

**REVIEW OF THE MENTAL HEALTH ACT 1983:
THE ECHR AND THE HUMAN RIGHTS ACT**

INTRODUCTION

1. Justice have been invited by the Mental Health Legislation Scoping Study Review Team to comment on the Key Themes identified by the team at the start of their review.
2. In these comments, Justice seek to identify the human rights implications of the proposals set out in the Key Themes document. Justice would welcome the opportunity to comment further on the proposals made by the Review Team at the conclusion of their review.
3. Before turning to the individual themes, Justice would make the following observations of general application.
4. First, the Review Team have indicated that they intend considering the need for legislation to cover those who receive care in their own homes or in residential settings. Deprivation of liberty under the ECHR is a concept that has been broadly defined by the Strasbourg institutions. Individuals may come within the protection of Article 5 of the Convention even though they are not compulsorily detained within an institution.
5. Second, the Review Team intend to consider the position of carers in any new legislation. It should be remembered that the allocation of responsibility to private carers will not necessarily mean that their actions escape scrutiny under the Human Rights Act 1998. By

Section 6 of the Act it is “*unlawful for a public authority to act in a way which is incompatible with a Convention right.*” By sub-section 3 “*public authority*” includes “*any person certain of whose functions are functions of a public nature*”. Consideration should be given to whether functions devolved to carers mean that they are performing a public function.

6. Third, a recent decision of the European Court of Human Rights in *Osman v United Kingdom* (October 28th 1998) suggests that the relevant authorities may be liable under the 1998 Act towards victims of crimes committed by mentally ill patients who have been released into the community. This judgment may have implications for situations such as the *Darren Carr* case.

KEY THEMES

A Coverage of legislation

7. Article 5 of the ECHR provides that:

“1. *Everyone has the right to liberty and security of person. No-one should be deprived of his liberty save in the following cases and in accordance with the procedure prescribed by law ...*

(e) *the lawful detention ... of persons of unsound mind ...*”

8. The meaning of “*persons of unsound mind*” was considered in *Winterwerp v Netherlands* (A33 para.39). No definitive interpretation was provided, the Court taking the view that that was not possible because the medical profession’s understanding of mental disorder was still developing. The Court held that determining whether a person is of “*unsound mind*” is a matter for the domestic Court which needs not define or list the categories of

mental illness to which it extends. If new legislation is to comply with the Convention it will be necessary for the definition to be flexible enough to reflect psychiatric knowledge as it develops.

9. There is danger, from a human rights point of view, in including in a definition of those caught by future mental health legislation specific groups of the sort itemised in the Key Themes document. Article 14 of the Convention prohibits discrimination. The Article includes an open-ended list of prohibited grounds for discrimination. Discrimination on grounds of age, for example, may come within its ambit so that any automatic inclusion of “*elderly people*” as being within the scope of the legislation may amount to a violation of Article 14 when combined with other relevant Articles such as the right to a private life (Article 8), protection from unlawful deprivation of liberty (Article 5), the right to a fair trial (Article 6) and protection from degrading treatment (Article 3).
10. Any legislation which attaches the stigma of mental illness to individuals who are only temporarily unwell may fall foul of Article 5, which only allows deprivation of liberty on the basis of a persisting disorder (see *Winterwerp*).
11. It seems to Justice essential that any new mental health legislation should address the issues raised by *Bournewood*. There are substantial grounds for thinking that the common law doctrine of necessity, as preserved by Section 131(1) of the Mental Health Act 1983, would not survive a challenge under the Convention, nor scrutiny under the 1998 Act. “*Necessity*” provides a poor legal basis for detention. There must be real doubt, furthermore, whether the current definition of necessity is sufficiently precise to meet the

requirement that it is “*prescribed by law*” for the purposes of Articles 8-12.

12. To ensure proper compliance with human rights objectives, any new legislation ought to adopt a proportionality test. The onus should be on the public authority to establish that the particular circumstances of a case justify the measure proposed.

2. Ensuring quality of care

13. A patient’s entitlement to care is in essence a social and economic right. Nonetheless there are circumstances in which a failure to provide care may, arguably, engage the United Kingdom’s obligations under the Convention and found a challenge under the 1998 Act. For example, if the absence of care poses a threat to life there may be a breach of Article 2. If the absence of care amounts to inhuman or degrading treatment there may be a breach of Article 3. It is possible that in some circumstances a mentally ill patient might be able to establish the “arbitrariness” of deprivation of liberty, under Article 5, if no mental health care facilities are available in the place of detention.

14. The Review Team contemplate legislation covering the registration and regulation of providers of mental health care. Such legislation would have to be compliant with Article

6. Article 6 provides that

“In the determination of his civil rights and obligations ... everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law.”

The membership and proceedings of professional disciplinary bodies deciding matters of registration and regulation must comply with Article 6 since their decisions would concern the civil rights and obligations of mental health care providers (see by comparison *Diennet*

v France (1995) HRC 491 and *Stefan v UK* (1998) 25 EHRR CD130).

15. It has been argued in the past that the availability of judicial review of disciplinary bodies' decisions may be sufficient to ensure compliance with Article 6. The limited scope of judicial review, depending as it does upon proof of illegality, irrationality or procedural impropriety, means that there are real doubts as to whether it provides adequate protection of human rights.

3. Compulsory power

(i) Interventions in the case of a capable patient

16. The common law principle of autonomy, set out in *R v Collins Ex parte S* [1998] 3 AER 673 reflects the position taken by the European Court on Convention points. Any interference with private autonomy requires precise justification if it is not to amount to a breach of Articles 3 and 8. For example, an ECT should only be given with the consent of a patient. Artificial feeding and enforced medical treatment would only be justified on medical therapeutic grounds (see *Herczegflavy v Austria* (1992) 15 EHRR 437).

17. Compulsory treatment may also constitute deprivation of liberty contrary to Article 5. Such treatment will only be justified on the basis of Article 5(1)(e) if a true mental disorder has been established of a kind and degree sufficient to warrant compulsory confinement.

(ii) The thresholds which must be met

18. The European Court of Human Rights has granted a relatively wide margin of appreciation

to Member States in their definition of “*unsound mind*”. There have been no cases in which the Member States’ medical evidence has been rejected. It is difficult to see, however, how margin of appreciation will be applicable in domestic Courts in cases brought under the 1998 Act. A proper respect for human rights necessitates the prohibition of compulsory treatment against the wishes of the patient save where such treatment can be justified on medical evidence objectively assessed.

19. The law which defines the thresholds which must be met before compulsory powers can be used must provide both accessibility and certainty. The law should only permit the use of compulsory powers where the proposed measures are proportionate to the patient’s condition.

(iii) By whom should the necessary judgments be made?

20. Whoever makes the first judgment as to the need for detention and/or the use of compulsory powers it is essential that that decision is subject to review. Such review should be before an independent tribunal with sufficient powers to decide on the propriety of the proposed actions, not just the lawfulness or rationality of the primary decision-maker’s decision.

21. The European Court has accepted that certain curtailed proceedings, such as consultation by telephone, may be acceptable where an emergency has arisen (see *Wassink v Netherlands* [1990] EHRR 820) but that should be seen as the exception rather than the rule.

(iv) and (v) What form should compulsory powers take? and How should those powers be enforced?

22. Whatever form the compulsory powers take, they are likely to involve a deprivation of liberty. Deprivation of liberty covers a wide variety of circumstances in Strasbourg jurisprudence (see for example *Ashingdane v United Kingdom* [1985] 7 EHRR 529). For example, compulsory powers to ensure compliance with a care programme in the community which may include medical treatment is likely to constitute deprivation of liberty (see by comparison *Guzzardi v Italy* [1980] 3 EHRR 333). That being so, the safeguards provided by Article 5 of the Convention must be applicable in any case where compulsory powers apply. The enforcement of those compulsory powers, therefore, must be subject to review by an independent tribunal.

(vi) Retaining remaining civil liberties

23. The presumption must be that patients retain all their civil liberties subject only to such suspension of liberties as is essential for necessary medical treatment.

4. Treatment

24. The test for what compulsory treatment is permissible as a matter of law must be flexible enough to reflect changes in accepted psychiatric practice. There is great danger in listing as acceptable identified treatments, when changing medical opinion may lead to doubts as to their efficacy or acceptability.

25. The Strasbourg authorities approach compulsory treatment by looking to see whether prevailing psychiatric principles support it. Thus the use of physical force as a therapeutic

necessity may escape censure under Article 3 if medical opinion indicates that it is necessary (see *Herczegfalvy v Austria*).

5. Confidentiality and sharing information

(i) and (ii) Sharing information and the right to privacy

26. Article 8 guarantees the right to respect for private life and correspondence. The sharing of any confidential information about a patient prima facie breaches that right. Such sharing of information should only be permitted when it meets the requirements of paragraph 2 of Article 8 namely that such sharing is lawful, pursues a proper aim and is necessary in a democratic society.

27. There will be occasions where the prevention of disorder or crime or the protection of health of others justifies breach of a patient's privacy within the meaning of Article 8. Thus, for example, in *TV v Finland* No. 21780/93 76 ADR 140, the European Court of Human Rights regarded as justified the disclosure of a prisoner's HIV status to prison staff.

28. A patient ought to be provided with the opportunity to challenge the communication of confidential medical information.

6. The ending of compulsion

(i) Limitations on the duration of compulsion

29. The duration of compulsion should correspond with the need for compulsion. There must be procedures in place whereby as soon as a patient's condition improves so that

compulsion or detention is no longer medically required he can regain his freedom. The European Court of Human Rights scrutinises very strictly any delay in the ending of compulsion. It is likely to be a breach of Article 5(1)(e) to maintain detention or the use of compulsory powers once the medical need for them has ended even if there is practical justification for the continuation of such powers, such as the absence of suitable alternative accommodation (see *Johnson v UK* [1997] 25 EHRR). There must be strict compliance with any procedural rules regarding extensions of detention (see *Erkalo v Netherlands* 2nd September 1998).

(ii) Mechanisms for the review of compulsion

30. If the judgment in question amounts to a decision to deprive an individual of his or her liberty, or to continue that deprivation, that individual must have the chance to challenge the lawfulness of the treatment before an independent tribunal. *X v United Kingdom* [1981] 4 EHRR 188 lays down minimum requirements of independence and impartiality of the judicial body which is to test the lawfulness of the deprivation of liberty under Article 5(4).
31. The presence of interested parties on the panel which makes the judgment may not prejudice the patient but other members must be independent and any conclusions reached by the panel must not be superseded by the executive (*X v UK*). In any proceedings regarding the continuation of circumstances that amount to a deprivation of liberty under Article 5, the Applicant must be heard in person or through a representative.
32. Habeas corpus and judicial review are unlikely to fulfil the requirements of Article 5(4)

in this context. The reviewing body should possess powers to reach an independent view on the need for continued compulsory treatment or continued detention based on an objective assessment of the medical evidence.

7. Safeguards

33. This note has attempted to address the need for safeguards in responding to each of the other questions set out above.

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NOTE