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

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[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 Paper[[2]](#footnote-2) 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 complete[[3]](#footnote-3). 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 1998[[4]](#footnote-4), 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 problems[[5]](#footnote-5). 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

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.*[[6]](#footnote-6)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 Court[[7]](#footnote-7)6. 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).

**(1) 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.

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’[[8]](#footnote-8)7. A person may not be detained simply because his views or

behaviour deviate from the norms prevailing in a particular society[[9]](#footnote-9)8;

(b) The disorder must be of a ‘kind or degree’ warranting compulsory confinement[[10]](#footnote-10)9;

The new diagnostic criteria proposed in the Green Paper would cover, for example, a person

suffering from a temporary needle-phobia[[11]](#footnote-11)10. 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)[[12]](#footnote-12)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;[[13]](#footnote-13)12 the new definition would arguably be wide enough to

permit her detention[[14]](#footnote-14)13.

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

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 hospital[[15]](#footnote-15)14 (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 disorder[[16]](#footnote-16)15, 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’[[17]](#footnote-17)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).

**(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)[[18]](#footnote-18)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 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.

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’[[19]](#footnote-19)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[[20]](#footnote-20)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 developing[[21]](#footnote-21)20.

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

law[[22]](#footnote-22)21. However, in R v United Kingdom[[23]](#footnote-23)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

proceedings[[24]](#footnote-24)23, and in some circumstances must be the same[[25]](#footnote-25)24. 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’[[26]](#footnote-26)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 themselves[[27]](#footnote-27)26. The specific minimum guarantees that are required include:

(i) A right to be heard either in person or, where necessary, through some form of

representation[[28]](#footnote-28)27.

(ii) The right to legal representation, paid for by the state[[29]](#footnote-29)28. This has been held to extend to

the right to be represented by a lawyer of the patient’s choice[[30]](#footnote-30)29.

(iii) The right (as a component of the principle of ‘equality of arms’), in appropriate cases, to

independent expert medical opinion[[31]](#footnote-31)30.

(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 patient[[32]](#footnote-32)31) than for subsequent reviews[[33]](#footnote-33)32.

For first reviews, a period of 8 weeks between application and final determination has

been held to constitute a violation of Article 5(4)[[34]](#footnote-34)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)[[35]](#footnote-35)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’[[36]](#footnote-36)35.

(vi) The right to a speedy decision following the hearing.[[37]](#footnote-37)36

(vii) Right to reasons[[38]](#footnote-38)37 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)[[39]](#footnote-39)38.

(viii) Right to further reviews at regular intervals[[40]](#footnote-40)39.

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 defence[[41]](#footnote-41)40. It is not for the patient to take the initiative

in securing those safeguards[[42]](#footnote-42)41; nor is the onus on the patient even to apply for a tribunal

in the first place[[43]](#footnote-43)42.

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

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 Court[[44]](#footnote-44)43. 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 fulfil[[45]](#footnote-45)44. 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)[[46]](#footnote-46)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

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 limits[[47]](#footnote-47)46.

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 movement[[48]](#footnote-48)47. 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.

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 law[[49]](#footnote-49)48. 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 case[[50]](#footnote-50)49 (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 rights[[51]](#footnote-51)50.

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 treatment[[52]](#footnote-52)51, 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 consent[[53]](#footnote-53)52. Second, the duty of care owed by a prison is a lower one than that owed by a

hospital[[54]](#footnote-54)53. Third, the defendant will be entitled to rely upon the maxim *‘volenti non fit injuria’*,

explained by Donaldson MR in *Freeman v Home Office*[[55]](#footnote-55)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

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’[[56]](#footnote-56)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*[[57]](#footnote-57)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 prison[[58]](#footnote-58)57. A particular issue arises in relation to transferred discretionary lifers.

While they cannot be discharged by a Tribunal[[59]](#footnote-59)58, 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*[[60]](#footnote-60)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[[61]](#footnote-61)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.

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 merits[[62]](#footnote-62)61.

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 arise[[63]](#footnote-63)62.

**(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 licence[[64]](#footnote-64)63, 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)[[65]](#footnote-65)64. In both cases,

Article 5(4) requires adequate judicial scrutiny of the continued detention and of any recall[[66]](#footnote-66)65. It is

also lawful to detain a person under Article 5(1) (e) as a ‘vagrant’ without any reciprocal right to

treatment[[67]](#footnote-67)66. 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’.

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)’[[68]](#footnote-68)67. All that Article 5(1) (e) requires

is that the detention is effected in a ‘hospital, clinic or other appropriate institution’[[69]](#footnote-69)68. Detention

without treatment may raise issues under Article 3[[70]](#footnote-70)69, 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[[71]](#footnote-71)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[[72]](#footnote-72)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[[73]](#footnote-73)72’, contrary to Article

5(1)(e). This was acknowledged by the Percy Commission in its 1957 Report[[74]](#footnote-74)73, 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.”

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)[[75]](#footnote-75)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

intervention[[76]](#footnote-76)75.

(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 reciprocity[[77]](#footnote-77)76, 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

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 instruments[[78]](#footnote-78)77. 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)[[79]](#footnote-79)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

treatment[[80]](#footnote-80)79. A particular duty to provide treatment has been found to exist in relation to detained

persons[[81]](#footnote-81)80. 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*[[82]](#footnote-82)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-saving[[83]](#footnote-83)82. The question whether absence of resources will justify

refusing life-saving treatment has yet to be considered by the Strasbourg Court[[84]](#footnote-84)83, 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[[85]](#footnote-85)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

1995[[86]](#footnote-86)85. So far as Article 14 is concerned it should be noted that the right is not a stand-alone

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 introduced[[87]](#footnote-87)86.

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 rights[[88]](#footnote-88)87. The right of a capacitated individual to refuse

consent to treatment[[89]](#footnote-89)88 and nutrition[[90]](#footnote-90)89 are well established. As a matter of convention law, a state

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 prevail[[91]](#footnote-91)90.

The situation differs where the patient lacks capacity to make such decisions[[92]](#footnote-92)91. 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 individual[[93]](#footnote-93)92. 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

Hercegfalvy v Austria[[94]](#footnote-94)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[[95]](#footnote-95)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 8[[96]](#footnote-96)95.

*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 Appeal[[97]](#footnote-97)96 where the Article 6 implications will be fully explored.

**(10) 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 safeguards 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 housed[[98]](#footnote-98)97. The more recent case of *Burton v United Kingdom*[[99]](#footnote-99)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*.[[100]](#footnote-100)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 accommodation[[101]](#footnote-101)100.

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[[102]](#footnote-102)101 the UK was found to have violated Article 3 by its decision to deport the Applicant,

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*[[103]](#footnote-103)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 relevant 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[[104]](#footnote-104)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*[[105]](#footnote-105)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*[[106]](#footnote-106)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 engaged[[107]](#footnote-107)106.

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*[[108]](#footnote-108)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.

**(11) 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’[[109]](#footnote-109)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’ competence[[110]](#footnote-110)109). 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*[[111]](#footnote-111)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*)[[112]](#footnote-112)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’.

This argument is undermined, however, by the Strasbourg Court’s decision in *Nielsen v*

*Denmark*[[113]](#footnote-113)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*[[114]](#footnote-114)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.

1. \* Barrister, Doughty Street Chambers, London [↑](#footnote-ref-1)
2. ‘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. [↑](#footnote-ref-2)
3. see Hakansson and Sturesson 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 [↑](#footnote-ref-3)
4. See R v Director of Public Prosecutions ex p Kebilene [1999] 3 WLR 972, 996D-F [↑](#footnote-ref-4)
5. See Handyside v U.K. (1976) 1 EHRR 737 [↑](#footnote-ref-5)
6. 5 [1999] 3 WLR 972, at 993: [↑](#footnote-ref-6)
7. 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. [↑](#footnote-ref-7)
8. 7 Winterwerp v Netherlands (1979) 2 EHRR 387, §39 [↑](#footnote-ref-8)
9. 8 ibid, §37 [↑](#footnote-ref-9)
10. 9 ibid, §39 [↑](#footnote-ref-10)
11. 10 As in Re MB (An Adult: Medical Treatment) [1997] 2 F.C.R. 541, CA [↑](#footnote-ref-11)
12. 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. [↑](#footnote-ref-12)
13. 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 [↑](#footnote-ref-13)
14. 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. [↑](#footnote-ref-14)
15. 14 Similar criteria apply governing a patient’s admission into guardianship. [↑](#footnote-ref-15)
16. 15 R v Home Secretary ex p K [1991] 1 Q.B. 270 [↑](#footnote-ref-16)
17. 16 Kay v United Kingdom (1998) 40 B.M.L.R. 20 [↑](#footnote-ref-17)
18. 17 O. Thorrold, ‘The Implications of the European Convention on Human Rights for UK Mental Health Legislation’, [1996] EHRLR 619 [↑](#footnote-ref-18)
19. 18 De Wilde, Ooms & Versyp v Belgium (1971) 1 EHRR 373, §76 [↑](#footnote-ref-19)
20. 19 (1981) 4 E.H.R.R. 188 [↑](#footnote-ref-20)
21. 20 Johnson v United Kingdom (1997) 22 EHRR 296, §66 [↑](#footnote-ref-21)
22. 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. [↑](#footnote-ref-22)
23. 22 Decision of 18 July 1986 [↑](#footnote-ref-23)
24. 23 De Wilde, Ooms & Versyp, ibid, §79 [↑](#footnote-ref-24)
25. 24 Megyeri v Germany (1992) 15 EHRR 584, §22 [↑](#footnote-ref-25)
26. 25 Neumeister v. Austria, 1 E.H.R.R. 91, at para. 22 [↑](#footnote-ref-26)
27. 26 Winterwerp v. the Netherlands (1979) 2 EHRR 387, para. 60 [↑](#footnote-ref-27)
28. 27 ibid, para 60 [↑](#footnote-ref-28)
29. 28 Megyeri v Germany (1992) 15 EHRR 584, §23 [↑](#footnote-ref-29)
30. 29 Cottenham v United Kingdom [1999] EHRLR 530 [↑](#footnote-ref-30)
31. 30 App. No. 24557/94 Musial v Poland, Decision dated 25 March 1999, ECHR, §46; see also Cottenham v United Kingdom, ibid [↑](#footnote-ref-31)
32. 31 Roux v United Kingdom App. No. 25601/94, 16 September 1997 [↑](#footnote-ref-32)
33. 32 Khoendjbiharie v Netherlands (1990) 13 EHRR 820 [↑](#footnote-ref-33)
34. 33 E v Norway (1994) 17 EHRR 30 [↑](#footnote-ref-34)
35. 34 Cottenham, ibid [↑](#footnote-ref-35)
36. 35 Farmakopoulos v Belgium (1992) Series A, No. 235-A, EComHR [↑](#footnote-ref-36)
37. 36 Van der Leer v Netherlands (1990) 12 EHRR 567, para 35 [↑](#footnote-ref-37)
38. 37 Both under Article 5(2) and as a component of Article 5(4): (X v United Kingdom (1981) 4 EHRR 188, §66 [↑](#footnote-ref-38)
39. 38 (Fox, Campbell & Hartley v United Kingdom (1991) 13 EHRR 157, §40 [↑](#footnote-ref-39)
40. 39 Winterwerp v. the Netherlands (1979) 2 EHRR 387, para. 55 [↑](#footnote-ref-40)
41. 40 App. No. 24557/94 Musial v Poland, Decision dated 25 March 1999, ECHR, §46 [↑](#footnote-ref-41)
42. 41 See, e.g., Megyeri v Germany, ibid, para 22(d) (obtaining legal representation) [↑](#footnote-ref-42)
43. 42 App. No. 33267/96 Croke v Ireland, Admissibility Decision of 15 June 1999, EcomHR [↑](#footnote-ref-43)
44. 43 See, e.g., R v MHRT ex p Hall [1999] 4 All E.R. 883 [↑](#footnote-ref-44)
45. 44 R v Oxford MHRT ex p Home Secretary [1988] AC 120 [↑](#footnote-ref-45)
46. 45 See R v Ealing HA ex p Fox [1993] 1 W.L.R. 373 [↑](#footnote-ref-46)
47. 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) [↑](#footnote-ref-47)
48. 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)). [↑](#footnote-ref-48)
49. 48 Sunday Times v United Kingdom (1979-80) 2 E.H.R.R 245, at paragraph [47] [↑](#footnote-ref-49)
50. 49 Sunday Times case, ibid, paragraph [49] [↑](#footnote-ref-50)
51. 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 [↑](#footnote-ref-51)
52. 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) [↑](#footnote-ref-52)
53. 52 Freeman v Home Office [1984] 1 All ER 1036, CA [↑](#footnote-ref-53)
54. 53 Knight v Home Office [1990] 3 All E.R. 237 [↑](#footnote-ref-54)
55. 54 [1984] 2 WLR 802 [↑](#footnote-ref-55)
56. 55 Winterwerp v. the Netherlands (1979) 2 EHRR 387, para. 55 [↑](#footnote-ref-56)
57. 56 See footnote 16 (supra) [↑](#footnote-ref-57)
58. 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 Pilditch [1994] COD 352. This does not, however, include discretionary lifers who have served the tariff component of their sentences. [↑](#footnote-ref-58)
59. 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) [↑](#footnote-ref-59)
60. 59 [1995] QB 43, CA. [↑](#footnote-ref-60)
61. 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 [↑](#footnote-ref-61)
62. 61 App. No. 28212/95 Benjamin & Wilson v United Kingdom, Admissibility decision 27 October 1997 [↑](#footnote-ref-62)
63. 62 Wynne v United Kingdom (1995) 19 EHRR 333, ECHR [↑](#footnote-ref-63)
64. 63 Weeks v United Kingdom (1987) 10 EHRR 293, ECHR [↑](#footnote-ref-64)
65. 64 Van Droogenbroeck v Netherlands (1982) 4 EHRR 443 [↑](#footnote-ref-65)
66. 65 Weeks, ibid [↑](#footnote-ref-66)
67. 66 De Wilde, Ooms & Versyp v Belgium (1971) 1 EHRR 373 [↑](#footnote-ref-67)
68. 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 [↑](#footnote-ref-68)
69. 68 Aerts v Belgium (2000) 29 E.H.R.R. 50 [↑](#footnote-ref-69)
70. 69 B v United Kingdom (1984) 6 EHRR 204 [↑](#footnote-ref-70)
71. 70 [1999] 2 WLR 28 [↑](#footnote-ref-71)
72. 71 Times, 21 June 2000 [↑](#footnote-ref-72)
73. 72 Winterwerp, ibid, §37 [↑](#footnote-ref-73)
74. 73 Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency (‘Percy Commission’), HMSO, 1957, Cmnd 169 [↑](#footnote-ref-74)
75. 74 This is a different question from that faced by the House of Lords in Reid v Scotland [1999] 2 WLR 28 [↑](#footnote-ref-75)
76. 75 Evidence of Dr. Reed to the Fallon Enquiry Report, Cm 4194-II, §6.1.75 [↑](#footnote-ref-76)
77. 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.’ [↑](#footnote-ref-77)
78. 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.’ [↑](#footnote-ref-78)
79. 78 D v United Kingdom (1997) 24 EHRR 423 [↑](#footnote-ref-79)
80. 79 Keenan v UK, App. 27229/95, ECssnHR Report 6 September 1999; Hughes v UK (1986) 48 DR 258, ECssnHR [↑](#footnote-ref-80)
81. 80 Cyprus v Turkey 4 EHRR 482, EcssnHR Report 10 July 1976 [↑](#footnote-ref-81)
82. 81 (1984) 6 EHRR 204 [↑](#footnote-ref-82)
83. 82 Soobramoney v Minister of Health, KwaZulu-Natal (1997) 50 BMLR 224 [↑](#footnote-ref-83)
84. 83 [1995] 1 WLR 898 [↑](#footnote-ref-84)
85. 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) [↑](#footnote-ref-85)
86. 85 Note the approach of the Supreme Court of Canada in Eldridge v A-G of British Colombia (1997) 3 BHRC 137 (failure to fund sign-language violated deaf persons’ right to equal treatment) [↑](#footnote-ref-86)
87. 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. [↑](#footnote-ref-87)
88. 87 Airedale NHS Trust v Bland [1993] A.C. 1, per Lord Goff at 864 [↑](#footnote-ref-88)
89. 88 Re. T (Adult: Refusal of Medical Treatment) [1993] Fam. 95 [↑](#footnote-ref-89)
90. 89 Robb v Secretary of State for the Home Department [1995] 2 W.L.R. 722 [↑](#footnote-ref-90)
91. 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) [↑](#footnote-ref-91)
92. 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 [↑](#footnote-ref-92)
93. 92 Re. F [1990] 1 A.C. 1 [↑](#footnote-ref-93)
94. 93 (1992) 15 EHRR 437, at §83). [↑](#footnote-ref-94)
95. 94 (1992) 15 EHRR CD 100 [↑](#footnote-ref-95)
96. 95 See Re. F (Adult Patient), (Unreported) 26 June 2000, CA, per Sedley LJ [↑](#footnote-ref-96)
97. 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. [↑](#footnote-ref-97)
98. 97 X v Germany (1956) 1 Yearbook 202 [↑](#footnote-ref-98)
99. 98 (1995) 22 EHRR CD 135 [↑](#footnote-ref-99)
100. 99 [1999] 28 EHRR CD 175 [↑](#footnote-ref-100)
101. 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 [↑](#footnote-ref-101)
102. 101 (1997) 24 EHRR 423 [↑](#footnote-ref-102)
103. 102 (1999) 31 H.L.R. 10 [↑](#footnote-ref-103)
104. 103 (1978) 13 DR 40 [↑](#footnote-ref-104)
105. 104 (1996) 23 EHRR 101 [↑](#footnote-ref-105)
106. 105 (1986) 47 DR 274 [↑](#footnote-ref-106)
107. 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 [↑](#footnote-ref-107)
108. 107 [1999] Lloyd’s Rep. Med. 306 [↑](#footnote-ref-108)
109. 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 [↑](#footnote-ref-109)
110. 109 Gillick v West Norfolk and Wisbech Area Health Authority and the DHSS [1986] 1 A.C. 112 [↑](#footnote-ref-110)
111. 110 [1993] 2 FLR 187 [↑](#footnote-ref-111)
112. 111 [1997] 2 F.L.R. 180 [↑](#footnote-ref-112)
113. 112 (1988) 11 EHRR 175 [↑](#footnote-ref-113)
114. 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. [↑](#footnote-ref-114)