

Mental Health and Compulsion

*Margaret Pedler**

This article looks at the role of compulsion in mental health law as it applies to civil patients. It starts by setting out the existing position and the Government's proposals for reform as set out in the current Green Paper "Reform of the Mental Health Act 1983"¹. It goes on to consider principles which might be relevant to this area of law and the application of these to the Government proposals. Finally, it looks at the relevance of the European Convention on Human Rights.

The existing position

Compulsion lies at the heart of the Mental Health Act 1983 which provides both for compulsory detention and compulsory treatment. Key powers under existing law are:

1. A non-renewable power (under section 2) to detain a person in hospital for assessment for up to 28 days on the grounds that they are suffering from a mental disorder which warrants such detention in the interests of their own health or safety or with a view to the protection of other persons.
2. A renewable power (under section 3) to detain a person in hospital for treatment for up to 6 months initially on the grounds that they are suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment which warrants such detention in the interests of their own health or safety or the protection of other persons and treatment (which in the case of psychopathic disorder or mental impairment is likely to alleviate or prevent a deterioration of his condition) cannot be provided unless they are so detained.
3. A power (under sections 7 and 8) to admit a person to guardianship on the grounds that they suffer from mental illness, severe mental impairment, psychopathic disorder or mental impairment which warrants such admission in the interests of the person's welfare or for the protection of other persons. Once admitted to guardianship a person can be required to:
 - a) live at a specified place;
 - b) attend at specified places for the purposes of medical treatment, occupation, education or training;
 - c) provide access to medical practitioners, social workers and other specified persons.

* *Head of Policy Development, MIND*

¹ *Reform of the Mental Health Act 1983 - Proposals for consultation (1999) HMSO, London.*

4. A power (under section 25A) to make a person previously liable to detention under section 3 subject to supervised discharge on the grounds that they suffer from mental illness, severe mental impairment, psychopathic disorder or mental impairment and there would be substantial risk of serious harm to the health or safety of the patient or the safety of other persons or of the patient being seriously exploited if they were not to receive section 117 aftercare services whose receipt will be facilitated by use of this power. Once a person is subject to supervised discharge requirements can be imposed on them identical to those available under guardianship and in addition there is a power to take and convey them to the place they are required to live or attend for other specified purposes.
5. Once a person has been detained they can be subjected to compulsory treatment under Part 1V of the Act. This allows treatment for mental disorder [recently controversially expanded] to be given without consent except for certain specified treatments which are subject to additional safeguards. These are ECT and drug treatment lasting more than three months which require either consent or the support of a second opinion from a doctor appointed by the Mental Health Act Commission and psychosurgery and surgical implantation of hormones which requires both consent and a second opinion.
6. Various powers also exist to allow compulsory detention and treatment of those appearing before the criminal courts. These account for about 10% of formal admissions and are not dealt with in this article.

Proposals for reform

In July 1998 the then Secretary of State for Health - Frank Dobson - announced that he was appointing a group of experts, to be chaired by Professor Genevra Richardson, to carry out a review of the Mental Health Act 1983. The stated aim of this review was “to ensure that mental health legislation supports the safe and effective delivery of modern patterns of clinical and social care for people with a mental disorder and to ensure that we achieve a proper balance between individual rights and the requirements of the safety both of the individual and the wider community. The Government wanted “a legal basis to ensure individuals get supervised care if they fail to comply with their medication or if their condition deteriorates for any other reason”. This thinking was expanded on by the then relevant Minister Paul Boateng in his speech to the first meeting of the review team. He described the 1983 Act as reflecting a bygone age in which treatment for mental illness was largely hospital based. He said that community care had failed and needed to be replaced by a system which:

- a) made the full range of high quality interventions available to provide proper positive support to those living within the community;
- b) placed a responsibility on individual patients to comply with their programme of care. “Non-compliance”, he said, “can no longer be an option when appropriate care in an appropriate setting is in place”.

The Government received the report of their review team in July 1999² and in November published in a Green Paper their own outline proposals. In relation to compulsion these are as follows:

1. The Act should apply to all those with a “mental disorder” to be defined broadly as “any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning”. This would be broad enough to include not only mental illnesses such as schizophrenia but also learning disability, personality disorder, epilepsy, Parkinson’s disease or even temporary effects resulting from alcohol or drugs.
2. There should be a single point of entry for all patients (apart from those who enter from the criminal justice system) who are to be subject to compulsory care and treatment. This would be via a formal structured assessment, lasting for up to 28 days, which could take place either in the community or in hospital. Worryingly, the Green Paper gives no indication of the criteria which would have to be satisfied in order to justify the use of compulsory assessment powers. I have heard it suggested informally by Department of Health officials that the criteria will be the same as those for a longer-term compulsory order (see c) below). However, it seems difficult to see how this could be the case since they depend on the existence of an appropriate care and treatment plan which will not exist at the start of the assessment period. From the information available it seems likely that the Government have in mind very broad criteria on the lines of :
 - The presence of mental disorder requiring referral to specialist mental health services;
 - Assessment appearing necessary for the health and safety of the patient or the protection of others from serious harm or the patient from serious exploitation.
 - Assessment being unable to be implemented without the use of compulsory powers.

The Green Paper also fails to address how compulsory community assessment will work. The Review team concluded that the most that could be done in the community would be to require a person to co-operate with the assessment process on the understanding that failure to do so would lead to compulsory admission to hospital for assessment purposes. They described this process as “formal” rather than “compulsory” assessment. The Green Paper does not refer to this distinction. Will their version of compulsory assessment require a person effectively to remain at home under a form of house arrest? Will they use electronic tagging in this context?

3. Following assessment further imposition of compulsory powers would require the authorisation of an independent tribunal. A key issue here is whether or not the capacity of the detained person to take treatment decisions is a relevant consideration. The Government suggest that it should not be on the grounds that the only important consideration is the degree of risk presented. They put forward the following criteria for use of compulsory powers:
 - The presence of mental disorder which is of such seriousness that the patient requires care and treatment under the supervision of specialist mental health services; and
 - 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
 - The proposed care and treatment cannot be implemented without use of compulsory powers; and

2 *Review of the Mental Health Act 1983 - Report of the Expert Committee (1999) Department of Health. Free copies of this report can be obtained from the Department of Health by telephoning 020 7972 4471 or 020 7972 4670.*

- The proposed care and treatment is necessary for the health and 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.

The Government do acknowledge that the review team recommended a higher threshold for the imposition of compulsion on those with capacity. They recommended that in such cases the grounds for compulsory treatment should be that “there is substantial risk of serious harm to the health and safety of the patient or to the safety of other persons if s/he remains untreated and there are positive clinical measures included within the proposed care and treatment which are likely to prevent deterioration or to secure an improvement in the patient’s mental condition.” The Government is seeking views on the merits of this alternative approach.

Assuming a person meets the criteria for use of compulsory powers it would then be for an independent tribunal to decide whether these powers should be exercised by detention in hospital or via a community order. Community orders could:

- Say where a person should live.
- Define a proposed care and treatment plan.
- Require the patient to allow access and be present for scheduled visits by identified caseworkers.
- Impose a duty on health and social services to comply with arrangements set out in the plans.
- Set out the consequences of non-compliance including powers to:
 - enter premises
 - convey the patient to a specified place for the care and treatment set out in the care plan
 - convey the patient to hospital.

The overall effect of these proposals is to widen vastly the numbers of people who could find themselves subject to a compulsory order. Under the present system, the criterion of hospital admission acts as a limiter. That limiter is now removed leaving all those in contact with the psychiatric system beyond the primary care level potentially subject to compulsion if they do not agree with the proposed treatment plan. This can perhaps best be illustrated by an example.

Ms A has been to see her GP because she is feeling very low and tearful and frightened at having suicidal thoughts. The GP is relatively inexperienced in mental health matters and, because of the mention of suicidal thoughts, refers her to specialist mental health services. Ms A is not keen on taking medication and would like access to talking treatment of some kind. The only talking treatments in the area have long waiting lists and the psychiatrist therefore only offers anti-depressants. Ms A does not want to go along with this and attempts to disengage from services and seek the assistance she wants elsewhere. Under existing law Ms A would not come within the scope of compulsory powers because there are no grounds for believing that she needs admission to hospital. However, under the government’s proposals she could meet the criteria for a community order because:

- a) she has been referred to specialist services;*
- b) taking medication is, in the doctor’s view, necessary for her health and is the least restrictive alternative available other than doing nothing which the doctors argue would not be effective care.*
- c) Ms A has indicated that she will not voluntarily co-operate with the proposed treatment plan.*

The Government may argue that in practice the powers would not be used in such circumstances. However, it would appear to be both bad and dangerous legislative practice to extend the scope of such draconian powers wider than those to whom it is specifically intended they should apply. I would suggest the Government need to consider some limitation on the scope of community powers by, for example, confining their use to people who, were they not to receive the proposed community interventions, would need to be detained in hospital.

Principles relevant to this area of law

2 issues fall to be considered here:

- a) what is the justification, if any, for the use of compulsion in mental health law;
- b) if it is justified, what principles should govern such a legal framework.

Justifying compulsion

There would appear to me to be two possible justifications for the use of compulsion in mental health law - protection of the health and safety of a person who is incapable of making healthcare decisions for themselves ("the health justification") and protection of the public ("the public safety justification").

The health justification

Leaving aside the Mental Health Act, the general position in relation to medical (or other) treatment for adults aimed either to improve health or save life is that it can only be given with a person's consent even if a refusal risks permanent injury or premature death unless a person lacks capacity. Adults are presumed to have capacity but this is rebuttable. The test of capacity centres on:

- a) being able to comprehend and retain treatment information;
- b) being able to believe it;
- c) being able to weigh it in the balance to arrive at choice³

Thus the law will not intervene if:

- (As in the case of *Re C*) a person with a diagnosis of schizophrenia refuses amputation of a gangrenous leg which doctors argue is necessary to save his life.
- A person refuses to take prescribed medication because it makes them feel sick or their hair drop out.

In these situations the law respects a person's autonomy.

If a person is found to lack capacity for whatever reason then medical treatment can be given in a person's best interests which are essentially determined by the clinical team. There are few safeguards.

Compare this with the situation in relation to mental health. Under the Mental Health Act 1983 the law allows a person's consent to be overridden regardless of capacity. The only safeguard, after medication has continued for three months, is a second opinion from a doctor appointed by the Mental Health Act Commission who will be concerned only with whether the treatment proposed is in accordance with

good medical practice. The Government appears to propose that this should continue by retaining a person's health alone as justification for use of compulsory powers regardless of capacity. Take, for example, a person with a diagnosis of schizophrenia who takes the view that the medication which has been prescribed is dulling their perceptions and ability to function or having physical side-effects such as shaking or dribbling. They may decide that they prefer, say, to hear voices and find other strategies for coping with this than to suffer these side-effects. Under the Government proposals such a person could be compulsorily treated with powerful anti-psychotics by a doctor who had a negative view of voice hearing and substituted their values for those of the patient. Indeed, the Green Paper specifically states that best interests should be determined by the professional opinion of the care team and not by the patient.

Mind believes that there is no justification for the continuing legal discrepancy in relation to medical treatment decisions between physical and mental health. In both cases, we believe that treatment should always require consent unless the person lacks capacity. Where the person does lack capacity then, subject to certain safeguards, treatment should be allowed in a person's best interests. Where they are capably refusing treatment and assessed as posing a high risk to others then compulsory detention may be justified under the public safety criterion as discussed below.

It may be that Paul Boateng is right in this respect to say that the current Mental Health Act reflects a bygone age in that it assumes either that all people with mental health problems who are compulsory detained must lack capacity to take treatment decisions or at least that their views should be assumed to have less weight than the views of those responsible for their care. Research shows however, that most people with mental health problems are as capable as any other member of society of taking decisions about their lives. Mental health and incapacity are not inextricably linked, although there are times when mental health problems do affect capacity.

The MacArthur Treatment Competence Study⁴, supported by the Research Network on Mental Health and the Law of the John D and Catherine T MacArthur Foundation found that:

- Patients hospitalised with mental illness more often showed deficits in their decision making performance compared with hospitalised medically ill patients and non-patient control groups. This was especially true for patients hospitalised with schizophrenia, and to a lesser extent for patients with depression.
- Nevertheless, the majority of patients hospitalised with schizophrenia performed adequately on any particular measure of decision making ability, and about half did well on all the measures combined. When patients with schizophrenia performed poorly, they usually had more severe psychiatric symptoms, especially disturbances of thought and perception (e.g. disorganised thinking and delusions). In contrast, decision making performance was not associated with simple demographic variables (e.g. age, gender, race) or other mental status variables (e.g. degree of anxiety).
- Patients hospitalised with depression showed intermediate levels of decision making performance, with about three quarters performing well on all measures combined. Patients with more severe depression did not necessarily perform more poorly than those with less serious depression.

⁴ Appelbaum P.S., Grisso T., (1995) *The MacArthur Treatment Competence Study: 1 Mental illness and competence to consent to treatment. Law and Human Behaviour* 19 pages 105-126.

- Medically ill patients, although hospitalised with a potentially life-threatening condition, performed about as well as healthy persons in the community, although a small proportion of these patients did show some decision making deficits.
- When patients hospitalised for schizophrenia were re-tested after a two week period of treatment, substantial improvement in decision making abilities was observed for patients whose psychiatric symptoms had decreased in severity.

Clear definitions of both capacity and best interests will be required. Mind accepts the view of the Law Commission⁵ that any definition of incapacity must be a functional one. In other words capacity must be assessed separately in relation to each type of decision. At any one time a person may have capacity in relation to one decision but not another. They may, for example, have capacity to buy goods in a shop but not to enter in to a more complex contractual arrangement such as a mortgage. Capacity must also be reviewed over time especially when dealing with fluctuating conditions such as mental distress. The focus of definition should not be on the content of the decision made (i.e. Is this decision sensible? Does this person accept my advice?) but on the process by which it was made (i.e. Does this person possess the ability to understand what this decision is about, to take in relevant information and use that information to reach a decision?)

Mind supports the following definition as proposed by the Law Commission in their 1995 Report.

“Incapacity

A person is without capacity if at the material time he or she is:

- (i) unable by reason of mental disability to make a decision on the matter in question, or
- (ii) unable to communicate a decision on that matter because he or she is unconscious or for any other reason.

Mental disability

Any disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning.

Unable to make a decision by reason of mental disability

The person is:

- (i) unable to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or failing to make the decision, or
- (ii) unable to make a decision based on such information (for example, some people may be unable to exert their will, whether because of delusions or compulsions, or because of susceptibility to influence, or any other reasons connected with their disability).”

“Best interests” is again something which has been considered in depth in the Law Commission’s report.⁶ They recommended that in determining a person’s best interest regard should be had to the following factors:

- the ascertainable past and present wishes and feelings of the person concerned and the factors they would consider if able to do so;

5 *The Law Commission (1995) Mental Incapacity Law Commission no 231 (HMSO) pages 36-40.*

6 *Law Commission (1995) op cit. pages 42-48*

- the need to permit and encourage the person to participate or improve his or her ability to participate as fully as possible in anything done for and any decision affecting him or her;
- the views of other people whom it is appropriate and practical to consult about the person's wishes and feelings and what would be in his or her best interests; and
- whether the purpose for which any action or decision is required can be as effectively achieved in a manner less restrictive of a person's freedom of action.

Mind supports this approach.

Proper safeguards will be required where treatment is proposed to be given without consent. These will include:

- 1) Right of appeal to an independent body in relation to a decision on capacity.
- 2) The right of the person themselves to have a free independent advocate representing them throughout the process.
- 3) Regular review. The right to continue treatment without consent would lapse once capacity was regained. Reviews would need to be built in at appropriate intervals which would need to vary according to a person's condition. Perhaps the initial decision as to capacity should specify the appropriate timescale for review.
- 4) Controls on certain controversial treatments. In the case of mental health this would include psychosurgery; ECT and drug treatments.
- 5) Appointment of attorneys as substitute decision makers as recommended in the Law Commission's report.⁷
- 6) Advance directives.

The other issue here is whether compulsion is always justified to save a person's life. Attempted suicide ceased to be a criminal offence in 1961 and the law does not currently see fit to intervene in all situations where a person is putting themselves at risk of serious harm. For example:

- a) A person has the right to refuse a blood transfusion on religious grounds even if such refusal means inevitable death;
- b) A heavy drinker has the right to refuse to go for detoxification or stop drinking even though, without this, a doctor says they will die of cirrhosis of the liver within six months;
- c) Hunger strikers such as Bobby Sands or Barry Horne are allowed to starve themselves to death.

However, the Mental Health Act 1983 does allow a person to be detained and treated against their will if they are deemed to be suffering from a mental disorder and their safety is at risk whether from self-neglect or more active self-harm/attempts at suicide. Under the Government's proposals this justification would continue.

Mind again believes that the key issue here is capacity. As before, the question is can the person understand and retain information relevant to the decision including information about the reasonably foreseeable consequences and can they make a decision based on that information? For example, if a

⁷ Law Commission (1995) *op.cit* Part VII.

person is hearing voices telling them that they should kill themselves or cause themselves serious harm then they would not, in our view, meet the Law Commission's proposed definition of capacity because they would be making their decision as a result of an external influence and not based on relevant information. If, however, a person had weighed up all the relevant issues and been offered services to help but still decided that their preferred option was to kill themselves then, difficult as that may be, their autonomy should be respected. That is not to say that every effort short of compulsory intervention should not be made to prevent this outcome.

The public safety justification

It is important to state at the outset that a mental health diagnosis is not a predictor of violence and that there has in Mind's view been serious misreporting in the media of the risks represented by people with mental health problems. A recent report by John Gunn and Pamela Taylor⁸ which analysed the data extracted from Home Office statistics for England and Wales between 1957 and 1995 and found that, despite media and public perceptions there had been little change in the number of homicides committed by people with mental illness. In fact, the research shows that since 1957 there has actually been a steady 3% annual decline in the proportion of homicides committed by people with mental disorders.

Nevertheless there will be occasions when people with mental health problems do present a risk to others and may not be prepared to accept treatment.

There are physical health powers based on this justification. The most obvious example is the Public Health (Control of Disease) Act 1984 which allows for the compulsory medical examination of persons suffering from specified notifiable diseases such as tuberculosis and for their subsequent compulsory detention (but, interestingly, not treatment) in hospital if they are likely to spread the disease in the event of being allowed to leave. In physical health these powers are the exception rather than the rule. For example, there are health conditions which, if not properly managed, can put others at risk. There was a case last year of a diabetic who did not properly manage his insulin and drove at a time when he was passing in and out of consciousness. As a result he mounted the pavement and killed two pedestrians. Yet no-one suggests that there should be compulsory treatment of diabetics. Is this because the risk of the spread of tuberculosis and other notifiable diseases is virtually certain whereas other types of risk are much less predictable?

The current Mental Health Act allows both compulsory detention and treatment on the grounds of protection of others. The Government not only propose that this should continue but propose extending its scope by removing any requirement of treatability. Under present law, there is a requirement for those detained under the categories of mental impairment or psychopathic disorder that the medical treatment proposed for them is likely to alleviate or prevent a deterioration of their condition. The Review Team similarly recommended that before confirming any long-term compulsory order in the case of a person with capacity the tribunal would have to be satisfied that three were positive clinical measures within the proposed care and treatment plan which were likely to prevent deterioration or secure an improvement in the patient's mental condition. None of this appears in the Government's proposals. Under their scheme any one with a diagnosis of personality disorder would fall within the

8 Taylor P J and Gunn J (1999) 'Homicides by people with mental illness: myth and reality' in *British Journal of Psychiatry* Vol 174 pages 9-14.

widened definition of mental disorder. If such a person were receiving treatment from specialist mental health services who concluded that although there were no positive interventions which could assist them they posed a risk to others and should therefore be kept in a secure setting they would appear to be able to be indefinitely detained. Why should this group alone be subject to a preventive detention regime when other groups which pose as high - if not higher risks - are not covered? Is this really the remit of mental health law?

Other relevant principles

The Government propose to include in the new Act four principles to act as a guide as to how the Act should be interpreted. The proposed principles are:

- Informal care and treatment should be considered before recourse to compulsory powers.
- Patients should be involved as far as possible in the process of developing and reviewing their own care plans.
- The safety of both the individual patient and the public are of key importance in determining the question of whether compulsory powers should be imposed.
- Where compulsory powers are used, care and treatment should be located in the least restrictive setting consistent with the patient's best interests and safety and the safety of the public.

These principles differ markedly from those recommended by the review team who particularly highlighted the principles of patient autonomy and the need to ensure that wherever possible the principles governing mental health care should be the same as those which govern physical health. They suggested 10 principles overall which were informal care; least restrictive alternative; consensual care; participation; reciprocity; respect for diversity; equality; carers; effective communication and provision of information.

In line with these principles the Review Team made a number of important recommendations which have been largely rejected or ignored by the Government. These were:

- a) A user's right to an assessment of mental health needs. This was intended to ensure that an individual's needs were taken seriously when they asked for help. The team referred to a recent survey⁹ which suggested that one in three people with a severe mental illness were turned away when seeking help. The proposal was designed to remedy this gap and presumably thus reduce the need for resort to compulsory powers at a later stage. The Green Paper makes no reference to this proposal.
- b) An obligation on care teams to provide all patients, prior to discharge from compulsion, with information about and assistance with the creation of an advance agreement about care. Again this was intended to promote informal and consensual care. The recommendation has not been accepted.
- c) A duty on the Secretary of State to ensure the adequate provision of advocacy for those subject to compulsion. The review team described such access as "vital" to the achievement of the aims of their report. The government are not minded to accept this recommendation and state that the value of advocacy requires further research.
- d) The protection of remaining civil liberties for those detained including the right to safe containment

consistent with respect for human dignity. This would cover issues such as use of seclusion and restraint and protection from sexual assault. Again this is not referred to in the Green Paper.

There is a further issue around reciprocity. The Review Team expressed a desire to ensure that those subject to compulsion received an appropriate standard of treatment and care. They recommended that, if feasible, as part of the assessment process there should be an assessment of a person's community care needs under section 47 of the NHS and Community Care Act 1990. They also recommended that before approving any care plan the Tribunal would have to be satisfied that it was in a person's best interests. Once a care plan existed health and social services would be under an obligation to deliver what had been promised. The Government have accepted the last of these recommendations but by rejecting the first two they have made it less likely that a care plan will truly reflect a person's full needs rather than just what is readily available and easy to administer. I would suggest that it is arguable that where a person is being compelled to accept medical care and treatment they should have an entitlement to the best possible care for their condition. Much has been made of the Department of Health's proposal to produce league tables of hospitals and doctors so that, for example a parent could have chosen to avoid the Bristol hospital for their child's heart operation. Will those subject to compulsory powers be entitled to treatment only from those at the top of any league table or will they have to put up with what they are given? Would it not be true reciprocity to give those subject to compulsion a right to whatever treatment they were objectively assessed as needing rather than just what was readily or cheaply available?

The Government's principles (and their rejection of many of the 'softer' recommendations of the review team) seem likely to encourage a very different culture in mental health care and one which it seems will inevitably lead to greater use of compulsion and alienation of users of services from the psychiatric system.

The European Convention

Article 5 of the European Convention on Human Rights (Right to Liberty and Security of Person) does allow the detention of "persons of unsound mind" provided that it is in accordance with a procedure prescribed by law and meets the criteria set down in the leading case of *Winterwerp v. Netherlands*¹⁰. These are that:

1. The decision to detain has to be supported by objective medical evidence.
2. The evidence has to show that the patient's disorder is of a kind or degree warranting compulsory confinement.
3. The disorder must persist throughout the period of detention.

Article 5 does not include a requirement of treatability. However Article 3 (Freedom from inhuman or degrading treatment or punishment) does include an obligation to provide adequate medical treatment (including psychiatric care) for persons in detention so that would presumably preclude indefinite detention without the offer of positive interventions of some kind.

In the past it has been argued that compulsory community treatment orders would breach the Convention. Indeed it was partly fears on that point which led the previous Government to accept the

compromise of supervised discharge rather than introducing full-blown community treatment. However opinion now seems to be that such orders would not in themselves breach either Article 3 or 5. It seems unlikely that forced community treatment would be held to be inhuman or degrading treatment. In the case of *Grare v France*¹¹ a patient alleged a breach of Article 3 on the basis of being obliged to receive psychiatric treatment with unpleasant side effects. The Commission held that the consequences of the treatment were insufficiently severe to engage Article 3 and rejected the application as manifestly ill-founded. In *Herczegefalvy v Austria*¹² a far more extreme form of treatment was held not to breach Article 3. The applicant complained that he had been forcibly administered food and neuroleptics, had been isolated and attached to a security bed with handcuffs. The Court held that “.....as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading”.

In relation to Article 5 there seems some doubt about whether requiring a person to attend at a particular place for treatment or to make themselves available for visits would even be held to amount to deprivation of liberty.

In the case of *W v Sweden*¹³ where a provisional discharge was in issue the Commission held:

“The provisional discharge was accompanied by an order that the applicant should take medicine and present herself for medical control at the hospital once every second week. The Commission considers that these conditions attached to the provisional discharge were not so severe that the applicant’s situation after her provisional discharge could be characterised as a deprivation of liberty.”

That is not to say, however, that things would be entirely plain sailing in European terms. Difficulties may arise in respect of Article 5 if a person refuses to comply with a community treatment order and enforcement action is to be taken. In these circumstances where a person is to be compulsorily conveyed and forced to accept treatment such as an injection it is likely that it would be unsafe to discharge them immediately and they would need to be kept in hospital at least for a short while for observation. The criteria for compulsory detention of persons of “unsound mind” laid down in the *Winterwerp* case would therefore have to be met. That means that the individual would have to be shown, on the basis of objective medical expertise, to be suffering from a mental disorder of a kind or degree warranting compulsory (in-patient) confinement. This may not always be the case at the time of non-compliance with any community treatment order.

Where next

The consultation period on the Green Paper lasts until 31st March 2000. Responses should be sent to:

Will Niblett

Department of Health,

Wellington House,

135-155 Waterloo Road,

London SE1 8UG.

11 *Grare v France* 15 EHRR 300

12 *Herczegefalvy v Austria* 15 EHRR 437

13 *W v Sweden* Application 12778/87, D & R 158-161

*Barrister, Coram Chambers, London, EC4Y 9AD. Legal member of the London North & East MHRT

- 1 *Final Report of the Expert Committee: Reform of the Mental Health Act 1983* (Department of Health November 1999)
- 2 On which see for example Peay, J., *Tribunals on Trial* (Oxford: Clarendon Press 1990), the recent research into decision making in the MHRTs of Dr E. Perkins of Liverpool University (in press), Thorold, O., "the ECHR and UK Mental Health Legislation" EHRLR p. 619 (1996), Richardson, G., and Thorold, O., "Law as Rights Protector: Assessing the Mental Health Act 1983" in Eastman and Peay eds. "Law without Enforcement integrating Mental Health and Justice (Oxford: Hart 1999), Richardson, G., and Machin, D., "A Clash of Values Mental Health Review Tribunals and Judicial Review" *Journal of Mental Health Law* February 1999 p.3.
- 3 *Reform of the Mental Health Act 1983 Proposals for Consultation Cm 4480* November 1999
- 4 Professor Richardson has made her own views on the way in which the Green Paper deals with the Committee's report clear. Vol. 3. Issue 5, *Mental Health & Learning Disabilities Care*, (January 2000)
- 5 Green Paper Chapter 4 para. 7.
- 6 Green Paper Chapter 5 para.9.