to provide second medical assessments for this group; and how many extra clinical staff would need to be engaged to undertake this work? Similarly, how many extra hearings would be required, and how much extra professional legal time?
- 3.8 The Government would like to use this consultation process, and work being done alongside it, to estimate with greater accuracy the numbers of people in hospitals and care homes who lack mental capacity and might be considered to be deprived of their liberty in the light of the Bournewood judgment. This will enable the Government to understand the scale of the population affected and the costs, practicability and affordability of potential solutions.

Consultation questions: How many people of unsound mind who lack capacity might be deprived of their liberty each year: in what settings could they be found and how might we identify how many people are affected? In particular, how realistic are the estimates set out above; and how many temporary admissions to care homes might fall within the Bournewood group? What will be the extent of the additional demand placed on clinicians and others?

4 A Framework for Future Government Policy

4.1 In developing policy to reflect the Court's judgment the Government must address the following:

- which groups of people are affected;
- in what settings might they be found;
- what steps can be taken to minimise the numbers of people being deprived of liberty;
- what approach would provide appropriate safeguards within an acceptable policy framework;
- how any new approach could ensure compatibility with the 1983 Act and the draft Mental Health Bill;
- the need to ensure that any solution is proportionate, affordable and workable;
- the importance of keeping statutory regulation to the minimum necessary; and
- how soon a revised policy can be implemented.

4.2 In this document we assume that:

- only people who lack mental capacity are affected by the Bournewood judgment;
- there is the potential for people to be deprived of their liberty in care homes (whether in the public or independent sectors) as well as in hospitals;
- people affected by the Bournewood judgment may not meet the criteria for detention under the 1983 Act;
- the framework for future policy must deliver adequate safeguards in a way which meets the needs of the individual patient and takes into account the views of all interested parties;
- while the implementation of appropriate safeguards is the paramount policy consideration in evaluating different options, we must have regard to the resources available and their optimal use;
- the gap between the delivery of the ECtHR's judgment and the implementation of a revised policy framework should be as short as possible, in order to limit the period of uncertainty for service providers as well as for people who lack capacity and their families, friends and carers, and to provide safeguards as soon as possible;

- where capacity fluctuates, it would be undesirable for the power to detain a person to fluctuate correspondingly between mental health legislation and mental capacity legislation.

4.3 This document also assumes that nothing in it will affect those groups of incapacitated patients who have historically been detained under the 1983 Act, rather than being admitted to hospital informally. As now, the 1983 Act will normally be used for those incapacitated patients who need to be detained in hospital for treatment for a mental disorder and who resist treatment, or whose incapacity is only temporary. It is intended that the same policy would be applied under the proposed Mental Health Bill. The proposals in this document therefore relate to those incapacitated people who have not in the past typically been detained under the 1983 Act.

Consultation questions: Are the right issues addressed in the framework for developing Government policy for Bournewood set out in paragraph 4.1: how valid are the assumptions set out in paragraph 4.2?

5 Closing the “Bournewood Gap”: Protective Care

- 5.1 The ECtHR has identified an important gap in public policy. As the foregoing states, we do not know how many people fall within this gap. The Government is however committed to rectifying the situation as soon as possible.
- 5.2 Subject to the consultation responses, the Government is inclined to adopt an approach entitled “**Protective Care**”. This approach would consist of a new system to govern admission/detention procedures, reviews of detention and appeals. This new system would be specifically for people who lack capacity and are therefore treated in accordance with the principles and procedures set out in the Mental Capacity Bill. It is described in the following paragraphs, although much of the detail remains to be worked out. We see this system being used only when:-
- A person needs to be detained in order that care and treatment can be provided in the person’s best interests.
 - A public authority is involved in arranging the placement.
- 5.3 Under this option powers would be taken to enable a procedure, governed by law, to be put in place, thus rectifying the omission identified by the ECtHR.
- 5.4 The powers could provide a basis for new procedures to govern admission and detention and therefore the circumstances in which a person might be lawfully deprived of liberty. The powers could also set out the arrangements for review of, and appeals in relation to, decisions and detention. This would enable matters to be reviewed at regular intervals and give speedy access to a court to determine the lawfulness of detention. Release could be ordered if the detention was not lawful.
- 5.5 Such procedures and arrangements might specifically cover the following topics:-
- i. The action to be taken on admission/at the stage when deprivation of liberty initially occurs.
 - ii. The nature of the decision in relation to admission/detention, and the identity of the decision makers.
 - iii. The reasons why detention is necessary in order for care and treatment to be provided in the person’s best interests.
 - iv. The nature and extent of the medical and other recommendations required: if second medical opinions are needed, the degree of independence appropriate for the second opinion (where a person is deprived of liberty in hospital, could it, for example, be given by another doctor in the same hospital?).

- v. Who should be consulted in the decision making process (eg the person being deprived of liberty (to the extent possible) and/or his/her representative or advocate).
- vi. The means of recording decisions.
- vii. Whether there should be a statutory record as there is for applications under the 1983 Act (here it would be helpful to know what record keeping arrangements exist at present in hospitals and care homes for people who may be affected by the Bournewood judgment, and whether they can be adapted to form the basis for a more formal procedure).
- viii. The coverage of any such record.
- ix. The desirability of having a legally constituted “checklist” of actions which, if not followed, could provide the basis for challenge.
- x. Who should be informed and at what stages.
- xi. Who might conduct reviews.
- xii. How often reviews should be conducted.
- xiii. What should be included in a review.
- xiv. What role the courts and/or tribunals might play, and which would be the most relevant court or tribunal.

5.6 We would need to decide the precise group of people to whom the powers would apply. Our starting point would be to include all those people of unsound mind who lack capacity and who might be deprived of their liberty in hospitals or other settings.

5.7 Under these powers the procedures would not apply to those detained under the mental health legislation; and, as explained in paragraph 4.3, we would expect that incapacitated patients who meet the criteria for detention under the 1983 Act will typically continue to be detained under that Act where they resist treatment or their incapacity is only temporary. However, the 1983 Act would also be amended to ensure it could still be used even though a person might also meet the criteria for Protective Care. This would allow professionals to retain the flexibility to decide which was the appropriate option in the light of each person’s individual circumstances. It would also avoid the need to create a rigid dividing line in legislation between groups of patients, for example those who “resist” and those who are “compliant”.

5.8 The powers would need to make provision for somebody to be able to challenge detention on behalf of the incapacitated person. Such an approach would:

- constitute a “procedure prescribed by law”;
- potentially cover all people in the “Bournewood gap”, including those in care homes;
- provide appropriate safeguards for those people.

- 5.9 It would however:
- need a suitable legislative vehicle to secure the appropriate powers - subject to the outcome of this consultation, powers could be taken by amending the Mental Capacity Bill, once enacted;
 - potentially impose an additional burden on care homes where there are no set admission procedures;
 - possibly be seen as creating unnecessary bureaucracy.

Consultation points : How should the Government best use Protective Care powers to tackle the Bournewood issue? Are the suggested topics to be covered in procedures and arrangements to be put in place under such powers the right ones, and what needs to be done under each of the topics? What are the minimum elements that must be included in legislation and what should more appropriately be left to guidance?

Arrangements for reviews of detention

- 5.10 Under Article 5(4) of the ECHR everyone who is deprived of liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of detention shall be decided speedily by a court and release ordered if detention is not lawful. The ECtHR said in the Bournewood judgment that the right of access does not require the court to have the power to consider all aspects of the case or to substitute its own discretion for that of the decision making authority. But it also said that the court must be able to consider those conditions which are essential for the lawful detention of a person.
- 5.11 Following the coming into force of the Human Rights Act 1998, the Government initially took the view that rights under Article 5(4) were sufficiently protected by existing mechanisms such as judicial review and habeas corpus. But that view has now been called into question by the recent decision of the Court of Appeal in MH (whereby section 2 of the 1983 Act was found incompatible with Article 5(4) of the ECHR because there is no provision for automatic review by the tribunal of the detention (under that section) of patients who lack capacity). The Government has lodged an appeal with the House of Lords which is due to be heard at the end of July. If the Court of Appeal’s decision were upheld, an automatic referral mechanism to a court or tribunal might need to be made available to persons of unsound mind who lack capacity and are deprived of their liberty.
- 5.12 Either way, however, we would be interested in views on what role the courts or tribunals should play in new arrangements. Which would be the most appropriate court or tribunal? When should entitlement to an initial review by a court arise for a person of unsound mind lacking capacity who is deprived of liberty, and how frequently should follow-up reviews take place/be carried out?
- 5.13 Routine involvement of a court or tribunal would inevitably have significant resource implications. For example, if the Mental Health Review Tribunal (MHRT) were to be used, the pool of professionally qualified people on whom the tribunal depends might well not be adequate to support a substantial increase in workload, especially in the short term. Such

considerations are likely to apply also to alternative options for a court, such as the new Court of Protection (not expected to be available until the Mental Capacity Bill, if enacted, has come into force, likely to be in 2007), the County Court or High Court. The proposals will probably also have to embrace appeal rights, which will again occupy court or tribunal time and resources.

Consultation question : what should the role of courts and tribunals be? What might be the most appropriate mechanism and procedures for reviewing the detention of people of unsound mind who lack capacity and who are deprived of their liberty?

Scope for alleviating pressure on courts or tribunals

- 5.14 There would be much advantage in reducing the need for tribunal or court proceedings, or appeals, by having a “first tier” review, perhaps involving family and friends and with an independent element. The independent element might be provided by somebody with a knowledge of the mental health system. This could replace routine applications to courts for reviews. Such a role, where the third party is independent of both the service provider and the service recipient, has the potential to offer regular, effective, practical and informal resolution of disputes regarding a patient’s admission/detention.
- 5.15 Consideration is needed as to how such reviews might be conducted. They could be undertaken by a professional of some kind, e.g a social worker or clinician, and held at regular intervals.
- 5.16 Such reviews might also have some additional independent element. A model that might be considered is that used for reviewing the cases of children looked after by local authorities under the Children Act 1989. At such reviews an independent reviewing officer has particular responsibility for ensuring that the process takes full account of the views of the child and relatives in the plans for the child’s care. The officer also has a role in monitoring the implementation of what is decided. If not satisfied by the outcome of the review, or its implementation, the officer may refer the case to the Children and Family Court Advisory Support Service (“CAFCASS”), who will consider whether proceedings should be brought against the local authority under the Children Act.

Consultation question : to what extent might the concerns raised in the Bournewood judgment be met by having a “first-tier” review with the involvement of an independent person in the review process, and how should the process operate?

Role of carers, friends and relatives or advocates

- 5.17 When a person of unsound mind who lacks capacity is deprived of liberty the involvement of carers, friends and relatives or advocates in the decision making processes could be used to guard against potential infringements of Article 5 of the ECHR.
- 5.18 What arrangements should be made for carers, friends and relatives or advocates to object to admission/detention, and what should happen if there are differing opinions among carers, friends and relatives or advocates about the appropriateness of admission/detention?

- 5.19 Would it be appropriate to identify one individual – perhaps an advocate – as having special rights and responsibilities to represent the patient’s views, in the way that the nearest relative of a patient detained under the 1983 Act does? If so, how should that person be identified?

Consultation question : What rights, responsibilities and roles might carers, friends and relatives or advocates have?

Monitoring of implementation

- 5.20 We envisage that arrangements will be put in place to monitor the implementation of whatever new processes are agreed, in order to ensure that the procedures are correctly operated, and to assess whether deprivations of liberty are occurring in circumstances not covered by those new processes.
- 5.21 The manner in which powers under the 1983 Act are exercised in hospital settings is kept under review by the MHAC on behalf of the Secretary of State for Health and the National Assembly for Wales. The MHAC may make arrangements to visit and interview patients detained in hospital under the Act. Whilst the Commission’s focus is on formally detained patients, it might be possible to extend its remit to cover hospital patients who, whilst not formally detained, are deprived of their liberty. If the MHAC ceases to exist as proposed under the draft Mental Health Bill and its functions transferred to the Healthcare Commission (HC), this role could be included in the transfer.
- 5.22 In England, social care facilities are regulated by the Commission for Social Care Inspection (CSCI), although some services, such as day care, are unregulated. In Wales the CSCI’s functions are carried out by the Social Services Inspectorate Wales and the Care Standards Inspectorate Wales. Most facilities are currently inspected once a year but care homes are inspected twice a year. These regulatory requirements are currently under review. To the extent that it emerges that deprivation of liberty could occur in care homes or other regulated social care facilities, consideration could be given to asking the above bodies to monitor or review the new arrangements.
- 5.23 To extend the role of the MHAC beyond hospitals, or that of the CSCI and its Welsh equivalent bodies into hospitals, would require primary legislation.
- 5.24 The planned merger of the HC and the CSCI, announced on 16th March, should facilitate the monitoring of implementation across health and social care from 2008.

Consultation question : What arrangements might be made for monitoring the new processes that are put in place to address the “Bournewood gap”?

6 Other Options for Closing the “Bournewood Gap” (not mutually exclusive, nor necessarily complete in themselves)

6.1 Following publication of the ECtHR’s judgment, it is not possible to maintain the current situation in which people of unsound mind who lack capacity and are not detained under the 1983 Act are admitted to hospital for treatment in circumstances which might amount to the deprivation of liberty. It is probably unrealistic to think that a solution could be achieved whereby deprivation of liberty could be avoided except for people detained under the 1983 Act in its current form.

6.2 The following paragraphs look at the extent to which 1983 Act powers, extended as necessary, could be used instead of, or in addition to, Protective Care.

Extending the use of detention under the 1983 Act to the Bournewood group of patients

6.3 The 1983 Act exists primarily to provide a framework for detaining and treating patients against their will where a mental disorder makes that necessary. It contains a range of powers, procedures and safeguards (including powers to take people into legal custody) designed with that purpose in mind. Since the Act provides safeguards that meet the requirements of Articles 5(1)(e) and 5(4) of the ECHR, detaining all people of unsound mind who lack capacity and meet the detention criteria under the Act would close the “Bournewood gap” for this group of people. It would:

- represent an “immediate” solution for that group of people, as it could be implemented within existing legislation; and
- provide adequate safeguards.

6.4 On the other hand, extending the scope of the Act might not be seen as a proportionate response; and would leave unprotected those people of unsound mind who lack capacity and do not meet the criteria for detention under the 1983 Act (eg people in care homes who do not need to be in hospital for treatment for mental disorder).

6.5 It would theoretically be possible to amend the criteria in the 1983 Act to detain people who need care of the type that care homes provide, but who are currently not sectionable. But this would run counter to the spirit of the 1983 Act and the draft Mental Health Bill, significantly extend the scope of the 1983 Act, and make people detainable even if they do not require specialist health care.

6.6 Extending formal detention under the 1983 Act would provoke mixed reactions. Some mental health service users and user groups feel strongly that sectioning should be avoided wherever possible. Others feel that the advantage of the safeguards provided under the 1983 Act outweighs any negative connotations perceived to attach to detention.

Consultation question : in the light of the Bournewood judgment, to what extent would it be desirable to extend the use of sectioning of people of unsound mind who lack capacity, and are deprived of their liberty, under existing mental health legislation?

Using existing arrangements for guardianship under the 1983 Act (modified as necessary)

- 6.7 Under the 1983 Act a patient aged 16 or over may be received into guardianship for a period of up to 6 months (which may be renewed) on the grounds that he or she is suffering from a mental disorder and that it is for the patient’s own welfare or for the protection of others. An application for guardianship requires the written recommendations of two doctors, and can be vetoed by the nearest relative. There is provision for a person received into guardianship to apply to an MHRT for discharge. The person named as guardian may be either the local authority or a person approved by the local authority.
- 6.8 Although originally intended for patients in the community, it has been suggested that the guardianship powers already contained in the 1983 Act might be extended to embrace people of unsound mind who lack capacity (perhaps people in care homes, or people who are in hospital but not sectionable) and might be considered to be deprived of their liberty.
- 6.9 Under guardianship arrangements as they are now, the guardian may decide where the patient is to live (and is sometimes used by local authorities where the place of residence of a person who lacks capacity is in dispute) and may say that the patient should attend specified places for treatment or training. The arrangements were not however intended as a way of detaining people.
- 6.10 Using the guardianship approach:
- all those affected by the “Bournewood gap” but who could not be “sectioned” under the 1983 Act as it stands, whether in hospital or care home settings, could be covered;
 - might be more widely acceptable to interested parties than an extension of sectioning;
 - some safeguards would be available.
- 6.11 On the other hand:
- implementation would be subject to making such primary legislative amendments as would be necessary to the mental health regime;
 - it would run counter to the Government’s policy to repeal the current guardianship provisions in the draft Mental Health Bill;
 - it would create an additional and significant burden on local authorities.
- 6.12 It would be necessary to consider:
- whether to extend the scope of guardianship beyond those people who currently fall into the categories of “mental illness”, “mental impairment”, “severe mental impairment” or “psychopathic disorder” under the 1983 Act. These categories may

exclude, for example, some people with learning disabilities who might nonetheless require care of a type that amounts to deprivation of liberty;

- whether it would be possible to extend the powers of the guardian to include detention (rather than merely being able to require the person under guardianship to live at a particular place), and whether this would be restricted to particular types of residences (eg hospitals, care homes);
- whether it would be necessary to increase the safeguards for patients (for example, the right to apply to the MHRT can be exercised only by the patient - a person lacking capacity is not necessarily able to exercise that right - and there is no automatic referral of guardianship cases to the MHRT even where the patient makes no application for many years). If so, what additional safeguards would be necessary?
- whether it would be necessary to change other features of the guardianship regime: for example a guardian cannot at the moment prevent a nearest relative from discharging a person from guardianship, except by obtaining a county court order displacing the nearest relative;
- guardianship currently tends to be used frequently in some areas but is seldom used in others. New schemes which made provision for the use of guardianship to be significantly extended across the country would be likely to have extra costs of implementation.

6.13 The current fragmented use of guardianship perhaps implies that there would not be a great deal of support for extending its coverage. But using it as a solution to the “Bournewood gap” might make it a more attractive proposition. What are the disadvantages of using guardianship, and are there ways in which the arrangements might be changed to make it more effective? Would the potential take-up of widened and altered guardianship arrangements justify the necessary amendment to the mental health legislation, and what would be the practical implications?

Consultation questions : What would be the advantages and disadvantages of extending the use of guardianship in respect of people of unsound mind who lack capacity? What changes to current legislation would be needed to make this a feasible option?

7 Implementation

Timescale for implementation

- 7.1 There is at this stage no specific set timescale for the implementation of the Bournemouth solution(s). However, we are concerned to ensure as soon as possible that the process by which a person is deprived of liberty is lawful. It is expected that it will take about two months to come to policy decisions following the planned completion of this consultation process in June.
- 7.2 The timetable thereafter will depend on what those decisions are and what are feasible/realistic timescales for their implementation. It is possible that there will need to be different solutions for different groups of people who lack capacity, for example those in hospitals and those in care homes; those identified as within the “Bournemouth gap” when admitted and those who fall into the group after admission because of a deterioration in their condition.
- 7.3 In determining policy and the timetable for implementation, factors that will need to be taken into account include:-
- What legislative changes need to be made?
 - What are the resource implications of the solution(s)?
 - How many additional personnel will be required to enable implementation of the solutions and how long will they take to recruit and train?
 - To what extent is there a “backlog” of people who need to be assessed to ensure they are not deprived of their liberty, and, if there is a backlog, how long will it take to clear?
 - At what rate might new deprivation of liberty cases arise?

Impact on service providers in the interim

- 7.4 It would be helpful to know how things have progressed in the field since the publication of the interim advice by the Department of Health and the National Assembly for Wales:-
- What issues and problems have arisen locally?
 - Are there any damages cases in the pipeline for the alleged wrongful deprivation of liberty?
 - What arrangements have so far been made to meet the “Bournemouth gap”?
 - If costly “belt and braces” care plans are being applied, what are the cost implications and what do they contain?
 - What further guidance is needed?

Consultation question : what local developments have occurred following the publication of the interim advice by the Department of Health/the National Assembly for Wales?

8 Summary

- 8.1 The Bournemouth judgment raises complex issues to which there is no easy answer. The Government wishes to identify a way of delivering a workable system which gives to people of unsound mind who lack capacity appropriate safeguards against the unlawful deprivation of their liberty. The Government also wishes to secure the legislation required to address the findings of the ECtHR while maximising the scope for local discretion on implementation mechanisms.
- 8.2 We would welcome your comments on the implications of the Bournemouth judgment and potential solutions to the issues it raises. This document identifies topics that the Government sees as relevant to the Bournemouth debate. But respondents should not feel constrained to limit their comments to these topics if they consider there are other relevant issues that need to be aired.
- 8.3 The consultation process runs until 17 June 2005. Please submit your comments within that timescale to:-

Ms Debra Clarke
Room 315
Department of Health
Wellington House
133-155 Waterloo Road
London SE1 8UG
Telephone : 020 7972 4879
E-mail : Debra.Clarke@dh.gsi.gov.uk

9 Government Code of Practice on Consultation

- 9.1 This consultation process is being conducted in accordance with the Government's Code of Practice on Consultation. This requires that we should:-
- i. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.
 - ii. Be clear about what our proposals are, who may be affected, what questions are being asked and the time-scale for responses.
 - iii. Ensure that our consultation is clear, concise and widely accessible.
 - iv. Give feedback regarding the responses received and how the consultation process influenced policy.
 - v. Monitor our Department's effectiveness at consultation, including through the use of a designated consultation co-ordinator.
 - vi. Ensure our consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.
- 9.2 The Code also requires that respondents should be invited to comment on the extent to which the criteria have been adhered to and to suggest ways of further improving the consultation process. Comments or complaints about this consultation process should be directed to:

Steve Wells
Consultations Coordinator
Department of Health
Skipton House
80 London Road
London SE1 6LH
Email: steve.wells@dh.gsi.gov.uk

Attachments:-

- Annex A: List of Questions for Consultation
- Annex B: Summary of the Findings and Implications of the ECtHR's Judgment in the Bournemouth case
- Annex C: Partial Regulatory Impact Assessment

Bournewood Consultation Process : List of Questions for Consultation

1. *The population affected (paragraphs 3.1 to 3.8):*

How many people of unsound mind who lack capacity might be deprived of their liberty each year: in what settings could they be found and how might we identify how many people are affected? In particular, how realistic are the estimates set out above; and how many temporary admissions to care homes might fall within the Bournewood group? What will be the extent of the additional demand placed on clinicians and others?

2. *Framework for future Government policy (paragraphs 4.1 to 4.3):*

Are the right issues addressed in the framework for developing Government policy for Bournewood set out in paragraph 4.1: how valid are the assumptions set out in paragraph 4.2?

3. *Protective Care (paragraphs 5.1 to 5.9):*

How should the Government best use Protective Care powers to tackle the Bournewood issue? Are the suggested topics to be covered in procedures and arrangements to be put in place under such powers the rights ones, and what needs to be done under each of the topics? What are the minimum elements that must be included in legislation and what should more appropriately be left to guidance?

4. *Arrangements for reviews of detention (paragraphs 5.10 to 5.13):*

What should the role of courts and tribunals be? What might be the most appropriate mechanism and procedures for reviewing the detention of people of unsound mind who lack capacity and who are deprived of their liberty?

5. *Scope for alleviating pressure on courts or tribunals (paragraphs 5.14 to 5.16):*

To what extent might the concerns raised in the Bournewood judgment be met by having a “first-tier” review with the involvement of an independent person in the review process, and how should the process operate?

6. *Role of carers, friends and relatives or advocates (paragraphs 5.17 to 5.19):*

What rights, responsibilities and roles might carers, friends and relatives or advocates have?

7. *Monitoring of implementation (paragraphs 5.20 to 5.24)*

What arrangements might be made for monitoring the new processes that are put in place to address the “Bournewood gap”?

8. *Extending the use of detention under the 1983 Act (paragraphs 6.3 to 6.6)*

In the light of the Bournewood judgment, to what extent would it be desirable to extend the use of sectioning of people of unsound mind who lack capacity and are deprived of their liberty, under existing mental health legislation?

9. *Using existing arrangements for guardianship under the 1983 Act (paragraphs 6.7 to 6.13):*

What would be the advantages and disadvantages of extending the use of guardianship in respect of people of unsound mind who lack capacity? What changes to current legislation would be needed to make this a feasible option?

10. *Impact on service providers in the interim (paragraph 7.4):*

What local developments have occurred following the publication of the interim advice by the Department of Health/the National Assembly for Wales?

Summary of the Findings and Implications of the ECtHR's Judgment in the Bournemouth Case

The scope of the judgment

1. The ECtHR found that the circumstances surrounding the care and treatment of H.L. in Bournemouth Hospital during a period in which he was not detained under the 1983 Act constituted infringements of:-

Article 5(1) of the ECHR – Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: 5(1)(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants.

Article 5(4) of the ECHR – Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

2. In the light of the judgment, there is a need to establish which groups of people require safeguards to prevent unlawful deprivation of liberty and to confer a right of review by a court. It is clear that situations in which the circumstances are the same as in the Bournemouth case must be covered. H.L. lacked the capacity to consent or object to medical treatment. Although he met the criteria for detention under the 1983 Act he had not been formally detained because he did not resist admission.
3. Looking beyond people such as H.L., soundings taken to date indicate that there is no consensus among stakeholders as to the settings in which deprivation of liberty might occur, the groups of people that might need to be covered or the measures necessary to protect them.
4. Although the Bournemouth judgment was specifically about a hospital patient lacking capacity who could have been sectioned under the 1983 Act, the judgment appears to have wider implications which extend to other people who are deprived of their liberty in hospital, and perhaps also to similar people in non-hospital settings such as care homes.
5. It seems, in the light of the Bournemouth judgment, that deprivation of liberty could take a wide variety of forms where people lacking capacity are concerned. For example, “control” through medication, or placing people who are also physically frail in situations from which they cannot gain egress under their own volition, might in certain circumstances be considered to represent deprivation of liberty. We believe the extent to which people in care homes, including people placed in a private care home by a public body, could be deprived of their liberty will depend crucially on the nature of the regime in the care home. It seems possible that a regime in a care home could be of such a nature as to amount to a deprivation of liberty. The conditions in

which persons are treated in care homes will vary considerably, reflecting the individual circumstances of the person and also the skills, resources and overarching regime of the particular home. Where, for example, an individual has a severe mental disorder and the regime in the care home is exceptionally “closed” (lack of outside contact, constant control and supervision, etc), the possibility that deprivation of liberty might arise within the meaning of Article 5(1)(e) and 5(4) of the ECHR is greater than in a home where the regime is more “open”.

6. The Bournewood judgment relates specifically to persons of unsound mind who lack capacity. Where deprivation of liberty occurs in respect of such people, the ECHR requires that there must be (a) a procedure prescribed by law for their detention and (b) an entitlement to access a court to challenge the lawfulness of detention.
7. The term “persons of unsound mind” is used in Article 5(1)(e) without further definition and has been said by the courts to be an evolving term. In UK law the term would generally be defined by reference to the Mental Health Act 1983 to cover **mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind**. However, the Government considers that it may be preferable in this context to keep to the actual wording in the Convention because, first, in that way it will ensure that all cases affected by Article 5(1)(e) are covered and secondly because it is likely the draft Mental Health Bill, if introduced and enacted, will make changes to the definition of mental disorder. Using the words in the Convention will mean that the term has the meaning given to it in court decisions on the subject. In this way the cases where safeguards are provided will evolve over time.

Establishing capacity

8. This consultation process focuses on people who are of unsound mind and lack capacity. Clearly not all people who are of unsound mind lack capacity. The Mental Capacity Bill (see <http://www.publications.parliament.uk/pa/ld200405/ldbills/048/2005048.htm>) establishes in Clauses 1 to 3 the basis for determining a person’s capacity to make decisions. The Bill starts from the basis that the person is assumed to have capacity unless it is established that he lacks it. It is proposed that this basis for establishing incapacity should be applied to persons coming within the scope of the Bournewood judgment and that the decision for which capacity would need to be lacking in the Bournewood context is that the person is not capable of consenting to such constraints as amount to a deprivation of liberty.

Safeguards needed to meet Article 5 requirements

9. For those patients who are admitted and treated under compulsion the ECtHR decision in Bournewood did not question whether the provisions of the 1983 Act were compatible with the ECHR. Indeed, the safeguards available to those people formally detained under that Act would appear to fulfil the requirements stipulated by the ECtHR. Accordingly the Government considers that people detained under the 1983 Act have no need of additional safeguards as a result of the Bournewood judgment.
10. Unless all who can be made subject to the compulsory powers in the 1983 Act, there is a need to establish appropriate procedures/safeguards for (a) people deprived of their liberty who do meet the criteria for detention under the 1983 Act but are not brought under compulsion and (b) those who are so deprived but do not meet the criteria for detention under the 1983 Act.
11. The Government notes, however, that the ECtHR did not state that 1983 Act safeguards should be extended to all incapacitated people of unsound mind who are deprived of their liberty otherwise than under the Act and noted “the Government’s understandable concern to avoid the full, formal and inflexible impact of the 1983 Act.”

Deprivation or restriction of liberty?

12. The ECtHR judgment does not define what is meant by “deprivation of liberty”, though it confirmed that it was different from mere restriction of liberty. The difference between deprivation and restriction was said to be one of degree or intensity. The judgment in the Bournewood case concluded that health care professionals exercised complete and effective control over the patient’s assessment, care, treatment, contacts, movement and residence. He was under constant supervision and control and not free to leave; this amounted to a deprivation of liberty requiring Article 5(1)(e) and 5(4) safeguards which would not have been required had there been only a restriction of liberty.
13. It is apparent from the Bournewood judgment that the decision as to whether deprivation of liberty occurs should be related to the specific circumstances of the individual case. There is no clear threshold at which restrictions placed upon various freedoms of choice amount to a deprivation of liberty for Article 5 purposes. It is, however, possible to identify factors that need to be weighed in considering whether a combination of limitations imposed on different freedoms of choice amount to an overall deprivation of liberty. These may include:-
 - a. The regime within the facility where a person is accommodated and the extent to which the person has freedom, within such constraints as safety considerations (safety of patient and others) will permit, eg to move around within the facility and to leave the facility without hindrance if he or she wishes to do so.

- b. The process governing the person’s admission to the facility, whether the person himself was, as far as possible, permitted to participate in that process and was compliant with admission, whether family/friends were consulted and whether there was any independent element to the process.
- c. What influence a person or his/her family/friends have in the arrangements made for his/her care and treatment and whether there is freedom to choose whether to receive different treatments.
- d. Whether a person has any limitations imposed on people who may visit him/her or with whom he/she may make contact.
- e. The duration of any imposed limitations on freedoms of choice and the arrangements/timescales for reviewing such limitations.

Partial Regulatory Impact Assessment

1. Title

“Bournewood” Consultation: The approach to be taken in response to the judgment of the European Court of Human Rights (ECtHR) in the “Bournewood” case

2. Purpose and intended effect of measure

(i) The objective

To identify a way forward that meets the concerns raised by the ECtHR in a manner that provides necessary safeguards for people of unsound mind who lack capacity and is proportionate, affordable and workable.

(ii) The background

On 5th October 2004, the ECtHR published its judgment in the case of H.L. v United Kingdom (commonly referred to as the “Bournewood judgment”, since the circumstances that led to the reference to the ECtHR occurred while H.L. was a patient in Bournewood Hospital). The ECtHR ruled that H.L., who was of unsound mind and lacked capacity, was detained in Bournewood Hospital in circumstances that amounted to a deprivation of liberty and, since appropriate safeguards surrounding the patient’s detention were not provided, infringed Articles 5(1)(e) and 5(4) of the European Convention on Human Rights (ECHR).

(iii) Risk assessment

The main risk of proceeding with any one of the three action options identified in the consultation document surrounds the ability of the mental health and social care systems to cope with the additional requirements that will be imposed upon them. However, this risk is outweighed by the risks arising from not taking action in response to the ECtHR judgment:-

- Denying patients of unsound mind who lack capacity and are deprived of their liberty their rights under the ECHR.
- Making it unlawful to deliver appropriate care.
- Legal actions and compensation claims from people against health and social care services on the grounds that they are illegally being deprived of their liberty.
- Reneging on public commitments to address the Bournewood issue in an appropriate manner.

- Criticism from the ECtHR for failing to close the gap that they have identified and for permitting the continuation of a system that has been found to infringe the ECHR.

3. Options

- (i) Do nothing – This would be unacceptable for the reasons set out under “Risk assessment” above.
- (ii) Introduce a new system of “Protective Care” to provide a legal basis for depriving of their liberty people of unsound mind who lack capacity, in order to provide care or treatment in their best interests. Such a system could fully address the shortcomings identified in the ECtHR judgment. A suitable legislative vehicle will need to be identified to introduce the system. Its implementation will impose additional requirements on the field and have resource implications.
- (iii) Extend the use of existing powers to detain people of unsound mind who lack capacity under the Mental Health Act 1983 (the 1983 Act), and perhaps cover the whole of the “Bournewood group” through this route.
- (iv) Extend the use of existing 1983 Act powers to place people under guardianship.

4. Benefits

- *Economic*

Option 1

Doing nothing would avoid the additional costs of providing appropriate safeguards for people of unsound mind who lack capacity and are deprived of their liberty but would still leave other potential cases open to challenge, which has associated costs.

Options 2, 3 and 4

Will save the unpredictable costs of legal actions and compensation claims of the type referred to under 2.(iii) above. Will also lead to increased economic activity (eg increased work for clinicians and increase in the requirement for reviews of the lawfulness of deprivations of liberty).

- *Environmental*

Not applicable for all four options.

- *Social (including Health Impacts)*

Option 1

None.

Options 2, 3 and 4

Living conditions have a significant effect on a person’s health and well-being, and respect for individuals’ ability to exercise a degree of control over their living conditions should enhance their well-being. For people of unsound mind who lack capacity this would support their treatment and care. It is anticipated that efforts will be made to avoid depriving people of their liberty wherever possible and, where deprivation of liberty does occur, there will be safeguards surrounding the initial deprivation of liberty and arrangements for reviews of continuing deprivation of liberty. This should lead to improvements in quality of life for those who might, but for the ECtHR judgment, have been deprived of their liberty and reassurance that there is a sound legal basis for deprivation of liberty where it does occur. This will provide for more equitable treatment of disadvantaged groups of people.

5. Costs

- *Economic*

In advance of consultation, it is very difficult to cost the options given the uncertainty over numbers of people affected and the precise nature of safeguards that will be implemented.

Care and Treatment

While we would hope that it would be a further spur for improvements in quality and appropriateness, in principle the care and treatment that people receive should not be different, simply because there are new procedural safeguards relating to their detention. However, those safeguards will have costs.

Assessment and examination at point of detention

If good practice is being followed then, in cases where the Bournewood judgment might apply, it should be that patients who lack capacity who are admitted to hospital or (if relevant) to care homes are already routinely subject to proper assessment before the decision is taken. The assessment should be properly recorded.

However, it is perhaps unlikely that two doctors are always involved (as would be required for detention or reception into guardianship under the 1983 Act). It is therefore perhaps reasonable to assume that the effect of Options 3 and 4 would be to impose an additional assessment cost equivalent to one medical recommendation under the 1983 Act.

We estimate that such an examination requires 2 hours of a doctor’s time in total at a cost of around £190.00. For 10,000 extra examinations that would suggest a need for the time of around 16 full time equivalent (fte) doctors, at a cost of £1.9m per year. For 100,000 extra examinations that would be 160 fte and £19m.

Whether there were similar costs for Option 2 would depend on the answers to questions raised in the consultation.

Review

Again, peoples’ care and treatment should already be subject to periodic review, but it is likely that Options 2, 3 and 4 would all add a more formalised review process to what is already in place.

For Option 2, the cost would depend on the nature of the review. But if, for example, reviews were carried out by an independent medical expert, it is reasonable to think that that would require at least the same level of input as an initial examination (see above), probably with significant additional input from other people (eg nursing staff).

For Option 3 and potentially (depending on what amendments were made to the legislation) Option 4, formal review would take the form of a “manager’s hearing” each time the patient’s detention was reviewed. We estimate that a manager’s hearing requires around 4.5 hours of a psychiatrist’s time, nursing input of around 2.5 hours, social work input of around 13 hours as well as administrative input and the time of the hospital managers and that the total cost is around £1,100.

Assuming 10,000 hearings a year, that would imply a need for 36 fte doctors, 18 fte nurses and 102 fte social workers and a total cost of £11m. (For 100,000 hearings, 360, 180, 1,020 ftes and £110m respectively.)

Treatment safeguards

For Option 3 and potentially (depending on what amendments were made to the legislation) Option 4, patients could be treated without their consent, subject to Part IV of the 1983 Act. Part IV contains various safeguards, the most important of which is the involvement of a Second Opinion Appointed Doctor (SOAD) when it is proposed to give a patient electroconvulsive therapy or (after an initial three month period) medication.

We estimate an average SOAD examination requires 3 hours of the SOAD’s time in total and costs around £350. For 10,000 extra examinations a year (approximately double the current number) that implies a need for the time of around 24 fte doctors and a total cost of £3.5m. (For 100,000 examinations, 240 fte and £35m respectively.)

Option 2 would not automatically incur these extra costs, unless it was decided that it was appropriate to introduce safeguards not only in relation to detention, but also to treatment.

Court or Tribunal

Under Options 3 and 4, people would automatically have the right to apply to an MHRT at least once a year. Under Option 3 and potentially (depending on what amendments were made to the legislation) Option 4, those who did not apply would be referred automatically after three years. There are currently around 12,000 MHRT hearings a year. If 10,000 patients generated 2,000 new hearings a year (ie 1 in 5 patients), that would be a 17% increase. The same ratio applied to 100,000 patients would mean a 167% increase in cases.

We estimate that an MHRT hearing requires input from psychiatrists – both as treating clinicians and members of tribunal panels – of around 10.5 hours, around 2.5 hours of nursing input, and 13 hours of social work input, plus the time of the legal and lay members of the tribunal panel (around 4 hours each) and administration. We estimate the total cost to be around £2050.

Assuming 2,000 hearings a year that implies a need for around 15 fte doctors, 4 fte nurses and 20 fte social workers, and a total cost of £4m. (For 20,000 hearings, 150, 40, 200 ftes and £40m respectively.)

Costs would also arise under Option 2. Without knowing which legal forum, and how often applications/referrals would be made, it is difficult to cost. But we think it would be reasonable to assume a cost in the same order as an MHRT.

There would also be legal costs for detained people and their representatives, some or all of which would be met by legal aid.

Basis for costs

Estimated ftes (and therefore costs) above include an overhead to cover the requirements for professional and personal development, training, audit, administration, other duties, sickness and other absences. For doctors (other than tribunal members), specialist nurses and social workers the overhead is 30%, for others it is 15%. Ftes are calculated on the basis of 220 working days and a 7.5 hour working day, giving a working year of 1,650 working hours per person per year. Cost and staff time estimates are based on the 1983 Act. For the expected effect on costs and workforce requirements of the changes set out in the draft Mental Health Bill, please see the explanatory notes to that Bill which are available at <http://www.legislation.hmso.gov.uk/legislation/uk.htm>

On whom costs will fall

Options 2, 3 and 4 will have economic costs for the Government, the NHS, local authorities and independent sector providers. It would be reasonable for these purposes to assume that the Government would directly meet the costs of MHRTs, or their equivalent, and SOADs. The costs of initial examinations, first-tier reviews (see paragraph 5.14 of the consultation document) and local preparation and input into MHRT (or equivalent) hearings (including social work input) would be met locally by the relevant health or social care authority and/or care provider. On the basis of the type of hospitals in which patients are detained under the 1983 Act in England, it is estimated that any costs arising for hospital providers might break down into 85% for the NHS and 15% for the independent sector. Independent sector providers are likely to recover the costs of NHS patients through charges to the Primary Care Trusts (or other NHS bodies) which place patients with them.

Similarly, we would expect independent sector care home providers to seek to recover any extra costs from the public authorities responsible for placing patients with them. Such costs would therefore largely fall on local social services authorities (though some may fall on NHS bodies).

Some of these local authority costs will be recovered from residents themselves, where they are liable to contribute to the cost of their accommodation and care.

- *Environmental*
Not applicable for all four options.
- Social (including Health Impact)

By not providing people with the most appropriate living conditions there could be less than optimal treatment conditions and therefore not the best use of resources for treatment and care.

6. Equity and Fairness

Options 2, 3 and 4 will benefit people of unsound mind who lack capacity and are deprived of their liberty, in that their situations will be brought into compliance with the ECHR and they will consequently be provided with safeguards that they do not currently enjoy. Elderly people, and people with learning disabilities, are likely to form the major proportion of the people who benefit.

7. Rural Proofing

There is no reason to believe that the distribution of people deprived of their liberty differs in any significant way between urban and rural areas, and thus no reason to suppose that the issues raised in the consultation document will impact on rural areas any differently from the way in which they impact on other areas.

8. Consultation with small business: the Small Firms' Impact Test

The consultation process is itself intended to encompass this issue. The “small businesses” most likely to be affected are independent hospitals and care homes. The impact upon them is uncertain at this stage due to the current shortage of information about the extent to which deprivation of liberty in ECHR terms may arise in such places.

9. Competition Assessment

These proposals are not expected to have a significant effect on competition as most of the resource implications are anticipated to impact on the NHS and local authorities. It is possible though that the proposals could have different effects on different independent hospitals and care homes, and thus affect their charges differently, depending on the extent to which they have “deprivation of liberty type” regimes.

10. Enforcement and Sanctions

How will the proposal be enforced? Who will enforce this legislation?

We expect that any arrangements put in place in response to the Bournewood judgment following the consultation process will have a legislative basis, so there will be a legal requirement to adhere to those arrangements. People of unsound mind who lack capacity, or others acting on their behalf, will have recourse to the courts, including the ECtHR, if they consider that deprivation of liberty is occurring without the necessary safeguards being in place.

Will the legislation impose criminal sanctions for non-compliance?

The legislation will not impose criminal sanctions for non-compliance.

11. Monitoring and Review

As part of the consultation process, views are being sought on the most appropriate arrangements for monitoring the implementation of the Bournewood “solution”. The consultation document points to possible roles for the Mental Health Act Commission, the Healthcare Commission, the Commission for Social Care Inspection, the Social Services Inspectorate for Wales and the Care Standards Inspectorate Wales. Final decisions on this matter will be taken following completion of the consultation process.

12. Consultation

i) Within government

Consultation within Government largely involves the Department of Health (with responsibility for mental health issues), the Department for Constitutional Affairs (with responsibility for mental capacity issues), the Welsh Office, the National Assembly for Wales and the Treasury.

ii) Public Consultation

The consultation document has been prepared following informal discussions with interested outside people and organisations, including representatives of the Law Society and clinicians working in the field. The consultation process will be drawn to the attention of a wide range of interested parties, including representative groups, the NHS and local authorities, the Mental Health Act Commission, the Healthcare Commission, the Commission for Social Care Inspection, the Social Services Inspectorate for Wales, the Care Standards Inspectorate Wales and the Law Society.

13. Summary

Section 5 above refers to the difficulty of costing the options given the uncertainty over numbers of people affected and the precise nature of safeguards that will be implemented.

Options 3 and 4 involve the extension of existing 1983 Act procedures for which we have information to enable us to estimate the unit costs of safeguards, but the unknown factor is the number of additional people who will need to be provided with the safeguards. (And for that reason, we have not attempted to estimate how unit costs might be affected by the change in overall numbers.)

The costs for Option 2 are more difficult to calculate because decisions about the nature of the safeguards to be provided will not be taken until the consultation process has been completed.

However, initial cost estimates, assuming 10,000 additional people requiring safeguards, are summarised in the table below. These figures would need to be reduced or increased proportionately for a different overall number of additional people requiring safeguards. We envisage that Options 3 and 4 will produce relatively similar additional costs so they are not shown in separate columns in the table.

Whilst it can be anticipated with some confidence that the costs for Option 2 will be lower than the costs for Options 3 and 4, the figures for Option 2 should be treated with particular caution due to the uncertainties referred to above.

Cost figures will be firmed up during, and following the end of, the consultation process so that final policy decisions are informed by a clearer indication of what the costs of different options will be.

Summary of Illustrative Costs (per year at current prices)

Safeguard	Option 2 £m per annum	Options 3 and 4 £m per annum
Assessment and examination at point of detention	1.9 ¹	1.9
Review	3.0 ²	11.0
Treatment safeguards	–	3.5
Court or Tribunal	4.0	4.0
Total	8.9	20.4

14. Declaration

I have read the regulatory impact assessment and I am satisfied that the benefits justify the costs.

Signed

(To be signed when the final Regulatory Impact Assessment is completed following consultation.)

Date

Minister’s name, title, department

Contact point

1 Assuming costs are of a similar order to Options 3 and 4

2 Assumes that, in addition to £1.9m for medical reviews identified in Section 5 above, there will be nursing costs of around £1.1m



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267902 1p Mar 05

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