

Reform of the Mental Health Act 1983 – Convention Implications of the Green Paper

*Paul Bowen**

[This article is based upon two lectures given by the author to the Institute of Mental Health Act Practitioners on 7 February and 6 March 2000.]

Assessing the Convention compatibility of the Government proposals for reform of the Mental Health Act 1983 set out in the Green Paper¹ is largely an exercise in speculation, for three reasons. First, the proposals are very broad; the detail, where the devil may be found, is yet to come. Second, the Convention does not permit the Strasbourg authorities to review the legality of national legislation in the abstract, but only with reference to particular cases after the proceedings are complete². Although that will not necessarily preclude a domestic court from reviewing the lawfulness of any provision of the new Mental Health Act after incorporation of the Human Rights Act 1998³, the comments that can be made in this article are necessarily confined to the general rather than the specific.

Third, and perhaps most significantly, it is impossible to predict the impact of the Convention following the coming into force of the Human Rights Act 1998 on 2 October 2000. The consequences of that Act will be far-reaching, but one in particular deserves mention. The Strasbourg Court's decision-making is constrained by the concept of the 'margin of appreciation'. The principle has been developed by the Strasbourg authorities to reflect an appropriate degree of deference by the international court to the expertise of national decision-makers, whether courts or governments, in applying national law to national problems⁴. It also reflects the practical problem faced by the Strasbourg authorities in applying Convention principles in a manner that can be relevant to all the Contracting States, which together present a wide range of different legal approaches to the same problems (and often widely different availability of resources). In practice

* *Barrister, Doughty Street Chambers, London*

1 *'Reform of the Mental Health Act 1983 - Proposals for Consultation' Department of Health 1999. Cmnd 4480. The Green Paper considers the proposals of the Expert Committee chaired by Professor Richardson, which are set out in their Report 'Review of the Mental Health Act 1983', also published by the Department of Health in November 1999.*

2 *see Hakansson and Stureson v. Sweden (1990) 13 E.H.R.R. 1, 11, para. 46; the Salabiaku case, 13 E.H.R.R. 379, 390, para. 30; Hoang v. France (1992) 16 E.H.R.R. 53, 78, para. 33*

3 *See R v Director of Public Prosecutions ex p Kebilene [1999] 3 WLR 972, 996D-F*

4 *See Handyside v U.K. (1976) 1 EHRR 737*

it has the effect of placing an additional hurdle for an applicant to clear in establishing a violation of his Convention rights before the Strasbourg authorities.

However, as Lord Hope recently noted in the House of Lords in *R v DPP ex p Kebilene*⁵

“This technique [the margin of appreciation] is not available to the national court when they are considering Convention issues arising within their own countries.”

It follows that it should be easier to prove a Convention violation before the national courts than to do so before the Strasbourg Court⁶. It also follows that the principles developed by the Strasbourg Court (which domestic courts must ‘take into account’, by s. 2(1) Human Rights Act 1998) are only a *starting-point* in determining the extent of Convention rights as a matter of domestic law. A greater degree of protection must, theoretically, be provided under domestic law than under international law. This paper can only address Convention law as it has been developed by the Strasbourg authorities.

With those reservations in mind, this article addresses the Convention implications of the specific proposals contained in the Green Paper, under the following headings:

The new criteria for the exercise of compulsory powers (Chapters 4 & 5)

The new procedure for Detention (Chapters 4 & 6)

Discharge procedures (Chapters 7 & 10)

Compulsory Community Orders (Chapter 6)

Compulsory Detention in Criminal Proceedings (Chapter 8)

Transferred prisoners (Chapter 8)

Severe Personality Disordered patients (Annex C)

The right to receive treatment

Compulsory treatment and the right to refuse treatment (Chapter 9)

The right to aftercare (Chapter 7)

Children and Incapacitated Adults (Bournewood).

(I) The new criteria for the exercise of compulsory powers

The Government’s proposals fall, broadly, under three headings: (a) a single, very broad, definition of mental disorder to replace the four existing categories of mental disorder justifying the use of compulsory powers (Green Paper, Chapter 4, §2-5); (b) a rejection of the Expert Committee’s proposed capacity-based detention criteria; (c) a new formulation of the criteria for the exercise of compulsory powers to replace the existing ‘appropriateness’, ‘treatability’ and ‘safety’ tests.

Under the Mental Health Act 1983 an individual cannot be subjected to compulsory powers (whether detention, a supervision order or guardianship) unless his mental disorder falls within one of four categories, respectively ‘mental illness’, ‘psychopathic disorder’, ‘severe mental impairment’ and ‘mental impairment. To fall within the definitions of ‘psychopathic disorder’, ‘mental impairment’ and ‘severe mental impairment’, an individual’s disorder must be ‘associated with abnormally aggressive or seriously irresponsible conduct’. If that criterion is not satisfied the individual cannot be subjected to compulsory powers.

5 [1999] 3 WLR 972, at 993:

6 It should be noted however that Lord Hope went on to recognise that the judiciary would “defer, on democratic grounds, to the considered opinion of the elected body or

person whose act or decision is said to be incompatible with the Convention...” This has been referred to as the “discretionary area of judgment” and could be seen as the start of a domestic margin of appreciation doctrine.

The Government proposes to follow the advice of the Expert Committee and remove the four classifications of mental disorder and replace them with a single definition: ‘any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of Mental Functioning’ (Green Paper, Chapter 4, §2). The requirement that certain types of disorder be ‘associated with abnormally aggressive or seriously irresponsible conduct’ before compulsion can be used will be abolished. The rationale for this broader definition is that the more specific definitions in the current Mental Health Act may have the effect of excluding some individuals who should fall within the compulsory powers of the Act. The only express exclusions from the definition are disorders of sexual preference and misuse of alcohol or drugs.

The arguments in favour of a single, broader, definition of mental disorder are powerful. The current definitions, some of which were set in 1959, no longer reflect current clinical diagnoses of the disorders that they represent. Some, such as psychopathic disorder, are stigmatizing. Moreover, to permit the exclusion of some individuals from the definition may be to deny them help and treatment of which they are in need.

On the other hand, the stricter the criteria for admission the greater the protection afforded to the individual against arbitrary detention. The current proposal constitutes an erosion of that protection and requires scrutiny as to its compatibility with the Convention.

The relevant admission criteria for the purposes of Article 5(1)(e) (detention on the grounds of ‘unsound mind’) are as follows:

- (a) The patient must be reliably shown, upon objective medical expertise, to be suffering from a ‘true mental disorder’⁷. A person may not be detained simply because his views or behaviour deviate from the norms prevailing in a particular society⁸;
- (b) The disorder must be of a ‘kind or degree’ warranting compulsory confinement⁹;

The new diagnostic criteria proposed in the Green Paper would cover, for example, a person suffering from a temporary needle-phobia¹⁰. It must be doubted whether all conditions falling within that broad definition could be termed a ‘true mental disorder’ for the purposes of Article 5(1)¹¹. The exceptions provided in relation to disorders of sexual preference and the misuse of alcohol or drugs may not be sufficient to exclude from the operation of the Act all those whose ‘views or behaviour deviate from the norms prevailing in a particular society’. The example of Mrs. S in the case of *R v Collins ex p S*, unlawfully detained under section 2 MHA because of her refusal to undergo a Caesarean, is in point;¹² the new definition would arguably be wide enough to permit her detention¹³.

As to the rejection of the ‘capacity’ test, the Strasbourg cases do not identify capacity, or lack of it, as being relevant in any way in determining the lawfulness of detention under Article 5. It must

7 *Winterwerp v Netherlands* (1979) 2 EHRR 387, §39

8 *ibid*, §37

9 *ibid*, §39

10 As in *Re MB (An Adult: Medical Treatment)* [1997] 2 F.C.R. 541, CA

11 It should be noted however that *Winterwerp* referred back to the definition of mental disorder in municipal law, and did not require a State to specify types of mental disorder.

12 ‘The Act cannot be deployed to achieve the detention of

an individual against her will merely because her thinking process is unusual, even apparently bizarre and irrational, and contrary to the views of the overwhelming majority of the community at large., per Judge LJ at [1999] Fam 26, 51

13 For another example of a person who would be ‘detainable’ under the new criteria see *Re. F (A Child)* (1999) 2 C.C.L. Rep. 445, CA; where the wish of a 17 year old girl leaving care to return to an abusive family home was held not to be ‘seriously irresponsible behavior’ justifying her admission to guardianship.

be the case, however, that the detention of a person who has capacity to consent to his admission to hospital, and who refuses that consent, is a relevant consideration in determining whether he is suffering from a disorder of a 'kind or degree' warranting compulsory confinement.

Turning, then, to the proposals for the criteria for the exercise of compulsory powers. Under the current Mental Health Act the criteria for admission for treatment are threefold: the patient must be suffering from one of the four categories of mental disorder of a nature or degree which makes it appropriate for him to be detained in hospital¹⁴ (the 'appropriateness test'); in the case of mental impairment or psychopathic disorder, any treatment must be likely to alleviate or prevent a deterioration of his condition (the 'treatability test'); and it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment, and it cannot be provided unless he is detained under this section (the 'safety test').

The Government proposes a new test, namely (Chapter 5,§7):

- (a) that the disorder be of 'such seriousness that the patient requires care and treatment under the supervision of specialist mental health services'; and
- (b) that the care and treatment proposed for the mental disorder, and for conditions resulting from it, is the least restrictive alternative available consistent with safe and effective care; and
- (c) that proposed care and treatment cannot be implemented without the use of compulsory powers; and
- (d) such treatment is necessary for the health or safety of the patient and/ or for the protection of others from serious harm and/or for the protection of the patient from serious exploitation.

These proposals differ little from the existing 'appropriateness' and 'safety test' and incorporate, in all but name, the European concept of 'proportionality': the degree of compulsion must be 'proportionate' both to the nature and degree of the disorder and to the level of risk the patient presents. To that extent, the proposals are capable of complying with the requirements of Article 5 as currently interpreted.

Two aspects of the proposals call for greater scrutiny, however.

First, does the removal of the 'treatability' test mean that a patient suffering from (what is now known as) 'psychopathic disorder' or 'mental impairment' may be detained notwithstanding there is no treatment that will 'alleviate or prevent a deterioration' of their condition? This issue is addressed further, below, in relation to the Government's proposals for the detention of persons with 'dangerous severe personality disorders' (DSPDs).

Second, little is said about the Secretary of State's recall power in relation to conditionally discharged restricted patients (currently s. 42(3) Mental Health Act 1983) (Chapter 8, §27 & 34). This power, as currently interpreted, permits recall in the absence of medical evidence of a qualifying mental disorder¹⁵, which has been held to violate the requirement of Article 5(1) that the patient 'be reliably shown, upon objective medical expertise, to be suffering from a true mental disorder'¹⁶. The same issue arises in relation to the detention of patients who may be returned to hospital for failure to comply with Compulsory Community Orders (see below).

14 Similar criteria apply governing a patient's admission into guardianship

15 *R v Home Secretary ex p K* [1991] 1 Q.B. 270

16 *Kay v United Kingdom* (1998) 40 B.M.L.R. 20

(2) The new procedure for Compulsory Detention

The government proposes that Compulsory Orders, whether requiring treatment in hospital or in the community, beyond an initial defined maximum assessment period, can only be made by an independent judicial body (Chapter 4, §24) (the Tribunal). The burden of proof (if the Expert Committee's proposal is adopted) will be on the care team 'to demonstrate that a further period of compulsory care was justified' (§14). Patients will be able to challenge the application, and such challenges will result in an oral hearing.

The removal of the 'reverse burden of proof' in section 72 MHA 1983, long considered a potential violation of Article 5(1) and 5(4)¹⁷, would be welcomed.

The requirement that the initial detention-for-treatment decision be made by a 'court', rather than the detaining authority itself (of course, in the case of those detained under criminal powers that has always been the case), is aimed at ensuring compliance with the requirement in Article 5(4) of a 'speedy' review by a court of the lawfulness of the detention; whether it does so is considered below under "Discharge procedures".

Two aspects of the proposals raise serious Convention issues.

First, where a patient does not contest a Compulsory Order, it is suggested that 'the tribunal decision should be straightforward, a one-person panel should be sufficient and there should usually be no need for an oral hearing' (Chapter 4, §39). Neither is it considered essential for an independent second opinion to be sought (although the Tribunal would have a discretion to obtain one). There is a real danger that the Tribunal would become a 'rubber-stamp', particularly in the absence of an independent second opinion or a medical member on the sitting in the Tribunal. In those circumstances it would be difficult to say that the patient had been 'reliably shown, upon objective medical expertise' to be suffering from a qualifying disorder, in accordance with Article 5(1). This also engages important issues under Article 5(4), considered below under 'Discharge procedures'.

Second, it is suggested that, at the time of detaining a patient, a Tribunal may order that he cannot be discharged without the Tribunal's approval (see Chapter 7, §5 & Consultation Point I). This conflicts with the principle that 'the validity of any continued detention depend[s] upon the persistence of a [qualifying] mental disorder'. Once the RMO has concluded that the patient no longer suffers from a mental disorder justifying detention, the patient should, in the absence of conflicting medical evidence, be discharged. Any detention between that time and a reconvened Tribunal hearing (which might take weeks) would, arguably, be unlawful. Moreover, where the detaining authority seeks to discharge the patient, for the Tribunal to refuse a discharge puts it in the position of gaoler, not guardian, and would arguably be in breach of Article 5(4). This proposal should be reconsidered.

(3) Discharge procedures

The Government proposals contain few details concerning the procedures for the new Tribunal. I propose setting out, first, the requirements of Article 5(4) and then considering their possible consequences for the proposals in the Green Paper.

¹⁷ O. Thorold, 'The Implications of the European Convention on Human Rights for UK Mental Health

Legislation', [1996] EHRLR 619

Article 5(4) provides:

(4) 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.

Relevant requirements of Article 5(4) are as follows:

- (a) The review must be by a 'court' that is 'independent both of the executive and the parties to the case'¹⁸.
- (b) The 'court' must be of a 'judicial character' in the sense of being competent to take a legally binding decision leading to the patient's release. It was the absence of the Tribunal's power to order the patient's discharge without the consent of the Secretary of State that constituted a violation of Article 5(4) in *X v United Kingdom*¹⁹.
- (c) The Tribunal must also have power to mandate the fulfillment of conditions placed upon a patient's discharge, or to amend conditions subsequently so as to avoid an impasse developing²⁰. Arguably, it should also have power to compel the fulfillment of conditions that have an impact upon the patient's future release, such as transfer to conditions of lesser security and leaves of absence. To extend the protection of Article 5(4) to decisions affecting a patient's prospects of future release as well as his immediate release is consonant with the approach taken by domestic courts in relation to the standards of procedural fairness required of such decisions at common law²¹. However, in *R v United Kingdom*²² the European Commission held that the lack of a power to order a patient's leave of absence from hospital did not constitute a violation of Article 5(4). It remains to be seen what the national courts make of the argument.
- (d) The 'judicial character' of the court must extend to the giving of procedural safeguards appropriate to the kind of deprivation of liberty in question. Where a lengthy deprivation of liberty is involved, resembling that which might be imposed by a court in criminal proceedings, the guarantees must be 'not markedly inferior' to those guaranteed by Article 6 in criminal proceedings²³, and in some circumstances must be the same²⁴. This imports the Article 6 concept, among others, of 'equality of arms', which requires that a detained person must have 'a reasonable opportunity of presenting his case to the court under conditions which do not place him at a substantial disadvantage vis-a-vis his opponent'²⁵. Special procedural safeguards may prove called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves²⁶. The specific minimum guarantees that are required include:
 - (i) A right to be heard either in person or, where necessary, through some form of representation²⁷.
 - (ii) The right to legal representation, paid for by the state²⁸. This has been held to extend to the right to be represented by a lawyer of the patient's choice²⁹.

18 *De Wilde, Ooms & Versyp v Belgium* (1971) 1 EHRR 373, §76

19 (1981) 4 E.H.R.R. 188

20 *Johnson v United Kingdom* (1997) 22 EHRR 296, §66

21 see *R v Home Secretary ex p Duggan* [1994] 3 All ER 277, DC per Rose LJ at 288b; *Reg. v. Home Secretary, Ex p. Harry* [1998] 1 W.L.R. 1741, *Lightman J.*

22 Decision of 18 July 1986

23 *De Wilde, Ooms & Versyp, ibid*, §79

24 *Megyeri v Germany* (1992) 15 EHRR 584, §22

25 *Neumeister v. Austria*, 1 E.H.R.R. 91, at para. 22

26 *Winterwerp v. the Netherlands* (1979) 2 EHRR 387, para. 60

27 *ibid*, para 60

28 *Megyeri v Germany* (1992) 15 EHRR 584, §23

29 *Cottenham v United Kingdom* [1999] EHRLR 530

- (iii) The right (as a component of the principle of ‘equality of arms’), in appropriate cases, to independent expert medical opinion³⁰.
- (iv) The right to a ‘speedy’ hearing. The obligation is more onerous in respect of the first review after detention (or recall of a restricted patient³¹) than for subsequent reviews³². For first reviews, a period of 8 weeks between application and final determination has been held to constitute a violation of Article 5(4)³³. Where, however, the delay is caused at the patient’s request, so as to enable the solicitor of his choice to represent him, a delay of 10 months has been found not to constitute a violation of Article 5(4)³⁴.
- (v) Adequate time and facilities to prepare the case. In particular, a time limit should not be placed upon the exercise of the right to apply to a Tribunal which is so short ‘as to restrict the availability and tangibility of the remedy’³⁵.
- (vi) The right to a speedy decision following the hearing.³⁶
- (vii) Right to reasons³⁷ in ‘simple, non-technical language that he can understand’, containing ‘the essential legal and factual grounds for his [detention]’, so the patient may, if he sees fit, ‘apply to a court to challenge its lawfulness in accordance with’ Article 5(4)³⁸.
- (viii) Right to further reviews at regular intervals³⁹.

One overriding considerations must also be borne in mind. The obligation is on the Contracting State to secure for its citizens the rights set out in the Convention. It is therefore the Tribunal’s responsibility to ensure that the specific safeguards referred to are made available to a patient, including to ensure that delays are not caused by, for example, medical experts appointed by the defence⁴⁰. It is not for the patient to take the initiative in securing those safeguards⁴¹; nor is the onus on the patient even to apply for a tribunal in the first place⁴².

Applying these principles to the Government proposals:

Constitution of the Tribunal. Three alternative models are mooted (Chapter 4, §28-30) which are intended to replace the current Tribunal constituted by a lawyer, psychiatrist and lay member. The proposals stem from the justifiable concern that the current role of the psychiatrist as both witness and judge violates the patient’s rights under Article 5(4), which requires that the tribunal be ‘impartial’. The first proposed change will retain the psychiatrist, but he will no longer conduct his own assessment of the patient; instead, the assessment will be carried out by an independent psychiatrist drawn from an approved panel who will then give evidence to the Tribunal. In the second option no psychiatrist will sit on the Tribunal, but the lawyer will be assisted by two people

30 *App. No. 24557/94 Musial v Poland, Decision dated 25 March 1999, ECHR, §46; see also Cottenham v United Kingdom, ibid*

31 *Roux v United Kingdom App. No. 25601/94, 16 September 1997*

32 *Khoendjibiharie v Netherlands (1990) 13 EHRR 820*

33 *E v Norway (1994) 17 EHRR 30*

34 *Cottenham, ibid*

35 *Farmakopoulos v Belgium (1992) Series A, No. 235-A, EComHR*

36 *Van der Leer v Netherlands (1990) 12 EHRR 567, para 35*

37 *Both under Article 5(2) and as a component of Article 5(4): (X v United Kingdom (1981) 4 EHRR 188, §66*

38 *(Fox, Campbell & Hartley v United Kingdom (1991) 13 EHRR 157, §40*

39 *Winterwerp v. the Netherlands (1979) 2 EHRR 387, para. 55*

40 *App. No. 24557/94 Musial v Poland, Decision dated 25 March 1999, ECHR, §46*

41 *See, e.g., Megyeri v Germany, ibid, para 22(d) (obtaining legal representation)*

42 *App. No. 33267/96 Croke v Ireland, Admissibility Decision of 15 June 1999, EcomHR*

with experience of mental health services. Independent psychiatric evidence will again be drawn from an expert panel. In the third option the legal member sits alone.

There must be concern about the appointment of second medical experts from a panel, if as a consequence, a patient's ability to appoint an independent expert is to be prohibited or limited. The principle of equality of arms suggests that a patient should be able to choose his own expert. A panel might be preferable to the existing system of an expert Tribunal member, but the existing system (although it has its drawbacks) could be improved by the following suggestions: (1) At the outset of the hearing, the medical member should be asked to identify those matters which he or she considers significant, thereby giving the patient the opportunity to make representations; and (2) at the end of the hearing the medical member should be asked to raise any matters which have not been dealt with in the course of the proceedings.

The onus is on the patient to choose to contest the care team's application to the Tribunal (Chapter 4, §39). This conflicts directly with the principle that the onus is on the state, not the patient, to ensure the guarantees in Article 5(4) are provided.

Power to mandate discharge conditions. The absence of any power to require local health and social services authorities to fulfill conditions of discharge, or to amend conditions, was a factor in the Court's decision that there had been a violation of Article 5(1) in *Johnson v United Kingdom*, by reason of the applicant's continuing detention for 3 years after an order of deferred conditional discharge. The absence of any such powers continues to cause regular delays in discharge and frequent applications to the High Court⁴³. There are no proposals in the Green Paper which remedy that situation (see Chapter 8, §34).

Power to amend or vary conditions of discharge. Where a Tribunal conditionally discharges a restricted patient, and then defers the patient's release pending suitable conditions being put in place, Tribunals have no power to reconsider the case to amend or remove conditions where they have proved impossible to fulfil⁴⁴. There is no proposal in the Green Paper giving the Tribunal this power. The only option currently is for the Home Secretary to remit the case back to a Tribunal to reconsider the matter afresh, in which case the patient is to be treated as if he had not been discharged at all (section 73(7) Mental Health Act 1983)⁴⁵. This raises profound issues under the Convention and it is strongly arguable that section 73(7) is itself incompatible with Article 5.

Power to mandate leaves of absence and transfers. At present the Tribunal has no power to order leaves of absence or transfer. In the case of unrestricted patients, the decision is taken by the RMO; in restricted cases the Secretary of State must consent. No proposals are made for giving the necessary powers to the Tribunal, notwithstanding (in the case of restricted patients) they already have the greater power of discharge (see Chapter 8, §34). In the light of *R v United Kingdom* (above) it is questionable whether this constitutes a violation of Article 5(4).

Adequate time and facilities to prepare a case. The procedures in the Green Paper are geared disproportionately towards 'speedy' hearings; insufficient regard has been had to the necessary corollary, ensuring effective legal representation and independent expert evidence. One suggestion would be for the Tribunal to grant legal aid for legal representation and, in suitable cases, independent expert evidence at the outset of a patient's detention. Moreover, strict timetables

43 See, e.g., *R v MHRT ex p Hall* [1999] 4 All E.R. 883

45 See *R v Ealing HA ex p Fox* [1993] 1 W.L.R. 373

44 *R v Oxford MHRT ex p Home Secretary* [1988] AC 120

must be laid down and adhered to for the service of the RMO's report and, where appropriate, the Secretary of State's objections, bearing in mind the obligation in Article 5(4) that hearings be 'speedy'. It should be noted, however, that where the Tribunal has given a patient adequate time and facilities to prepare his case by adjourning the proceedings, there is unlikely to be a breach of Article 5(4) if the final hearing does not take place within the usual time limits⁴⁶.

Further comment must await more detailed proposals.

(4) Compulsory Community Orders

The centerpiece of the Government proposals is the Compulsory Community Order (CCO) (Chapter 6, §§4-12). The CCO will place patients subject to similar conditions as restricted patients who are currently subject to conditional discharge. It will impose greater restrictions on the patient's liberty than supervision orders imposed under section 25A Mental Health Act, as there will be a power to impose compulsory treatment in the community (albeit in a 'stipulated place').

A CCO will not usually have Article 5 implications as a patient who is subject to conditions upon his freedom of movement (such as conditions of residence, treatment and the like) is not usually 'deprived of his liberty' for the purposes of Article 5; he is merely subject to restrictions on his liberty of movement⁴⁷. Article 2 of Protocol No. 4, which prohibits unjustifiable restrictions on liberty of movement, has not been incorporated by the Human Rights Act. There will be circumstances, however, where the conditions under a CCO (e.g. the requirement to stay in a 'stipulated place') may be so invasive as to constitute a 'deprivation' of liberty; the question is one of the 'degree or intensity' of the restrictions, rather than their 'nature or substance'.

A CCO will, however, have Article 8 (Right to respect for private and family life) implications, although potentially justifiable under the exception in Article 8(2) in relation to 'health' or the protection of the rights and freedoms of others in all cases other than where it will be a 'disproportionate' response to the patient's condition. It will very much depend on the kind of treatment that is imposed in the community as to whether it will be justified under Article 8(2).

The proposed power to convey a patient to hospital (Chapter 6, §12) will, on the other hand, engage Article 5. As with recalled conditionally discharged patients (see above), the recall must be on the basis of objective medical evidence of a 'true mental disorder', with a right to a speedy tribunal hearing, to satisfy the requirements of Article 5(1) and 5(4), other than in emergency situations.

(5) Compulsory Detention in Criminal Proceedings

The Government proposals for compulsory detention in the criminal justice system differ little from the current Mental Health Act Part III procedures (Green Paper, Chapter 8), save in respect of those considered to suffer from Dangerous Severe Personality Disorder (DSPD), considered later in this article. Two Convention issues do arise, however; one from the existing Mental Health Act, one from the new proposals.

46 *Cottenham v United Kingdom* [1999] EHRLR 530 (delay of 10 months did not violate Article 5(4) where occasioned by the patient's desire to be represented by the lawyer of his choice)

47 *Ashingdane v United Kingdom* (1985) 7 E.H.R.R. 528, at §41; *Johnson v United Kingdom* (1997) 22 EHRR 296, §65; *W v Sweden* (1988) 59 D.R. 158; *L v Sweden* (1986).

First, Section 51 of the Mental Health Act, which permits a Crown Court judge to make a section 37/41 restriction order in respect of a person charged with an offence who is suffering from a mental disorder, without a conviction or a finding that he had 'done the act or made the omission charged' (as required for a finding of Unfitness to Plead or Insanity), where it is 'impracticable or inappropriate to bring the detainee before the court'. There is no appeal against such an order (as an appeal against sentence under section 9 Criminal Appeals Act 1968 requires a person to have been 'convicted'), and there is no power (unlike in the case of a person found unfit to plead) to remit his case back to Court for trial in the event that he recovers. Accordingly, the patient is subject to 'sentence' in criminal proceedings in circumstances where there has been no trial, and where there is no prospect of any such trial in future. Section 51 appears to be incompatible with Article 6.

Second, of some concern is the Green Paper proposal that a criminal court can make an assessment order of up to 3 months, renewable up to 12 months (Chapter 8, §13) - if the proposal is intended to cover unconvicted defendants as well as those convicted. At present a court may only remand an unconvicted defendant to hospital for assessment (s. 35) or treatment (s. 36) for 28 days, renewable for up to 12 weeks. A detention of up to 12 months prior to conviction cannot be justified under Article 5(1)(a) (conviction by a competent court) or Article 5(1)(c) if the offence with which the patient is charged is not one that would justify a remand in custody for such a long period (i.e. most offences). Nor could a detention for such a period for assessment be justified under Article 5(1)(e), which permits detention for only a short 'emergency' assessment period of 28 days before the full criteria for detention have to be satisfied.

(6) Patients transferred from prison

The current arrangements for the transfer of prisoners to hospital are not considered to need 'significant legislative change' (Chapter 8, §36). However, two aspects of the current regime do require scrutiny in the light of Convention principles. They are:

- (i) Treatment of prisoners with mental disorders.
- (ii) Discharge of transferred life prisoners.

Treatment of prisoners with mental disorders. Neither the current, nor the proposed, Mental Health Acts provide any power to treat prisoners with mental disorders without their consent; nor, it follows, are there any statutory safeguards against inappropriate or arbitrary treatment. This is in contrast with the position of patients detained in mental hospitals, who may be treated without their consent provided the safeguards set out in Part IV of the Mental Health Act 1983 are complied with. Those safeguards include the requirement that certain treatment (including any course of medication administered for more than three months) may be given only where a second opinion has been obtained from an independent psychiatrist appointed by the Mental Health Act Commission.

The compulsory treatment of mentally disordered prisoners may be justified at common law under the doctrine of 'necessity', where the prisoner lacks capacity to consent to such treatment which must be in his 'best interests'. This is considered further, below, under 'the right to refuse treatment'. The imposition of such treatment is regulated by Standing Order 25 and Health Care Standards 2.4(f) and 9.4(m), which provide some safeguards (including the requirement of an independent second opinion). However, these guidelines do not have statutory force. Bearing in

mind that any invasive treatment constitutes an interference with an individual's right to private life under Article 8(1), to be justified under Article 8(2) it must be 'in accordance with the law'.

The word 'law' in the expression 'in accordance with the law' covers not only statute but also unwritten law such as the English common law⁴⁸. However, the expression 'prescribed by law' is not limited to the requirement that the measure in question has some basis in 'law', whether statute or common law, but includes the following further requirements: (a) the law in question must be sufficiently accessible: the citizen must be able to have an indication that is adequate in the circumstances of the legal rules applicable to a given case⁴⁹ (the 'accessibility test'); (b) the law in question must be formulated with sufficient precision to enable the citizen to regulate his conduct (the 'foreseeability' test). This element of the test requires the law in question to be compatible with the rule of law so as to include sufficient safeguards to protect the citizen from arbitrary interference with his Convention rights⁵⁰.

It is extremely doubtful whether the common law doctrine of 'necessity', taken together with the guidance contained in the Standing Order and Health Care guidance, complies with the requirement in Article 8(2) that the interference be 'in accordance with the law'. This is particularly so as there is no means by which a patient may challenge the lawfulness of his treatment other than by bringing an action for damages after the event. There is no requirement for the prison authorities to seek prior authorization of a prisoner's compulsory treatment⁵¹, so no judicial consideration is given to whether the prisoner has 'capacity' to consent to treatment and, if he does not, whether such treatment is in his 'best interests'.

In an action for damages a prisoner will face three particular hurdles which further erode the protection against arbitrary interference with his rights. First, it is for the prisoner to prove absence of consent⁵². Second, the duty of care owed by a prison is a lower one than that owed by a hospital⁵³. Third, the defendant will be entitled to rely upon the maxim '*volenti non fit injuria*', explained by Donaldson MR in *Freeman v Home Office*⁵⁴:

"The maxim "*volenti non fit injuria*" can be roughly translated as "You cannot claim damages if you have asked for it," and "it" is something which is and remains a tort. The maxim, where it applies, provides a bar to enforcing a cause of action. It does not negative the cause of action itself. This is a wholly different concept from consent which, in this context, deprives the act of its tortious character. "*Volenti*" would be a defence in the unlikely scenario of a patient being held not to have in fact consented to treatment, but having by his conduct caused the doctor to believe that he had consented."

In those circumstances it appears to the writer that the current legal framework for the compulsory treatment of mentally disordered prisoners does not comply with Article 8. Moreover, the absence of any court hearing prior to the treatment being imposed, and the restrictions on bringing

48 *Sunday Times v United Kingdom* (1979-80) 2 E.H.R.R. 245, at paragraph [47]

49 *Sunday Times case, ibid*, paragraph [49]

50 *Malone v United Kingdom* (1985) 7 E.H.R.R. 1, paragraphs 67-68; *Huvig v France* (1990) 12 E.H.R.R. 528, paragraphs [29] to [35]; *Winterwerp v Netherlands* (1979-80) 2 E.H.R.R. 387, at paragraphs [37] and [39]; *X v UK* (1989) 4 E.H.R.R. 189, at paragraphs [58] to [59]; *Kruslin v France* (1990) 12 EHRR 547

51 CO/1528/99 *R v Managing Medical Officer, HMP Wormwood Scrubs*, 27 April 1999 (leave refused by Jowitt J. for an application to move for judicial review of a decision compulsorily to medicate the applicant without first making a 'best interests' application in the Family Division)

52 *Freeman v Home Office* [1984] 1 All ER 1036, CA

53 *Knight v Home Office* [1990] 3 All E.R. 237

54 [1984] 2 WLR 802

proceedings thereafter, together give rise to a potential violation of the right to a fair trial under Article 6.

A further issue arises in relation to the lawfulness of a failure to transfer a prisoner who requires in-patient treatment on the grounds that there are insufficient hospital beds. Although the point has not yet been considered, it is the writer's view that a failure to transfer to hospital a mentally disordered prisoner who requires in-patient treatment constitutes a potential violation of both Articles 3 and 8 (see further, below, under 'Right to Treatment').

Discharge of transferred life prisoners. The second issue relates to the discharge of life prisoners transferred to psychiatric hospitals under sections 47 and 49 Mental Health Act 1983.

As already seen, Article 5(4) requires regular reviews of the lawfulness of a patient's detention. Not all detentions require such regular review, however: they are only necessary where 'the very nature of the deprivation of liberty under consideration would appear to require a review of lawfulness at reasonable intervals'⁵⁵.

Two concepts that have been considered to be changeable concepts requiring review at reasonable intervals are mental disorder and the risk posed to self and others. Both concepts are necessarily engaged where patients are sectioned under the Mental Health Act. The requirement under Article 5(4) that the lawfulness of detention under the Mental Health Act be regularly reviewed is satisfied by the powers and procedures of the Mental Health Review Tribunal, in particular the power to discharge restricted patients introduced following the decision in *X v United Kingdom*⁵⁶.

Tribunals do not, however, have power to discharge transferred prisoners who are subject to restriction directions, as it is for the Secretary of State to make the final decision as to discharge (see sections 50 and 74). He may permit the patient to be discharged, or may by warrant direct the patient's return to prison⁵⁷. A particular issue arises in relation to transferred discretionary lifers. While they cannot be discharged by a Tribunal⁵⁸, nor are they entitled to be released on life licence by a Discretionary Lifer Panel (DLP) under section 34 Criminal Justice Act 1991 until they are returned to prison (*R v Home Secretary ex p Hickey*⁵⁹).

For a discretionary lifer who has served the 'tariff' period of his sentence, this is potentially a violation of Article 5(4). A discretionary lifer is lawfully detained under Article 5(1)(a) (lawful conviction by a court). In respect of the 'tariff' period of the sentence, the requirements of Article 5(4) are satisfied by the sentencing proceedings before the Criminal Court, so no further review is necessary during that period. Thereafter, however, he is entitled to regular reviews by a 'court' with power to discharge him from detention: *Thynne, Willson & Gunnell v UK*⁶⁰. Prior to *Thynne* the Home Secretary retained the power to veto the release of a discretionary lifer; since then, in order to comply with the UK's Convention obligations, section 34 Criminal Justice Act 1991 was introduced to confer the necessary power on the DLP.

55 *Winterwerp v. the Netherlands* (1979) 2 EHRR 387, para. 55

56 See footnote 16 (*supra*)

57 *The Secretary of State does have a policy of designating certain transferred prisoners as 'technical lifers', by which he effectively promises not to remit the patient back to prison in the event of a recommendation for discharge by the Tribunal: R v Home Secretary ex p Pilditch* [1994] COD 352. This does not, however, include discretionary lifers who have served the tariff

component of their sentences.

58 Except those patients who are designated by the Home Secretary as 'Technical Lifers' (whereby the Home Secretary undertakes to abide by a Tribunal's decision on discharge)

59 [1995] QB 43, CA.

60 (1990) 13 EHRR 666. The same principle applies to youths sentenced to Custody for Life and at HM Pleasure: *Hussain v United Kingdom* (1996) 22 EHRR 1; *T & V v United Kingdom App. No. 24724/94*

Once transferred to hospital, a discretionary lifer is lawfully detained under both Article 5(1)(a) and 5(1)(e). When his tariff expires Article 5(4) entitles him to a review by a ‘court’ with power to discharge him from detention under both 5(1)(a) (namely, a DLP); in any event, he is entitled to a review by a Tribunal to discharge him from his detention under 5(1)(e). As matters currently stand, such an individual gets neither.

The European Commission has declared admissible an application complaining of a violation of Article 5(4) in precisely these circumstances; the case has yet to be heard on its merits⁶¹.

For mandatory lifers, those convicted of murder, Article 5(4) is satisfied by the initial sentencing process by the criminal court; no further review is necessary so the same anomaly does not arise⁶².

(7) Dangerous People with Severe Personality Disorders

The Green Paper confirms the Government’s proposals for this category of patient, originally set out in their July 1999 consultation paper ‘Managing Dangerous People with Severe Personality Disorder: Proposals for Policy Development’ (the DPSD Paper).

The Government proposes to remove the so-called ‘treatability’ requirement in relation to patients falling within the category of ‘psychopathic disorder’, permitting the indefinite detention – and, where released, power of recall - of such individuals solely on the ground of their dangerousness. The proposals are intended to apply both in criminal proceedings and in civil proceedings. Such individuals would not be detained in either a prison or a hospital, but in custom-built detention centers.

The Government defines a person with DPSD as having an ‘identifiable personality disorder to a severe degree, who pose a high risk to other people because of serious anti-social behaviour resulting from their disorder’ (DPSD Paper, Part 2 Para 1). It is estimated that in the United Kingdom between 300 and 600 men, and no more than 18-20 women, fall within this category.

In determining the compatibility of these proposals with the Convention, a distinction should be drawn between offender and non-offender patients. In relation to offenders, it is lawful to detain those who have committed serious criminal offences by way of life sentences, and to recall them after release on licence⁶³, under Article 5(1)(a). It may also be lawful to impose an indefinite sentence, with a power of recall, upon recidivist offenders under Article 5(1)(a)⁶⁴. In both cases, Article 5(4) requires adequate judicial scrutiny of the continued detention and of any recall⁶⁵. It is also lawful to detain a person under Article 5(1)(e) as a ‘vagrant’ without any reciprocal right to treatment⁶⁶. There is plainly no need for the individual to receive treatment for detention to be lawful under Article 5(1)(a).

However, where the justification for the person’s detention is that they are of ‘unsound mind’, the issue of treatability becomes very live indeed. There is conflicting authority as to whether a patient must be ‘treatable’ to be lawfully detained under Article 5(1)(e).

The Strasbourg Court has expressed the view in the past that no ‘right to treatment’ can be derived from the fact of a person’s detention under Article 5(1)(e) on the grounds he is of ‘unsound mind’.

61 *App. No. 28212/95 Benjamin & Wilson v United Kingdom*, Admissibility decision 27 October 1997

62 *Wynne v United Kingdom* (1995) 19 EHRR 333, ECHR

63 *Weeks v United Kingdom* (1987) 10 EHRR 293, ECHR

64 *Van Droogenbroeck v Netherlands* (1982) 4 EHRR 443

65 *Weeks*, *ibid*

66 *De Wilde, Ooms & Versyp v Belgium* (1971) 1 EHRR 373

In *Winterwerp v Netherlands* the Court stated that ‘a mental patient’s right to treatment appropriate to his condition cannot as such be derived from Article 5(1)(e)’⁶⁷. All that Article 5(1)(e) requires is that the detention is effected in a ‘hospital, clinic or other appropriate institution’⁶⁸. Detention without treatment may raise issues under Article 3⁶⁹, but treatment is not a necessary ingredient for a lawful detention under Article 5(1)(e).

The House of Lords has, however, reached a different conclusion. In the recent case of *Reid v Secretary of State for Scotland*⁷⁰, the House of Lords held that, in order for domestic law to comply with Article 5(1)(e), the ‘treatability’ criterion had to be considered by a Sheriff on an application by a patient for his discharge from hospital. Accordingly, if a patient is ‘untreatable’ then he must be discharged. Lord Clyde said:

“It was pointed out that the European Court did not specify the treatability of the patient as a condition to be examined by the court. But the court was concerned with the procedures rather than the grounds for discharge and it is not to be concluded from what the court said that in the present case the susceptibility of treatment may not be a proper criterion in determining discharge.”

The question is likely soon to arise before the Privy Council. In *Anderson, Doherty & Reid v Scottish Ministers*⁷¹, the Scottish Court of Session rejected arguments that section 1 Mental Health (Public Safety and Appeals) (Scotland) Act 1999 violated the Appellants rights under Articles 5(1) and 5(4). By section 1 of that Act a Sheriff must refuse to discharge a restricted patient suffering from a mental disorder ‘the effect of which is such that it is necessary, in order to protect the public from serious harm, that the patient continue to be detained in a hospital, whether for medical treatment or not’. The Court of Session ruled that for a detention to be lawful under Article 5(1)(e) it was necessary only for the patient to be detained in a hospital or other appropriate institution; it did not require that the patient should actually be treated. This case is currently on appeal to the Privy Council.

The question therefore awaits a conclusive determination. In this writer’s opinion, however, it must be that any patient, whether one who has committed a criminal offence or not, has a right to receive treatment that is reciprocal to his detention on the grounds that he is of ‘unsound mind’, and any such detention will be unlawful unless it is for the purpose of administering such treatment. An exception may be justified where the person is truly ‘untreatable’.

The argument is easier to put in relation to those who have not committed an offence. The following points may be made.

Without a requirement that a mental disorder (particularly a personality disorder) is ‘treatable’ to justify detention, there is a danger that patients will be detained on the grounds only that their ‘views or behaviour deviate from the norms prevailing in a particular society’⁷², contrary to Article 5(1)(e). This was acknowledged by the Percy Commission in its 1957 Report⁷³, at §338:

“If one concentrates on the patient’s behaviour rather than on the mental condition which lies behind it, one comes very close to making certain forms of behaviour in themselves grounds for segregation from society, which almost amounts to the creation of new criminal offences.”

67 *Winterwerp v. the Netherlands* (1979) 2 EHRR 387, para. 51; see also *Ashingdane v United Kingdom* (1985) 7 E.H.R.R. 528, §44

68 *Aerts v Belgium* (2000) 29 E.H.R.R. 50

69 *B v United Kingdom* (1984) 6 EHRR 204

70 [1999] 2 WLR 28

71 *Times*, 21 June 2000

72 *Winterwerp*, *ibid.*, §37

73 *Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency* (‘Percy Commission’), HMSO, 1957, Cmnd 169

It should be noted that the importance placed by the Percy Commission upon the requirement of 'treatability' led to proposals that personality disordered ('psychopathic') patients who were over 21 *could not be detained at all*, as by then the prospects of their benefiting from treatment were considered to be too small to justify detaining them. That recommendation was incorporated into the 1959 Mental Health Act and was not removed until the Mental Health (Amendment) Act 1982. The current proposals demonstrate a radical departure from the liberal philosophy that underpinned the 1959 reforms.

Furthermore, it is arguable that an untreatable personality disorder is insufficient to constitute, on 'objective medical expertise', a 'true mental disorder ... of a kind or degree warranting compulsory detention', as required by Article 5(1)(e)⁷⁴, bearing in mind:

- (a) Between 10-13% of the population are considered to suffer from a personality disorder;
- (b) The condition is notoriously difficult to define; it is not known what causes it, how it is to be measured, what interventions are effective and how to measure the consequences of intervention⁷⁵.
- (c) The proposals require psychiatrists (and psychologists) to assess the risk of offending in the future. Quite apart from the question of whether it is proper to use the medical profession to justify that which would not otherwise be justifiable, there must be grave concern as to the reliability of any assessment of dangerousness where a patient has not been proved to have committed any offence.

This leads to a further, more disturbing question. What of an individual who is tried, and acquitted, of a serious offence? Can he then be detained indefinitely as suffering from DSPD on evidence that a criminal court has decided is insufficient to convict him of a criminal offence? If so, the fundamental premise of the criminal justice system that a person is innocent until proved guilty (expressly preserved by Article 6(2) of the Convention) is undermined.

These points are all relevant to an assessment of whether indefinite detention is a proportionate response in any case other than where a serious criminal offence has been committed or where the individual is a serious recidivist. It may be, in practice (given that only 300-600 individuals are considered to fall within the DSPD category) that these new powers will not, in practice, be exercised so as to lead to violations of Article 5(1)(a) or (e). But the existing powers of the Criminal Courts to impose life sentences are already sufficient, it is submitted, to deal with those individuals.

(8) The right to treatment

The Expert Committee recommended that a new Mental Health Act should create a positive right to treatment, flowing from the principle of reciprocity⁷⁶, one of the guiding principles the Committee considered should be enshrined in the new legislation (Expert Committee Report, §§2.21, 3.2). The Government has not accepted those proposals. The principle of reciprocity is not to be included in the Act itself (The Green Paper, Chapter 3, §5) and no mention is made of a 'right

⁷⁴ *This is a different question from that faced by the House of Lords in Reid v Scotland [1999] 2 WLR 28*

⁷⁵ *Evidence of Dr. Reed to the Fallon Enquiry Report, Cm 4194-II, §6.1.75*

⁷⁶ *The principle of reciprocity: 'Where society imposes on an individual to comply with a programme of treatment and care it should impose a parallel obligation on the health and social care authorities to provide appropriate services, including ongoing care following discharge from compulsion.'*

to treatment'. However, the Government does intend to impose duties upon health and local authorities to provide health care and social care, including residential care, to people who are subject to an order providing for compulsory care and treatment (The Green Paper, Chapter 7, §11). It remains to be seen what form those duties take in the final legislation.

Does the Convention guarantee a right to treatment that is reciprocal upon the patient being subject to compulsory powers? There are two very distinct questions in issue here. The first is whether it is lawful to detain a person under Article 5(1)(e) on the grounds that he is of unsound mind without treating his mental disorder, discussed above in relation to patients with DSPD. If it is right that no detention is lawful under Article 5(1)(e) without treatment, then clearly the Convention creates a reciprocal right to treatment. If that is not the case, the second question engages, namely whether such a right to treatment can be derived from any other Convention Articles.

There is no generally recognized right to treatment in the European Convention, nor in any of the other international human rights instruments⁷⁷. The Court has recognized, however, that, in limited circumstances, there is a positive obligation on the state to provide treatment. For example, the removal of life-saving treatment may violate a patient's rights under Articles 2 (right to life) and 3 (right not to be subjected to torture or to inhuman or degrading treatment)⁷⁸. Articles 2 and 3 impose a positive obligation to provide life-saving treatment in circumstances where the State has knowledge of the individual's circumstances and it would be reasonable for it to provide such treatment⁷⁹. A particular duty to provide treatment has been found to exist in relation to detained persons⁸⁰. Moreover, the detention of a patient in hospital without any treatment for that disorder was held potentially to give rise to a violation of Article 3 by the Commission in *B v United Kingdom*⁸¹.

The positive rights created by Articles 2 and 3 are similar to the right to emergency treatment conferred by the South African Constitution, which does not guarantee a right to longer-term treatment, even where that is life-saving⁸². The question whether absence of resources will justify refusing life-saving treatment has yet to be considered by the Strasbourg Court⁸³, but a distinction might be drawn between emergency treatment and longer-term life-saving treatment, such as arose in *R v Cambridge HA ex p B*⁸⁴, particularly where resources are limited. The issue is a difficult one as neither Article 2 or 3 permit of any exceptions, by contrast with, for example, Articles 5 and 8.

A failure or refusal to provide any treatment that is unjustifiably discriminatory will be unlawful, either under Article 14 (prohibition on discrimination) or the Disability Discrimination Act 1995⁸⁵. So far as Article 14 is concerned it should be noted that the right is not a stand-alone

77 Lawrence Gostin and Jonathon Mann 'Health & Human Rights', Routledge, 1999, p. 54... the human rights community has rarely written or litigated in the area of public health. Even so fundamental a human rights concept as the right to health has not been operationally defined, and no organized body of jurisprudence exists to describe the parameters of that right.'

78 *D v United Kingdom* (1997) 24 EHRR 423

79 *Keenan v UK*, App. 27229/95, ECSSnHR Report 6 September 1999; *Hughes v UK* (1986) 48 DR 258, ECSSnHR

80 *Cyprus v Turkey* 4 EHRR 482, ECSSnHR Report 10 July 1976

81 (1984) 6 EHRR 204

82 *Soobramoney v Minister of Health, KwaZulu-Natal* (1997) 50 BMLR 224

83 [1995] 1 WLR 898

84 [1995] 1 W.L.R. 898 (judicial review refused of a Health Authority's refusal to provide expensive treatment that had little prospect of saving the applicant's life)

85 Note the approach of the Supreme Court of Canada in *Eldridge v A-G of British Columbia* (1997) 3 BHRC 137 (failure to fund sign-language violated deaf persons' right to equal treatment)

prohibition on discrimination. It may only be relied upon in conjunction with another Convention right. This may be contrasted with the new Protocol 12 to the Convention which the UK Government is yet to sign.

Article 8 also imposes positive obligations, which might include (in appropriate circumstances) an obligation to provide treatment to a patient where otherwise his right to private and family life will be interfered with in a disproportionate manner. One example would be a person suffering a debilitating long-term condition that can be alleviated by treatment. Another example is a patient detained in hospital, most obviously in High or Medium Security, for years on end without appropriate treatment being given. Those patients will often spend years longer in hospital than they would had they received the treatment they required at an earlier stage. Although it might not be open to allege a violation of Article 5(1)(e) in relation to those ‘extra years’ in detention, a failure to treat in those circumstances could well amount to a violation of Article 8 and (in the most extreme cases) Article 3.

In summary, it is strongly arguable that a limited right to treatment reciprocal upon a patient’s detention on the grounds of mental disorder can be derived from Articles 3 and 8. It should be noted that recommendation no. R(83)2 concerning the legal protection of persons suffering from mental disorder placed as involuntary patients, which was adopted by the Committee of Ministers on 22nd February 1983 under Article 15(b) of the Statute of the Council of Europe, recommends that patients detained involuntarily in hospital have the right to receive appropriate treatment and care. This recommendation is now the subject of consultation by the Council of Europe in their White Paper on Human Rights and Mental Health dated 3rd January 2000.

(9) The right to refuse treatment

Both common law and the Convention provide some protection, at present, for patients who do not wish to submit to treatment that their clinician considers necessary. The proposals in the Green Paper will permit compulsory medication of detained patients (similar to the existing powers under Part IV Mental Health Act 1983) and of those subject to compulsory community orders, although in the case of the latter such treatment may only be administered in a ‘stipulated place’ (Green Paper, Chapter 6, §9), or in hospital. The Expert Committee’s proposal that compulsory treatment be capacity-based – giving those detained patients who have capacity greater rights to refuse treatment - was rejected. For those not subject to a compulsory order, the lawfulness of the patient’s treatment will continue to be determined by the common law, at least until the Government’s proposed incapacity legislation (which is separate from the proposed mental health legislation) has been introduced⁸⁶.

The questions arise, here, as to whether the existing common law ‘power’ of treatment, and the proposed statutory powers of treatment, are compatible with the Convention.

Common law. At common law the individual’s right to integrity of the person and to self-determination are fundamental human rights⁸⁷. The right of a *capacitated* individual to refuse consent to treatment⁸⁸ and nutrition⁸⁹ are well established. As a matter of convention law, a state

86 In the Green Paper ‘Who Decides?’ Cm 3803, December 1997, the Government broadly endorses the Law Commission’s proposed Incapacity Bill published with its 1995 report ‘Mental Incapacity’, Law Com 231.

87 *Airedale NHS Trust v Bland* [1993] A.C. 1, per Lord Goff at 864

88 *Re. T (Adult: Refusal of Medical Treatment)* [1993] Fam. 95

89 *Robb v Secretary of State for the Home Department* [1995] 2 W.L.R. 722

will not violate Article 2 by respecting decisions of capacitated individuals to refuse treatment and nutrition, even where it leads to the individual's death. The capacitated individual's rights under Article 3 and Article 8, which (partly) reflect the common law rights of integrity of the person and self-determination, should prevail⁹⁰.

The situation differs where the patient lacks capacity to make such decisions⁹¹. At common law the doctrine of necessity justifies action that would otherwise constitute an assault which is taken in the 'best interests' of an incapacitated individual⁹². However, in cases where 'there remains a serious doubt about the patient's competence, and the seriousness or complexity of the issues', doctors are required to seek guidance by way of a 'best interests' declaration from the High Court, Family Division before carrying out the proposed treatment.

Lack of capacity will also justify unwanted treatment under both Article 3 and Article 8 of the Convention, provided that treatment is considered necessary by the patient's doctors. In *Hercegalvy v Austria*⁹³ the patient had been forcibly administered food and narcoleptics, isolated and attached with handcuffs to a security bed for some weeks, following a number of violent episodes and consistent refusals of medical treatment and nutrition. The Court, while emphasising the need for 'increased vigilance' in relation to psychiatric patients, given the 'inferiority and powerlessness' of their situation, noted that it was for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic method to be used, if necessary by force, to preserve the physical and mental health of incapacitated patients. In the circumstances there was no violation of Article 3.

Lack of capacity is not essential, however, for unwanted treatment to be justified. In *Grare v France*⁹⁴ the Commission held that the administering of drugs with unpleasant side-effects was insufficient to constitute a violation of Article 3; moreover, although the treatment constituted an interference with the applicant's right to private life under Article 8(1), it was justified by the need to preserve public order and the protection of the applicant's health under Article 8(2). The applicant's capacity, or lack of it, did not form part of the Commission's reasoning.

As seen above in relation to the treatment of prisoners (and below in relation to children), to be justified under Article 8(2) such treatment must be 'in accordance with the law'. Put shortly, unless the treatment has either (a) been administered under statutory powers or (b) has been authorized in advance by the High Court by way of a 'best interests' declaration, it is arguable that it will contravene Article 8 as not being 'in accordance with the law'. Where the treatment has been so authorized, it will be compatible with Article 8⁹⁵.

90 Harris, O'Boyle and Warbrick, 'Law of the European Convention on Human Rights', 1995, p. 40. Note, however, in *X v Germany* (1984) 7 EHRR 152, the Commission found that the force-feeding of a prisoner on hunger strike did not violate Article 3, referring to the state's obligation to preserve life under Article 2; the question of the patient's capacity did not enter the equation. It is questionable whether this decision would now be followed (Harris, O'Boyle and Warbrick, *ibid*, p. 40, n.18)

91 A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent or to refuse a proposed interference with their rights or liberties (invariably, some form of treatment). That inability will

occur when (a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question; (b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision: *Re. MB (An Adult: Medical Treatment)* [1997] 2 F.C.R. 541, CA, at 553H-554B per Butler-Sloss LJ

92 *Re. F* [1990] 1 A.C. 1

93 (1992) 15 EHRR 437, at §83.

94 (1992) 15 EHRR CD 100

95 See *Re. F (Adult Patient)*, (Unreported) 26 June 2000, CA, per Sedley LJ

Statute. The Government's rejection of a capacity-based test for the exercise of compulsory statutory powers of treatment is unlikely to fall foul of Articles 3 and 8 of the Convention. A question does arise, however, as to the compatibility of such treatment with Article 6 of the Convention. The right to integrity of the person and to self-determination are clearly 'civil rights' under Article 6, and compulsory treatment is an interference with that right. Whether it is a lawful interference is a question upon which the individual should be entitled to a determination by a court, under Article 6. There is no statutory right of appeal from an RMO's decision to treat a patient. An application for a 'best interests' declaration will be inappropriate, bearing in mind that statutory powers are involved. The only option is to judicially review the treatment decision, but on such an application the Court cannot consider the case on its merits. This issue is currently being considered by the Court of Appeal⁹⁶ where the Article 6 implications will be fully explored.

(I0) The right to after-care

Health and local authorities will be required to provide services for patients needing aftercare following discharge from a compulsory order (Green Paper Chapter 7, §11). This duty will replicate the existing section 117 duty, which goes much further than the Convention in guaranteeing discharged patients the right to free health care, social services and accommodation. The right to treatment has been considered. It is relevant, however, briefly to consider the limited extent to which the Convention operates to safeguard the right to accommodation and other community care services.

In one of its earliest decisions the ECHR ruled that Article 8 does not confer upon an individual the right to be housed⁹⁷. The more recent case of *Burton v United Kingdom*⁹⁸, suggests that Article 8 may, in appropriate circumstances, impose a positive obligation upon the State to provide accommodation, although that cannot extend to a 'positive obligation to provide alternative accommodation of an applicant's choosing'. A similar proposition was accepted by the European Court in *Marzari v Italy*.⁹⁹

Burton and *Marzari* do open the way, however, to a successful challenge to a local authority's refusal to provide basic accommodation to a homeless individual or family. It is as likely as not that such a refusal, to contravene Article 8, would be unlawful as a matter of domestic administrative law in any event, bearing in mind the wide range of circumstances in which local authorities are bound by existing statutes to provide suitable accommodation¹⁰⁰.

The most likely scenario where a local authority will come under a positive obligation to provide accommodation is where the applicant is in need of housing by reason of age, disability or ill health, and a failure to provide accommodation will violate their rights under Articles 2 or 3. In *D v UK*¹⁰¹ the UK was found to have violated Article 3 by its decision to deport the Applicant,

96 CO/967/2000 *R v Broadmoor Hospital ex p W*. The applicant is seeking to overturn the Judge's ruling in *R v Collins and Ashworth Hospital Authority ex parte Brady* (2000) (reviewed elsewhere in this issue of the JMHL) that the question of whether the treatment is "treatment for the mental disorder from which he is suffering" is not a question of precedent fact. If a question is one of precedent fact, a court in judicial review proceedings decides the question on its merits rather than by applying the *Wednesbury* test.

97 *X v Germany* (1956) 1 Yearbook 202

98 (1995) 22 EHRR CD 135

99 [1999] 28 EHRR CD 175

100 The domestic courts have come close to recognising a common law right to basic shelter, *R v Lincolnshire CC Ex p Atkinson* (1996) 8 Admin. L.R. 529. See also *R v Wandsworth LBC ex p O Times*, 18 July 2000

101 (1997) 24 EHRR 423

who suffered from AIDS, to St. Kitts where by virtue of there being inadequate medical facilities for his condition he would inevitably die sooner, and with greater suffering, than if he remained in the UK. Similarly, a local authority will be obliged to offer accommodation to such an individual if a failure to do so will hasten their death, a proposition that found favour with Moses J in 1997 when overturning a local authority decision refusing to provide accommodation under s. 21 NAA to a terminally ill overstayer in *R v Brent LBC ex p D*¹⁰².

Article 8 primarily protects a person's right not to be subjected to unjustified interference with their right to a 'home' and 'private life', and will have greatest relevance where local authority decision-making impacts upon a person's enjoyment of an existing home. This issue is most likely to arise in a mental health context where it is proposed to remove long-stay patients from residential care homes.

A decision to remove a person from their home may engage Article 8 even where the person is not permitted, as a matter of domestic law, to inhabit the property. In *Wiggins v UK*¹⁰³ the applicant owned a house but had no legal permission to occupy it; nevertheless the Commission found that it was his 'home' for the purpose of Article 8. Similarly, in *Buckley v United Kingdom*¹⁰⁴ the ECHR held that the absence of planning permission did not disqualify the applicant's caravan from being a 'home' for the purpose of Article 8. A more restrictive approach was taken in *S v UK*¹⁰⁵, where the Commission held that the applicant's right to occupy her home ended when her lesbian partner, in whose name the lease was held, had died; accordingly, Article 8 was not engaged¹⁰⁶.

Where a person's dwelling does qualify as a 'home' for the purpose of Article 8, local authorities will find domestic courts ready to strike down unjustifiable decisions to remove them from their homes. In the community care context, in *R v North & East Devon HA ex p Coughlan*¹⁰⁷, the Court of Appeal found that the local health and social services authorities' decision to close Mardon House, (Mrs. Coughlan's home for 6 years and, it had been promised to her, her home for the rest of her life), violated her right to a home under Article 8, notwithstanding alternative residential accommodation was to be provided elsewhere.

Coughlan provides a template for the application of Article 8 in challenging local authorities' decisions as to how social services needs are met. Whenever a person is assessed as being in need of community care services, Article 8 may be invoked so as to compel the local authority to provide those services in the person's home, rather than by the more cost-effective measure of removing them to a residential care home. Where the decision is taken to remove the person from their home, it will therefore need to be judged by the criteria in Article 8(2) if it is to be justified.

102 (1999) 31 H.L.R. 10

103 (1978) 13 DR 40

104 (1996) 23 EHRR 101

105 (1986) 47 DR 274

106 *Same-sex partners now have right of succession to a statutory or protected tenancy: Fitzpatrick v Sterling Housing Association* [1999] 3 W.L.R. 1113, HL

107 [1999] Lloyd's Rep. Med. 306

(II) Children and Incapacitated adults (the Bournewood case)

The Green Paper states that the Government has not yet come to a conclusion on the precise nature of any new arrangements to provide safeguards for long-term incapacitated patients not requiring formal detention under the Mental Health Act (Green Paper, Chapter 11, §7). The so-called ‘Bournewood gap’¹⁰⁸ - the absence of statutory safeguards for ‘informal patients’ - therefore remains unfilled.

The *Bournewood* case has been taken on appeal to Strasbourg, alleging violations of the applicant’s rights under Articles 3, 5(1), 5(4), 8 and 14. The violations under Articles 5 and 8 are founded on the argument that the common law doctrine of ‘necessity’ does not satisfy the requirement under Article 5(1) that a detention be ‘lawful’ and under Article 8(2) that any interference with the right to private life be ‘in accordance with a procedure prescribed by law’, primarily because of the absence of any safeguards against inappropriate or arbitrary detention and treatment of such patients. The government’s proposals to introduce safeguards is a recognition of the fact that the informal admission to hospital of incapacitated individuals is a violation of their Convention rights, but we must await the Strasbourg court’s conclusions.

There remains, however, a similar ‘gap’ in relation to the informal admission to hospital, and treatment, of children. A child under 18 cannot refuse to consent to treatment if their parent or guardian (in the case of a child in care, the local authority) consents to such treatment on their behalf, even if they have capacity to do so (known as ‘Gillick’ competence¹⁰⁹). Such a child only has the right to consent to treatment in the face of a parental refusal of that treatment. ‘Treatment’ in the present context would include informal admission to hospital: see *R v Kirklees MBC ex p C*¹¹⁰ and §31.6 Mental Health Act 1983 Code of Practice (1999).

Although section 25 Children Act 1989 prohibits the detention of a child (including by way of an ‘informal’ admission) without certain statutory safeguards being observed, it is limited to detention in ‘secure accommodation’. Not all hospitals or other places where a child is ‘deprived of his liberty’ (for the purposes of Article 5(1)) amount to ‘secure accommodation’. In *Re C (Detention: Medical Treatment)*¹¹¹, Wall J. held that a psychiatric unit for the treatment of eating disorders did not constitute ‘secure accommodation’. Notwithstanding, however, he ruled that equivalent safeguards to those in Section 25 should be incorporated into the order of the Court.

There is little danger of a child being inappropriately or arbitrarily detained in non-secure accommodation where an application has first been made to a judge of the Family Division to authorise that detention. However, there is no obligation on the parent or guardian to make such an application. In the writer’s opinion, there is a very real possibility that an informal detention in hospital of a Gillick-competent child, with his parent or guardian’s consent but against his will, constitutes a violation of Article 5(1)(e) as such a detention will not be ‘lawful’.

108 Following the decision of the House of Lords in *R v Bournewood Community Mental Health NHS Trust ex p L* [1999] 1 A.C. 458

110 [1993] 2 FLR 187

111 [1997] 2 F.L.R. 180

109 *Gillick v West Norfolk and Wisbech Area Health Authority and the DHSS* [1986] 1 A.C. 112

112 (1988) 11 EHRR 175

This argument is undermined, however, by the Strasbourg Court's decision in *Nielsen v Denmark*¹¹², in which the ECHR took a surprisingly paternalistic approach in relation to the detention of children with their parents' consent. The applicant had been admitted to a psychiatric hospital with his mother's consent rather than under the Danish equivalent of the Mental Health Act, but against his and his father's wishes. The ECHR, by a bare majority, concluded that the mother's parental rights, which were safeguarded by Article 8, were paramount, to the extent that considerations under Article 5 were not engaged at all. The decision has been heavily criticised and it is very possible that a different conclusion would now be reached, particularly in the light of *A v United Kingdom*¹¹³, where the Court did not consider that a parent had any right to chastise their child by virtue of Article 8.

It is therefore strongly arguable that such an 'informal' detention would be a violation of both Article 5(1) and Article 5(4) by reason of the absence of adequate safeguards against arbitrary detention – particularly the right to review of the lawfulness of detention by a tribunal. By the same reasoning, any sufficiently invasive treatment administered to a child with his parent or guardian's consent, but against his wishes, may violate his rights under Article 8.

113 (1999) 27 EHRR 611. Moreover, *Nielsen* did not consider the Convention on the Rights of the Child, which was ratified by the United Kingdom in 1991,

article 12 of which requires that decisions concerning the child should take into account the views of the child. The present situation constitutes a violation of that principle.