
The Human Rights Act and Mental Health Law: Has it Helped?¹

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The short and gloomy answer must be – not very much. But that all depends upon how one thinks about human rights and what one hoped for from the Act. Lawyers – perhaps especially the English lawyers who helped draft the European Convention and who practise in the administrative court today – tend to think of human rights in terms of civil liberties and political freedoms and only to a limited extent in terms of economic and social rights.³ But there is a much broader conception of human rights which can be found in the Universal Declaration of Human Rights of 1948 and its daughter Covenants of 1966, the International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights. It can also be found in the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.⁴

I think these principles can be summed up in five basic propositions:

- (1) People with mental disorders and disabilities should be enabled to receive the treatment and care which they need.
- (2) This applies to all people, without discrimination on grounds such as sex, racial or ethnic origin, sexual orientation, religion, membership of a particular social group, or the nature of their disorder or disability.
- (3) Enabling does not mean enforcing. Everyone should be assumed to have the ability to decide for themselves whether to accept the treatment or care that others think they need. A person's right to choose what may be done with his body or his mind should only be taken away in accordance with due process of law.
- (4) That process should not discriminate unjustifiably between the mentally and the physically ill or disabled. It should involve, as a minimum:
 - (i) Logical and defensible grounds for compulsion;
 - (ii) A fair process which enables both sides of the case to be put and heard; and
 - (iii) The appropriate treatment and care in return.

1 This was the title of the lecture delivered by Lady Hale at the North East Mental Health Law Conference on 16 June 2006. Lady Hale has kindly updated the text of that lecture for this issue of the *Journal of Mental Health Law*. It was accepted for publication on 3 April 2007.

2 *Baroness Hale of Richmond*.

3 For a discussion of the as yet unexplored potential of the Human Rights Act in this difficult area, see E Palmer, *Judicial Review, Socio-economic Rights and the Human Rights Act* (Hart Publishing, forthcoming).

4 General Assembly Resolution 46/119 of 19 December 1991.

(5) Underlying and overriding all of these principles is respect for the dignity and humanity of all people, however disabled or disordered in body or in mind or both.

I want to concentrate on (3) and (4) – the right to choose and the process of compulsion – because that is where the debates in our case law and legislation have mainly been.

The Presumption of Capacity and the Right to Choose

Section 1 of the Mental Capacity Act 2005 is quite clear about this. A person must be assumed to have the capacity to make his own decisions unless it is established that he does not. He is not to be treated as unable to take a decision unless all practicable steps to help him do so have been taken without success. But the Mental Capacity Act deliberately retained the common law concept of necessity from the case of *Re F*:⁵ that if a person is indeed unable to take a decision for himself, those looking after him may do whatever it is reasonable in the circumstances for them to do for him, provided that they act in his best interests.⁶ The original framers of the 2005 Act (which began its life in the Law Commission during my time as a Commissioner) did not think it practicable or desirable for there to have to be some formal process to enable family and carers to look after people who were unable to look after themselves.⁷ Formalities are cumbersome and can be both expensive and stigmatising. The better approach is to provide proper machinery for resolving disputes about treatment or care and to enact limits to what may be done without formal approval.

The limits we proposed were of two kinds: extra formalities for certain forms of medical treatment, such as ECT, and general prohibitions of coercion and confinement.⁸ We were concerned that if the *Re F* doctrine could be used to authorise major surgery it might well be used to authorise detention.⁹ The former kinds of limit did not find their way into the Act but the latter did. The Act limits the use of restraint. It also tries to make it clear that it does not allow anyone to go beyond restraint and deprive a person of his liberty within the meaning of article 5.1 of the European Convention on Human Rights.¹⁰

Article 5.1 says this:

'Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:'

It then lists six cases (a) to (f) where deprivation of liberty may be allowed, (e) being:

'the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants.'

Little attention has so far been paid to the 'security of person' aspect of article 5. It is all about deprivation of liberty. So what does that mean?

No doubt everyone is familiar with the *Bournemouth* saga. Section 131(1) of the Mental Health Act 1983 (repeating section 5(1) of the Mental Health Act 1959) was undoubtedly intended to allow both actively consenting and passively non-dissenting patients to be admitted to hospital and cared for there without any legal formalities. It was all part of the 1959 Act's normalisation of psychiatric care. No legal formalities are required for admission to hospital for treatment for physical disorders, so why should any be required for admission for treatment (or care) for mental disorders? Why should the thousands of

5 *Re F (mental patient: sterilisation)* [1990] 2 AC 1.

6 2005 Act, s 5.

7 Law Com No 231, *Mental Incapacity* (1995), paras 4.1 – 4.5.

8 Paras 6.3 – 6.15; 4.30 – 4.33

9 Para 4.31. *The Bournemouth* cases, discussed below, were to prove us right about this.

10 Section 6(5).

elderly demented or mentally disabled people then in long term hospital care be subject to formalities designed to compel the seriously mentally disturbed to accept treatment when no compulsion was needed in their case? Why should hospitals be any different from nursing and residential care homes in this respect? That was the thinking then and many would be sympathetic to it now.

Mr L did not quite fit the picture of a passive patient. An autistic, profoundly disabled man in his forties, he became agitated at his day centre, was sedated and taken to A & E. A psychiatrist there assessed him as needing in-patient treatment but it was not thought necessary to section him as by then he appeared fully compliant and unresisting. He was admitted to an unlocked ward. But he was sedated there and would have been sectioned had he tried to leave. His foster carers were prohibited from visiting him in case he wanted to leave with them. They wanted him home but the hospital was not prepared to release him until they thought he was ready.

The Court of Appeal held that section 131(1) applied only to positively consenting patients. They regretted that 'authoritative textbooks', such as those by Hoggett (now Hale) and Jones, had misinterpreted the effect of the Act.¹¹ They awarded Mr L £1 in damages for false imprisonment. The day that the Court of Appeal announced its decision, Mr L was formally detained under section 5(2) of the Act and then sectioned under section 3. The House of Lords unanimously allowed the hospital's appeal.¹² Their lordships were given much more information about the background to section 131(1) than the Court of Appeal had been. Three of them decided that Mr L had not been imprisoned at all. Two decided that he had indeed been detained. Lord Steyn described the suggestion that he was free to leave as 'a fairy tale'. But the minority agreed that his detention had been justified under the *Re F* doctrine of necessity. Indeed, Lord Steyn pointed out that it might even on occasions justify the detention of a non-compliant, actively dissenting patient. There are certainly common law decisions to this effect (which were quoted in Hoggett¹³) which had not been cited to the Court of Appeal.

So the case went to Strasbourg. The European Court of Human Rights¹⁴ agreed that Mr L had been deprived of his liberty. To do this they had to distinguish the case of *HM v Switzerland*.¹⁵ This was a typical case of an old lady being taken to a nursing home for her own good. The Court said that it had not been established that she was incapable of expressing a view; she had often said previously that she was willing to go there and within a short time of admission she was willing to stay (are they not always?); the regime in the nursing home was entirely different from that in hospital; it was an open institution allowing freedom of movement and encouraging links with the outside world.

So the first question is 'what amounts to a deprivation of liberty?' As is its custom, the Court repeats the same test in case after case, for example in *Storck v Germany*:¹⁶

'The Court reiterates that, in order to determine whether there has been a deprivation of liberty, the starting point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case, such as the type, duration, effects and manner of implementation of the measure in question.'

The *Storck* case is also important for holding that the first sentence of article 5.1 lays down a positive

11 *R v Bournewood Mental Health NHS Trust, ex parte L* [1999] AC 458, at 474, referring to Hoggett, *Mental Health Law*, 4th ed 1996, p 9 and Jones, *Mental Health Act Manual*, 5th ed 1996, p 340.

12 *Ibid.*

13 *Op cit*, pp 78 – 79.

14 *HL v United Kingdom, Applic No 45509/99*; (2005) 40 EHRR Case No 32.

15 *Applic No 39187/98*; [2002] MHLR 209.

16 *Applic No 61603/00, Judgment of 16 June 2005, para 71*; (2006) 43 EHRR 96.

obligation upon the State to protect the liberty of its citizens (in this case a young woman detained in a private psychiatric clinic) and that *ex post facto* sanctions, in the shape of criminal and civil liability for wrongful detention, do not provide effective protection for people in such a vulnerable position.¹⁷

So the second question is, 'what measures may be needed to safeguard the liberty of people such as Mr L?' In Mr L's case, the Court accepted that the deprivation of liberty was capable of being justified under article 5.1(e). Mr L had been shown to be of unsound mind during the whole period that he was in hospital. However, they decided that his detention had not been 'lawful'. It is not enough that the detention is lawful under domestic law, as this was. It must also meet the Convention standard of legality. This requires the law to be sufficiently clear and precise to allow the citizen to foresee the consequences of a given action. But it also requires the law to comply with the essential objective of article 5 'which is to prevent individuals being deprived of their liberty in an arbitrary fashion'.¹⁸ If there are no procedural rules, no criteria, no statement of purpose, no limits of time or treatment, and no requirement of continuing clinical assessment, there is nothing in the law to protect the citizen against the arbitrary deprivation of liberty on grounds of necessity. There was also no process whereby the legality of the detention could be speedily determined by a court, as required by article 5.4.

One might also have thought that some remedy was urgent. In the olden days, the Government might have reflected in tranquillity about what to do next. But section 6(1) of the Human Rights Act 1998 makes it unlawful for a public authority to act in a way which is incompatible with a Convention right. Even so, the Government took its time. It produced its *Bournewood Consultation* in March 2005¹⁹ and in June 2006 it announced that the proposed Bill to amend the Mental Health Act would also amend the Mental Capacity Act 'to introduce safeguards for patients with a mental disorder who are deprived of their liberty but are not subject to mental health legislation'.²⁰ It would also clarify when detention under the Mental Health Act should be used rather than the Mental Capacity Act or the proposed new Bournewood procedure: where there is a choice, 'the Government's intention is that the Mental Health Act will be used where people object to being detained or treated'.²¹ The new safeguards will put 'these people in broadly the same position as people who have capacity but refuse to consent to treatment'.

The Mental Health Bill introduced in the House of Lords on 16 November 2006²² makes elaborate provision to this effect.²³ In brief (and necessarily inadequate) summary,²⁴ the supervisory body responsible for a resident in a hospital or care home will be able to authorise detention for the purposes of care or treatment if certain qualifying conditions are met. The resident must be suffering from mental disorder (including learning disability), lack the capacity to decide for himself whether he should be accommodated in the hospital or care home, and not be ineligible, in effect because the authorisation would be inconsistent with the Mental Health Act regime to which he is already subject or because he meets the criteria for detention in hospital under the 1983 Act and objects to his detention or treatment. Crucially,

17 *Ibid*, paras 102 and 105.

18 *HL v United Kingdom*, para 115.

19 Department of Health, *Bournewood Consultation: The approach to be taken in response to the judgment of the European Court of Human Rights in the 'Bournewood' case*, Gateway Ref 4706, 23 March 2005.

20 Department of Health, *The Mental Health Bill – Plans to amend the Mental Health Act 1983*, Briefing sheet on Implementing Government Policies on Mental Health Law, June 2006, p 1.

21 Department of Health, *The Mental Health Bill – Plans to amend the Mental Health Act 1983*, Briefing sheet on The criteria for detention, April 2006, p 4.

22 The Bill is still going through Parliament, and many of its provisions are controversial, so reference will be made only to the version introduced on 16 November 2006.

23 Clause 38, introducing new sections 4A, 4B, 16A, 21A, 39A, 39B and 39C, and new schedules A1 and 1A and making numerous other amendments to the 2005 Act.

24 The Explanatory Notes to the Bill devote paragraphs 155 to 195 to the subject!

the detention must be in his best interests, necessary in order to prevent harm to him, and a 'proportionate response' to the likelihood and seriousness of that harm. The Court of Protection will also be able to authorise detention, and in places other than hospitals or care homes, provided that the resident is not ineligible. The object is to maintain a strict separation between the Mental Health Act and Mental Capacity Act procedures: but it seems strange that, if the case is already before the Court of Protection and the criteria are met, the Court should not be able to authorise the use of Mental Health Act powers.²⁵

So the main effect of the Human Rights Act in mental health law will soon be to make substantial inroads into the whole concept of informal admission, which was so central to the thinking underlying the 1959 Act. Do we think that that is a good thing or a bad thing? And how far will it go? What will be the effect on nursing and residential homes caring for elderly mentally infirm or younger mentally disabled people? How confident are we that we know the difference between unacceptable deprivation of liberty and acceptable limitations on freedom? And there is another question lurking in the future: what about other invasions of bodily integrity and autonomy? The Bournewood amendments deal only with safeguards against arbitrary deprivation of liberty. They do not introduce safeguards against unjustified medical treatment. There may well come a time when the *Re F* principle will be challenged as giving insufficient protection to the right to respect for a person's private life under article 8. For some treatments at least, as the Law Commission originally proposed, *ex post facto* remedies may not be enough. The Parliamentary Joint Committee on Human Rights, relying heavily upon *Storck v Germany*, has already suggested as much.²⁶

Logical and defensible grounds for compulsion

I am not sure that the Human Rights Act is much help here either. The leading Strasbourg case on what is required to demonstrate that a person is 'of unsound mind' within the meaning of article 5.1(e) is *Winterwerp v The Netherlands*.²⁷ The Court deliberately declined to define what this meant:

'... because its meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitudes to mental illness changes, in particular so that a greater understanding of the problem of mental patients is becoming more widespread.'

Does this mean that more and more people may be drawn into the net? Or does it on the contrary mean that as understanding grows, fewer and fewer people will be thought to be of such unsound mind that they may lawfully be deprived of their liberty? I hope the latter but am not at all sure that this is what Strasbourg meant.

The additional criteria set by the Court were scarcely demanding:

'The very nature of what has to be established before the competent national authority – that is a true mental disorder – calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder.'

There is little hint here of the debates about the moral justification for compulsory detention and treatment which have been troubling mental health lawyers for decades. The Percy Commission²⁸ which

25 As the Law Commission had recommended: *Law Com No 231, paras 8.27 to 8.30.*

26 *House of Lords, House of Commons, Joint Committee on Human Rights, Legislative Scrutiny: Mental Health Bill, Fourth Report of Session 2006-07, HL Paper 40, HC 288, 2007, paras 93 to 101. For a detailed consideration of this*

report, see David Hewitt's article in this issue of the JMHL. (1979) 2 EHRR 387.

28 *Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency 1954-1957, Cmnd 169, 1957.*

led to the 1959 Act drew careful distinctions between the major mental disorders – mental illness (by which they undoubtedly meant what had previously been called lunacy or madness) and severe mental subnormality – which would justify long term detention and treatment, the minor disorders – psychopathic disorder and subnormality – which would only justify long term compulsion while the person was young or when he had committed a criminal offence, and the ‘catch-all’ concept of mental disorder - which would only justify emergency intervention and short term assessment. These distinctions were eroded by the 1983 Act, which did away with the age limits upon the long term compulsion of psychopathic and mentally impaired patients in return for a treatability test. When the current review of that Act began, the Richardson Committee of experts²⁹ likewise devoted a lot of thought to the justifications for compulsion. The desire to promote the principle of non-discrimination on grounds of mental health was fundamental to their approach. They saw much of the answer in a rigorous definition of incapacity: why should society force treatment upon a person who is capable of making the decision for himself? But they also acknowledged that there might be people who retained capacity, in that their cognitive and choice-making powers enabled them to understand what was proposed and to make a considered choice about whether or not to accept it, but who nevertheless constituted such a risk to others that it was justifiable to compel them to accept treatment.

But the Government did not accept any of that. The Mental Health Bill amends the definition of mental disorder to remove all distinctions between the different types of disorder (although the use of long term compulsion for mentally disabled patients will be restricted to those whose disorder is associated with abnormally aggressive or seriously irresponsible conduct).³⁰ This is ‘to further simplify the Act and to help ensure that nobody who needs compulsion is arbitrarily excluded on the basis of a legal classification.’ The present distinctions ‘[encourage] some patients and their lawyers to argue about legal classifications in the hope of securing inappropriate discharge. Detention ought to be based on the needs of patients and the degree of risk posed by their disorder, not on their diagnostic label’.³¹

This is surely discriminatory as between people with mental disorders and people with physical disorders. People with physical disorders are entitled to refuse treatment which they undoubtedly need, at whatever risk to themselves. Nor can they be locked up before they have done anything wrong, no matter how likely it is that they will cause harm to others in the future. We have to ask what it is about mental disorder that makes a difference. What is the rational justification for subjecting people with mental disorders to compulsion when people with other disorders are not so subject? But there is little or nothing in the Strasbourg jurisprudence to encourage a more rigorous approach to this question.

Winterwerp does require that the disorder be of a type or severity to justify detention. This is reflected in the ‘nature or degree’ requirement in the current Act and the Bill does not change this. The main change will be to replace the current ‘treatability’ test in admission for treatment (but only for psychopathic and mentally impaired patients) with one which requires that appropriate medical treatment actually be available to the patient (whatever his disorder). This means ‘medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all the other circumstances of his case’.³² The definition of medical treatment is also to be amended, to include ‘nursing, psychological

29 Department of Health, *Report of the Expert Committee: Review of the Mental Health Act*, November 1999.

30 *Mental Health Bill [HL]*, clauses 1 and 2, amending section 1 of the 1983 Act.

31 Department of Health, *The Mental Health Bill, Plans to amend the Mental Health Act 1983, Briefing sheet, The definition of mental disorder*, April 2006, p 2.

32 Clauses 4 and 5, amending the criteria for admission for treatment under section 3, remands to hospital for treatment under section 36, hospital orders (including restriction orders) under section 37, hospital and limitation directions under section 45A, and transfers to hospital under section 47 and 48. The criteria for renewal under section 20 and discharge by a tribunal under sections 72 and 73 are also amended.

intervention, and specialist mental health habilitation, rehabilitation and care'.³³ The Government believes that the appropriate treatment test will be better 'because it calls for a holistic assessment of whether appropriate treatment is available, not focused only on the likely outcome of treatment'.³⁴ I think it may very well be right about this, and it could be a great improvement, but I doubt whether it has much to do with Strasbourg.

One of the main difficulties faced by people trying to secure their discharge from hospital is that they would be able to cope in the community if only the appropriate treatment and care were available to them there. One might have thought that it would be a breach of article 5.1 to detain someone in hospital if he did not need to be there. But in *R (H) v Secretary of State for the Home Department*,³⁵ the House of Lords held that there was no violation, even though a tribunal had granted a conditional discharge, when the community agencies would not make the arrangements necessary to meet the conditions. It seems that a patient's condition may be of a nature or degree justifying detention if there is no other treatment available for him even though it could quite properly be treated without the need to detain him. Once again, Strasbourg was no help because the *Winterwerp* criteria were met. Nor, of course, is it any help to those patients detained in secure hospitals who are ready to move on but who for one reason or another are prevented from doing so. In *Ashingdane v United Kingdom*,³⁶ the Court held that as long as their condition meets the *Winterwerp* criteria, and the place where they are detained is a psychiatric hospital, they cannot complain.

A fair process

It seems that the Human Rights Act may have more to offer on process issues than on the substance. (After all, the early case of *X v United Kingdom*³⁷ led to the power of mental health review tribunals actually to discharge, rather than to make recommendations to the Home Secretary about the discharge of, restricted patients.) The Mental Health Act relies on the right to challenge an admission *ex post facto* and to seek a review at regular intervals thereafter, rather than on prior authorisation or automatic reviews in every case. This means that many compulsory admissions go unchallenged. In some cases this may be because the patient accepts the situation. In others it may be because the patient is incapable of making an application and may not have a nearest relative who can take action on his behalf. One example is where proceedings are pending in the county court to remove a nearest relative on the ground that she is proposing to exercise her powers to discharge, or to object to long term compulsion, unreasonably. At present, this extends the life of an admission for assessment until the proceedings are completed, which can take years rather than months. The Court of Appeal thought that this provision was incompatible with the Convention but the House of Lords thought otherwise: the provision itself was not incompatible, although the authorities would have to take steps to operate it in a compatible manner.³⁸

There is nothing in the Convention jurisprudence to require an automatic review in every case. Article 5.4 guarantees the right of everyone deprived of their liberty 'to take proceedings by which the lawfulness of his detention shall be decided speedily by a court . . .' The onus is therefore placed upon the patient to bring the proceedings. This is in contrast to article 5.3, which requires that people arrested on suspicion

33 Clause 7, amending section 145(1).

34 Department of Health, *The Mental Health Bill, Plans to amend the Mental Health Act 1983, Briefing sheet, The criteria for detention*, p 2.

35 [2003] UKHL 59; [2004] 2 AC 253.

36 (1985) 7 EHRR 528.

37 (1981) 4 EHRR 181.

38 *R (H) v Secretary of State for Health* [2005] UKHL 60; [2006] 1 AC 441.

of crime be brought promptly before a judicial officer. Article 6.1 requires a fair trial in the determination of his civil rights or obligations, but this requires a *contestation*. Nevertheless, indefinite detention without review would be contrary to article 5.1, as 'the validity of continued confinement depends upon the persistence of such a disorder'.³⁹ So the Act should be operated in such a way as to ensure that such cases were referred to a tribunal for review. At present, this can be done by procuring a Secretary of State's reference under section 67 of the Act.⁴⁰ A hospital, which continued to detain without procuring such a reference might, therefore, be acting incompatibly.

Nor has the Convention prevented the professionals from invoking compulsory powers soon after a patient has been discharged by a mental health review tribunal. What could be more apparently unjust than for a patient to succeed before a tribunal only to find that the professionals immediately invoke the Act to detain him? But the Human Rights Act may have been influential in refining the circumstances in which this can be done: a social worker can only apply again if he reasonably and in good faith considers that he has information which was unknown to the tribunal and puts a significantly different complexion on the case.⁴¹

But there have been successful declarations of incompatibility, most notably in *R (H) v London North and East Region Mental Health Review Tribunal (Secretary of State for Health intervening)*.⁴² There it was held incompatible to require that the patient prove to the tribunal that he was not detainably ill, rather than that the hospital prove that he was. This led to the first remedial order under section 10 of the Human Rights Act.⁴³ The standard of proof, however, is still on the balance of probabilities rather than the stricter criminal standard.⁴⁴

The Human Rights Act has also spurred reforms in the process of selection and replacement of the nearest relative. Despite all the historical evidence to the contrary, the Mental Health Act proceeds on the assumption that the patient's nearest relative will always have his best interests at heart. It is much kinder to the relative who wants to admit the patient to hospital or guardianship than it is to the relative who resists this: a relative who unreasonably objects to admission may be replaced, whereas a relative who makes repeated and unnecessary emergency applications cannot. Under the Bill, the patient will be able to apply to replace the nearest relative and to discharge a replacement order. General unsuitability will be added to the grounds for replacement. But relatives displaced for unreasonable resistance to admission or guardianship will still not be able to apply for reinstatement.⁴⁵ Civil partners, unaccountably left out of the generally comprehensive assimilation of civil partners and spouses under the Civil Partnership Act 2005, will be added to the list alongside husband or wife, and unmarried same sex partners will be treated in the same way as unmarried opposite sex partners.⁴⁶

The nearest relative can be an important safeguard. So too can the independence of the recommending doctors and the Mental Health Review Tribunal. Article 6 requires that the tribunal be 'independent and

39 *Winterwerp v The Netherlands* (1979) 2 EHRR 387.

40 Clause 30 of the Bill amends section 68, so that the hospital managers will be under a duty to refer all patients on the expiry of six months from their admission for assessment, even if they have exercised their right to apply within 14 days of their admission.

41 *R (Von Brandenburg) v East London and The City Mental Health NHS Trust* [2003] UKHL 58; [2004] 2 AC 280.

42 [2001] EWCA Civ 415; [2002] QB 1.

43 *Mental Health Act 1983 (Remedial) Order 2001*, SI 2001/3712.

44 *R (N) v Mental Health Tribunal (Northern Region)* [2005] EWCA Civ 1605; [2006] QB 468; leave to appeal to the House of Lords has been refused.

45 *Mental Health Bill* [HL], clauses 21 to 24.

46 Department of Health, *The Mental Health Bill, Plans to amend the Mental Health Act 1983, Briefing sheet, Nearest Relatives*, April 2006. The House of Lords' decision in *Ghaidan v Godin-Mendoza* [2004] UKHL 50; [2004] 2 AC 557 may have been some encouragement.

impartial'. So what about the medical member? A patient might well think that a psychiatrist employed by the same NHS Trust as his own responsible medical officer, albeit at a different hospital, had at least the appearance of bias. But the test is not what the patient thinks but what a reasonable and fair-minded bystander in possession of the relevant facts might think. So the Court of Appeal dismissed the challenge.⁴⁷ This is a dilemma facing all administrative tribunals. The whole object is to have expertise which the ordinary courts do not have, not least so that they can be more user-friendly and effective. An ignorant tribunal is no great safeguard, no matter how objectively independent. A psychiatrist is much better at challenging another psychiatrist than any lawyer. But psychiatry is quite a small profession; the RMO and the medical member may very well know one another, quite apart from their natural professional solidarity. Like the Percy Commission, however, I tend to think that expertise and familiarity with the subject matter is likely to lead to more searching reviews than might happen in an ordinary court.

The appropriate treatment and care

Now I turn to the sensitive matter of what actually goes on in psychiatric hospitals. I mentioned earlier that Bill requires that 'appropriate medical treatment' is actually available for the patient before he can be compulsorily admitted to hospital for treatment. I do not know to what extent this may have been influenced by the Strasbourg case law under article 3. Article 3 prohibits torture and inhuman or degrading treatment or punishment. It is an absolute prohibition so the threshold of severity is high. But in *Keenan v United Kingdom*⁴⁸ Strasbourg stressed the special obligations owed to people who are deprived of their liberty:

'... the authorities are under an obligation to protect the health of persons deprived of liberty. The lack of appropriate medical treatment may amount to treatment contrary to Article 3. In particular, the assessment of whether the treatment or punishment is incompatible with the standard of Article 3 has, in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment.'

'... there are circumstances where proof of the actual effect upon the person may not be a major factor. For example, in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3. Similarly, treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though that person may not be capable of pointing to any specific ill-effects.'

That is all very encouraging, but note the reference to necessity. There are many things which are done in psychiatric hospitals which might be thought inhuman and degrading, in particular forcible medication or ECT and the use of seclusion. The leading case in Strasbourg is *Herczegfalvy v Austria*.⁴⁹ The patient, who was obviously not the easiest person to handle and objected violently to his detention, had been force-fed, forcibly given psychotropic drugs, and kept for more than two weeks in handcuffs tied to a security bed. He complained of degrading treatment. The Court started strongly:

'The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has

47 *R (PD) v West Midlands and North West Mental Health Review Tribunal* [2004] EWCA Civ 311.

48 (2001) 33 EHRR 28.

49 (1993) 15 EHRR 437.

been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are responsible, such patients nevertheless remain under the protection of Article 3, the requirements of which permit of no derogation.'

But then it weakened:

'The established principles of medicine are admittedly decisive in such cases: as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has convincingly been shown to exist.'

The reference to the 'established principles of medicine' looks very reminiscent of the *Bolam* test for medical negligence (which, you will recall, involved the administration of ECT without an anaesthetic).⁵⁰ Sure enough, the Court concluded:

'... the evidence before the Court is not sufficient to disprove the Government's arguments that, according to the psychiatric principles generally accepted at the time, medical necessity justified the treatment in issue.'

Forcible treatment would also contravene article 8 unless it could be justified by medical necessity. The European Court of Human Rights has recently reiterated, in *Storck v Germany*,⁵¹ that even a minor interference with the physical integrity of an individual must be regarded as an interference with the right to respect for private life under Article 8 if it is carried out against the individual's will'. In that case, the treatment was not lawful under domestic law and so the Court did not have to consider whether it was medically necessary.

The requirement that 'medical necessity be convincingly shown' did lead the Court of Appeal to hold, in *R (Wilkinson) v Broadmoor Special Hospital Authority and Others*,⁵² that despite the powers to impose treatment given by the Mental Health Act, the court might have itself to examine the facts to decide whether the proposed treatment would be incompatible with the patient's rights under articles 2 (right to life), 3 (prohibition of inhuman or degrading treatment) or 8 (invasion of privacy). That was a judicial review case, where the procedure is not well adapted to the resolution of factual disputes, and the Court of Appeal has since tried strenuously to restrict its impact.⁵³ But the patient has a freestanding right of action under section 7(1) of the Act, to which the procedural objections should not apply.

At least Broadmoor did not appeal to the House of Lords.⁵⁴ The Court of Appeal has fared less well with its attempts to control the use of seclusion in Ashworth. In the case of 'Colonel Munjaz', it held that the statutory Code of Practice under the Mental Health Act was designed, among other things, to protect patients against potential invasions of their human rights in hospital. Hence hospitals should follow what the Code said unless there were good reasons to depart from it in the individual case. They were not entitled to have a completely different policy on seclusion. The House of Lords, by a majority of four to one, disagreed.⁵⁵ A particularly disturbing feature of this case was that the Department of Health, having approved the Code and laid it before Parliament, supported Ashworth in its attempts to ignore it.

50 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

51 *Applic no 61603/00, Judgment of 16 June 2005, para 143*; (2006) 43 EHRR 96.

52 [2001] EWCA 1545; [2002] 1 WLR 419.

53 *R (N) v M* [2002] EWCA Civ 2335; [2003] 1 WLR 562;

R (B) v S [2006] EWCA Civ 28; [2006] 1 WLR 810.

54 *In fact, the Government relies upon Wilkinson to show how effective judicial review can be in cases where breaches of convention rights are alleged.*

55 *R (Munjaz) v Secretary of State for Health* [2005] UKHL 58; [2006] 2 ac 148.

That case also raised the possibility of using article 8 to challenge such decisions. The Court of Appeal held that seclusion was an interference with the patient's right to respect for his private life. This may be justified if it is 'necessary in a democratic society' in pursuit of legitimate aim. But it must also be 'in accordance with the law', in the sense explained earlier in the *Bournemouth* case. The Code of Practice aimed to regulate the use of seclusion so that patients would know where they stood. This was another reason why hospitals should respect it. Lord Brown and Lord Steyn agreed with the Court of Appeal (of which I was a member) but the majority did not.

The stress in recent Strasbourg case law (such as *HL v United Kingdom* and *Storck v Germany*) upon the State's positive obligations to take active steps to protect vulnerable people from breaches of their convention rights, rather than relying upon *ex post facto* sanctions, strengthens my view that the Court of Appeal were right in the *Munjaz* case. But the extent and limits of medical necessity remain unexplored. Mr Herczegfalvy succeeded under article 8 because the hospital had tampered with his correspondence; bad enough, I agree, but his physical treatment in hospital was much worse. However, there are signs⁵⁶ that the Court is beginning to develop article 8 into a right to personal autonomy, which might in time lead to a different approach.

All of this is very negative. It has more to do with *preventing* the authorities giving a person the care and treatment that they think he needs than with *ensuring* that the patient actually gets the care and treatment that he does need. There are some reciprocal obligations owed to those deprived of their liberty and there may be room for developing these. It is less easy to see how the Convention could be used to enforce a positive obligation to provide the treatment and care which a patient needs in the community. The Bill provides for supervised community treatment orders.⁵⁷ These would apply to a patient detained in hospital for treatment under section 3 or an ordinary hospital order who meets the criteria. In effect these require that he still needs treatment, that it can be given without his being detained in hospital, and that appropriate medical treatment is available for him in the community. 'An appropriate package of treatment and support will be put in place before a patient leaves hospital on SCT.'⁵⁸ Patients who refuse their consent to community treatment will not be treated against their will in the community but may be recalled to hospital where clinically necessary. This is not very different from the present situation, where leave of absence may be used for the same purpose.

The Bill protects people from long term compulsion without the quid pro quo of appropriate treatment. That is undoubtedly an advance and consistent with the *Keenan* principle. It stops far short of a positive duty to provide patients with what they need. I do not hold out much hope that the courts will construct such a duty out of an amended Mental Health Act. The Act does not spell out what the duties of the health and social services are towards people with mental disorders: these have to be found in other legislation which usually creates general duties rather than duties to individuals. Of course, those duties have to be performed in a rational way, so that arbitrary allocation or rationing decisions may be challenged on ordinary administrative law principles. The development of positive obligations under the Convention, for example to safeguard bodily integrity, may bring some further impetus in the future. But the House of Lords has been reluctant to imply obligations into the Convention ahead of the Strasbourg case law: it is an international treaty agreed between sovereign states with widely differing levels of public health care and social services. It is not for the courts tell Parliament that it has got things wrong if

56 *Mainly in Pretty v United Kingdom* (2002) 35 EHRR 1.

57 *Mental Health Bill [HL]*, clauses 25 to 29, inserting new sections 17A to 17G, 20A and 20B, 56 and 62A, and 64A to 64K into the 1983 Act and repealing sections 25A to 25J.

58 *Department of Health, The Mental Health Bill, Plans to amend the Mental Health Act 1983, Briefing sheet, Supervised Community Treatment (SCT), April 2006.*

Strasbourg would not do so. That is why, as a practising judge, I am rather sceptical of the help which the Human Rights Act can bring although, as a practising human being, I might wish that it could do more.

Dignity

However, the right to proper treatment and care is one thing; the right to be treated properly is another. Articles 3 and 8 are undoubtedly concerned with the latter. As the Court emphasised in *Pretty v United Kingdom*⁵⁹ the very essence of the Convention is respect for human dignity and human freedom. Examples abound in our health and social care settings of a quite unnecessary and unjustified lack of respect for human dignity. No-one should be expected to eat their breakfast while sitting on a commode, or to be exposed to public gaze while having their ablutions and necessary treatment done, or to be expected to wear incontinence pads because no-one is available to help them go to the lavatory.⁶⁰ We should not need legal challenges to put these things right – merely the empathy and imagination to see elderly or incapacitated people as people rather than packages. But I certainly hope that, if legal challenges are needed, they will be made and they will succeed in enough cases to make a difference.

59 (2002) 35 EHRR 1, para 65.

60 See *Something for Everyone: The Impact of the Human Rights Act and the need for a Human Rights Commission*, 2002, British Institute of Human Rights.
