

THE NORTHERN IRELAND HUMAN RIGHTS COMMISSION

**SETTING THE STANDARDS:
HUMAN RIGHTS AND HEALTH**

MENTAL HEALTH

Contents

Introduction

1.0 Getting the balance right

2.0 Setting the standards

3.0 Central issues in mental health law

3.1 *Capacity*

3.2 *Detention*

3.3 *Treatment*

4.0 Seclusion and the case of *Munjaz*

5.0 Tribunal discharge and the immediate use of statutory powers to detain

6.0 Legislative reform in Northern Ireland

7.0 Discharging the Commission's statutory duty in the mental health field

Appendix 1 - Northern Ireland Human Rights Commission – Statutory Remit Defined at Sections 68-71 of the Northern Ireland Act 1998

Appendix 2 - The Mental Health Care Principles

Appendix 3 - R (on the application of Mungaz) v Mersey Care NHS Trust [2003] AER (D) 265

Appendix 4 - R (on the application of Mungaz) v Mersey Care NHS Trust [2006] 4 All ER 736

Appendix 5 - Brian McGee: judicial review [2006] NIQB 78

Introduction

Currently in Northern Ireland we are in the midst of a process that is intended to culminate in wide-sweeping legislative reform of existing mental health law. In 2005, a government review, The Bamford Review, was established by the Department of Health, Social Services and Public Safety, to provide an independent review of law, policy and practice relating to mental health and learning disability. In February 2007, following the Review's Working Groups and its report, the Review issued a consultation report entitled *A comprehensive legislative framework*.

The Northern Ireland Human Rights Commission (the Commission) is especially interested in developments arising out of the Review's consultation exercise, given its statutory roles and responsibilities under the Northern Ireland Act 1998, which concern the protection of human rights in Northern Ireland, including people with mental health difficulties. (The full text of these legislative provisions - Sections 68-71 - is outlined in Appendix 1.) A pivotal part of the Commission's role is its duty to "*keep under review the adequacy and effectiveness in Northern Ireland of law and practice relating to the protection of human rights*". (Section 69(1))¹

Consequently, the Commission believes it important to contribute to current human rights debate. This paper considers the question of standard setting in mental health. Sections 1-2 of this paper consider concepts and principles germane to the formulation of human rights standards in this field. Section 2 particularly highlights the important distinction between human rights law and human rights standards. Section 3 then considers three of the main issues in mental health law: capacity, detention and treatment, and identifies relevant human rights standards relating to each. Thereafter it considers whether aspects of the law are inconsistent with a human rights approach. Sections 4-6 pick up on key themes arising out of the previous sections, providing:

- an illustration of how human rights standards can be innovatively assimilated into law on the part of lawyers and judges (Section 4);
- an exploration of the tension between legal decisions and professional discretion when considering situations where a person discharged by a tribunal is considered suitable for immediate re-admission (Section 5); and,

¹ In discharging its statutory duties in relation to the mental health field, the Commission has produced a valuable report entitled *'Connecting Mental Health and Human Rights'* (2003); and has made a significant contribution to the *Bamford Review* through the appointment of its Commissioner Lady Christine Eames as the Chair of the Sub-committee on Human Rights and Equality. A report has been completed by that sub-committee entitled *Human Rights and Equality of Opportunity*. (October 2006)

The Commission also has been engaged in protecting the rights of prisoners including prisoners with mental health difficulties. (See Commission publication *The Hurt Inside*; June 2005).

Most recently, the Commission was given leave by the High Court to intervene in a case raising human rights issues in relation to the treatment of a female prisoner with a personality disorder. (*Re.Ciara McCullough*)

- a discussion about the Bamford Review, highlighting its contributions to debate in this area and subjecting its proposals to appropriate scrutiny. (Section 6)

Finally, Section 7 identifies practices that could facilitate the Commission in fulfilling its statutory duty and in protecting the rights of mental patients.

1.0 Getting the balance right

Issues arising in mental health

It is imperative that society has adequate structures in place to protect the rights and interests of the vulnerable in society, e.g. children, elderly people and people with disabilities. People with mental health difficulties are often vulnerable and in need of assistance, including care and/or treatment.

Mental health brings with it a range of issues which public authorities, and in particular those specifically charged with responsibility for people with mental health difficulties, must properly negotiate.

Such issues include:

- the health and welfare needs of the individual
- the autonomy of the individual
- determining capacity
- appropriate intervention where a person is incapable
- non-consensual intervention
- the rights of the individual
- the interests of the individual
- the rights of others
- the interests of others

A simplistic 'autonomy versus paternalism' approach to mental health fails to contemplate the complexity of the mental health field. Rather it is necessary to strike an appropriate balance between the various legitimate and often competing rights, interests and duties in the field, including the human rights of the patient.

Striking the balance

In its decision in the case of *Soering v UK* [1989] 11 EHRR 439 at para 89, the European Court stated:

inherent in the whole of the Convention is the search for the fair balance between the demands of the general interest of the community and the requirements of the protection of the individual's human rights.

People with an interest in mental health generally come with a particular perspective. For example, persons with mental health difficulties have an obvious personal interest as the law can have a direct and profound impact on their lives. Health care professionals (such as Doctors and Nurses and Social Workers) are employed by the state to provide care and treatment for patients: their's is a professional perspective.

Carers, family and friends of people with mental health difficulties have their own experiences, opinions and needs.

The key legal and human rights issues generally arise at points of conflict between the respective perceptions, views and interests of the relevant participants: in particular, the patient and health care professional. For example, a patient may not want to be detained in hospital and may regard compulsory state intervention as an interference with his or her autonomy and human rights: but a doctor, social worker or nurse may take the view that intervention is necessary to protect the patient and/or others from harm.

The role of the law and the lawyer

In the mental health field, the role of lawyers acting on behalf of patients is to protect their clients' rights, interests and liberties in the face of public authority intervention. It centrally involves two inter-related questions, i.e. whether and to what extent the state can intervene in the life of the individual?

Law and psychiatry have been described as "languages of reason about madness".² Psychiatry is the field of diagnosis and treatment. Law considers the duties of public authorities and the rights of the individual and seeks to demarcate the boundaries of lawful intervention. According to Bartlett and Sandland, the languages are 'paradigms of rationality'. Whilst they are both rational, they involve very different ways of perceiving the field.

This paper is concerned with the legal paradigm. Mental health law gives power to health authorities and the professionals working in that field. As with any delegation of power, those entrusted with exercising the power must be subject to regulation.

The job of lawyers and advocates acting for the patient is both to limit state intervention to that which is lawful and appropriate, and to prevent unlawful, arbitrary, unnecessary, inappropriate and/or harmful intervention.

*Law glorifies the representation of the individual client: in our professional ideology, based in rights theory and liberalism, the model of the lawyer defending the interests and acting on the instructions of the individual client is pivotal.*³

Law cannot simply abdicate its responsibility and act as a rubber stamp for professional, and in particular medical opinion. The different language of law must speak clearly and authoritatively, to ensure the power delegated is exercised appropriately.

Law has a particular role in mental health in identifying the appropriate limits of health authority power, including the power of the psychiatrist. This involves proper consideration of human rights issues and identification of where the balance should be appropriately struck.

² *Mental Health Law Policy and Practice*; Bartlett and Sandland; Third Edition, 2007, page 1.

³ *Id.*

Human rights law

Northern Ireland is a jurisdiction that has the Human Rights Act 1998 in place, importing European Convention jurisprudence into its legal framework. But, and it is a big 'but', the level of protection accorded within European Convention (or Strasbourg) jurisprudence - whilst important - cannot be regarded as constituting adequate protection for the rights of mental patients. In many ways, the level of Convention protection is more akin to providing a floor of rights, that is, a minimum of rights.

The Convention was not drafted with the rights of mental patients at the forefront of the drafters' minds. Nonetheless, the jurisprudence of the European Court on Human Rights has developed a body of legal standards protecting the rights of mental patients. The domestic courts must contemplate these standards where applicable, per Sections 2-4 of the Human Rights Act 1998.

Pursuant to one of its main statutory functions; i.e. to "*keep under review the adequacy and effectiveness in Northern Ireland of law and practice relating to the protection of human rights*", the Commission has a continuing obligation to scrutinise legislation, case law, policy and practice to ensure that they conform to appropriate human rights requirements and standards.

The point of departure for human rights organisations should not be the presumption that the law appropriately protects human rights. Rather, the development of a stratagem for protecting mental patients from inappropriate public authority intervention involves:

1. identification of the relevant issues;
2. identification and development of applicable human rights standards; and,
3. scrutiny of law, policy and practice against the yardstick of standards.

A fundamental question for consideration is what human rights standards should be protected by law?

2.0 Setting the standards

Standards and law discussed

In mental health standards can be regarded as requirements necessary to properly safeguard the rights of mental patients. They are both procedural and substantive in nature.

Human rights standard setting does not simply involve the identification of relevant and prevailing human rights law. Rather, it is the job of the Commission as well as human rights lawyers, advocates and others to identify the standards that the law should protect in the field of mental health and attempt to persuade legislators, public authorities, courts and tribunals to adopt and/or adhere to those standards.

It is vital to distinguish between human rights law and human rights standards. By way of an illustration of the difference one can imagine a small circle inside a larger circle:

the small circle representing human rights law and the larger circle representing human rights standards.

For the purposes of this paper, human rights law refers to those human rights standards that have gained legal status in Northern Ireland. A major source of human rights law is the Human Rights Act 1998, which imports Strasbourg jurisprudence into Northern Ireland. This jurisprudence includes the European Convention on Human Rights (the Convention) and the decisions of the European Court on Human Rights (the European Court). The Northern Ireland courts must take account of Convention law where applicable, and the common law itself has become an important source of human rights law.

The broader concept of human rights standards includes both standards recognised by law (legal standards) as well as those requirements regarded as necessary to properly safeguard the rights of mental patients, but which have not obtained legal status in Northern Ireland. Such standards derive from various sources. One of the main sources of human rights standards are those adopted by International organisations, notably the United National General Assembly. The most pertinent example of such international standards is the “Principles for the protection of persons with mental illness and the improvement of mental health care”.⁴

Standard setting

It is not possible to precisely identify relevant human rights standards until the issue in question is accurately identified. Human rights standard setting depends upon the issue in question and considerations relevant thereto, including the nature and purpose of public authority intervention. It involves consideration of the various and often competing rights, interests, duties and other relevant factors, and in particular the identification of the nature and import of human rights considerations in the equation.

Standard setting is not simply dependent upon researching existing standards. It also involves the creative development or generation of standards applicable to specific case circumstances, particularly where no appropriate standards already exist.

Standard setting in mental health

In mental health, adequate protection is needed from arbitrary intervention, and in particular:

- inappropriate findings of incapacity;
- inappropriate detention; and/or,
- inappropriate treatment (including medical treatment).

Central to the development of appropriate human rights standards in the field of mental health are the following concepts:

1. capacity;
2. autonomy;
3. liberty;

⁴ General Assembly resolution 46/119 of 17 December 1991.

4. the right to health care; and,
5. the prevention of harm.

When discussing standard setting in the field of mental health law, the best place to start is probably the United Nations Mental Health Care Principles (hereinafter the 'Principles'). (See Appendix 2) Rosenthal and Sundram quote the Chairman of the Working Group who drafted the standards as stating that the Principles represent "*the minimum United Nations standards for the protection of fundamental freedoms and human and legal rights of persons with mental illness*".⁵ Their point is that compliance with the Principles does not necessarily amount to appropriate protection of human rights.

Even a cursory reading of the Principles reveals that the concepts of autonomy, liberty and capacity are highly prized and closely safeguarded. The Principles seek to maximise the protection of patients' autonomy and liberty. They seek to minimise interference with autonomy and liberty. They seek to protect against arbitrary intervention whether a patient is capable or incapable. Yet, they facilitate non-consensual intervention to prevent harm.

Another primary source of concepts underpinning human rights standards is the European Convention on Human Rights and its jurisprudence. Some important concepts and principles at the core of Convention jurisprudence include the following:

- non-derogability;
- interferences with human rights must be necessary to achieve a specific social objective;
- proportionality: i.e. "*a restriction will be proportionate only if the objective behind the restriction justifies interference with a Convention right, there is a rational connection between the objective and the restriction in question and the means employed are not more than is necessary to achieve the objective;*"⁶
- 'the least restrictive alternative': a principle derived from proportionality; and,
- close judicial scrutiny of measures which abrogate human rights with a correlation between the nature of the human rights abrogated and the intensity of the scrutiny.⁷

Leaving to one side the Convention context, such fundamental concepts underpin human rights standard setting. Together with the concepts (capacity, autonomy, etc.) identified above, they comprise raw materials for constructing a coherent and compelling set of standards to facilitate the scrutiny of law, policy and practice.

Law: an introduction

Law, *inter alia*, regulates the powers of public authorities and the limits of power. It is one of the chief mechanisms or structures able to protect the rights of the individual.

⁵ *International Human Rights and Mental Health Legislation; Conference Paper*, February 2003.

⁶ Starmer, *Human Rights Digest*, page 9.

⁷ See generally Starmer, *Human Rights Digest*, Chapter one.

In Northern Ireland, legislation has become the main legal mechanism used in the construction of legal frameworks of governance. In formulating legislation, policy-makers, legislative drafters and legislators must consider the various relevant and competing issues and considerations, and seek to ensure the legislation is appropriate and that it conforms to legal requirements. Since October 2000, one of the main legal requirements for Northern Ireland legislation is that it conforms to the Human Rights Act 1998.

More generally, legislation should be:

- (a) rational;
- (b) clear, coherent and consistent;
- (c) carefully drafted to secure its objective(s);
- (d) appropriate in the light of competing interests, rights, requirements and duties; including interfering with individual liberty to the minimum extent necessary (see f, below);
- (e) *intra vires*, (i.e. secondary legislation should be within the powers conferred by the Parent Act); and,
- (f) compatible with human rights legislation, and in particular with applicable Convention jurisprudence.

Over the last 50-100 years, mental health law in these islands has comprised an amalgam of measures, largely under the umbrella of a mental health statute. Such measures have variously sought to address the diverse issues arising in the field including involuntary detention; treatment with and without consent for detained persons; and, substitute decision-making for persons deemed incapable. Legislation and judicial decisions have delineated the legal framework by taking account of the different social objectives of mental health law, and seeking to weight and balance the perceived and often competing rights and interests inherent in the field.

The question for all in Northern Ireland concerned with the mental health field is whether the law sufficiently protects human rights. If not, how should it be reformed to properly protect human rights?

The current legal framework

The Mental Health Order (Northern Ireland) 1986 is the legislation currently in force. It is very similar to the English Mental Health Act 1983 with some Northern Irish modifications. Two of the main differences are:

- (1) the two stage process of admission for assessment and detention for treatment; and,
- (2) the definition of mental disorder and the exclusion of personality disorder from the definition. (See Article 3(1))

An underlying presumption can be identified in the legislation, i.e. that detained patients can be compulsorily treated (subject to such limitations as have been prescribed). It is submitted that this legislative approach constitutes a failure to accord detained patients sufficient protection. The legal framework conceives detention and treatment as a package, failing to properly contemplate the specific human rights

considerations in relation to the different aspects of intervention, e.g. the reason for the detention and the appropriateness of the treatment.

The nature of the system is best described most recently by the Lord Chief Justice Lord Phillips in the English Court of Appeal case of *R (on the application of B) v S and others* [2006] AER (D) 200, Lord:

[47] Thus the MHA provides for an integral package of detention and treatment and imposes restrictions designed to ensure that individual treatment is justified. It is not logical to consider the [consent to treatment] ... question in isolation from the overall objective of the package. The most important question is likely to be whether the package is justified, and that is a question that falls within the remit of the Mental Health Review Tribunal under Pt V of the MHA. If detention of a patient for treatment pursuant to s 3 is justified on the ground that the treatment is necessary for the protection of others, it is illogical to contend that a higher standard has to be applied to justify the administration of the treatment itself.

The above approach fails to take account of the fact that detention and treatment constitute separate (if related) forms of (involuntary) intervention and that different human rights standards are applicable to each.

The exclusion of persons with a personality disorder from the ambit of the Order has raised human rights concerns. In the case of Ciara McCullough, the Applicant, a female prisoner with a personality disorder and a history of self-harm, was denied care and treatment in a mental health facility by reason of the exclusion of personality disorder in the legislation. In a recent judicial review it was argued by the Commission that this exclusion contravened Articles 2 and 3 of the European Convention:

- (a) that as she was being subjected to a penal regime rather than receiving appropriate care and treatment at a mental health facility; and,
- (b) that the Mental Health Order (NI) 1986 by excluding personality disorder from its ambit was in breach of the state's human rights obligations including its positive obligations under Article 2 of the Convention.

The Judge (Mr Justice Deeny) held that whilst an important compatibility issue had been raised by the Commission, it was appropriate to await the findings of the *Bamford Report*, and that it was more appropriate for the legislature (potentially the Northern Ireland Assembly) to address the matter.

The adoption of a principles based approach

Sometimes objectives and principles are expressly stated in legislation to provide guidance for those charged with the interpretation and application of the legislation. This legislative practice can be termed a 'principles based approach'. (Such an approach was adopted in the Mental Capacity Act 2005: see below.)

The adoption of principles-based approach can greatly assist in ensuring that human rights standards are accorded appropriate weight in mental health law, policy and practice.

Draft mental health legislation is currently before the Westminster Parliament. The Mental Health Bill (as currently drafted) contains a clause aimed at importing a principles-based approach into mental health law, policy and practice.⁸ Clause 10 provides for the insertion of a statement of fundamental principles in the Mental Health Act Code of Practice designed to inform decision-making under the Act. In preparing this statement of principles, the clause requires the Secretary of State to ensure that each of the following matters is addressed:

- (a) respect for patients' past and present wishes and feelings;
- (b) minimising restrictions on liberty;
- (c) involvement of patients in planning, developing and delivering care and treatment appropriate to them;
- (d) avoidance of unlawful discrimination;
- (e) effectiveness of treatment;
- (f) views of carers and other interested parties;
- (g) patient wellbeing and safety; and,
- (h) public safety.

Central issues in mental health law

There are a number of central or key issues in mental health law: involuntary detention; the determination of capacity; non-consensual treatment; and, substitute decision-making and care for the incapable with the question of proper safeguards. For the purposes of this paper, these issues will be distilled into: incapacity; detention; and, treatment; and they are addressed in the next three sub-sections.

3.1 Capacity

A core issue in mental health is the question of capacity. Many human rights depend upon a positive determination. Autonomy (the right of self government) is dependent upon capacity.

Issues

Some of the main issues include:

1. The determination of capacity;
2. The rights of a person with capacity;
3. Provision for the care and treatment of persons without capacity; and,
4. Adequate safeguards in relation to the care and treatment of persons without capacity.

Standards

The common law has been a guardian of human rights standards in relation to the determination of capacity. Historically medical treatment has been premised upon the

⁸ www.publications.parliament.uk

concepts of capacity and autonomy. In the American case of *Schloendorff v Society of New York Hospital* [1914] 105 NE 92, 340, Justice Cardozo stated:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault.

In *Re F (Mental Patient: Sterilisation)* [1989] 2 FLR 376 Lord Goff stated:

I start with the fundamental principle, long established, that every person's body is inviolate.

At common law, capacity was presumed. Incapacity had to be (medically) established. This presumption of capacity is now statutorily recognised in England and Wales in the Mental Capacity Act 2005 (Section 1).

Of particular import is the fact that the threshold of capacity is low. In one case a patient with schizophrenia was permitted to refuse an amputation which would have prolonged his life, as he was deemed to have sufficient capacity to hold the opinion that a shorter lifespan with two legs was preferable to a longer lifespan with one. (See *Re C* [1994] 1 AER 819) More recent cases have similarly placed a premium upon autonomy. (See *Re MB* [1997] 2 FLR 426; and, *R (on the application of John Wilkinson v The Responsible Medical Officer Broadmoor Hospital and others* [2002] 1 A WLR 419, and in particular Lady Hale at paragraph 80.)

Another source of human rights standards is found in the European Court on Human Rights decision in the case of *HL v The United Kingdom (aka 'Bournewood')* [2005] 40 EHRR 32. HL was autistic and profoundly disabled. He was incapable of providing consent. He had been discharged to live with paid carers Mr and Mrs Enderby. At a day centre he became very agitated and a psychiatrist assessed him as requiring in-patient treatment. The psychiatrist considered it unnecessary to admit him under the Mental Health Act 1983 as he was compliant and did not resist admission. Consequently he was detained informally and not pursuant to the legislation.

HL by his cousin and next friend challenged the lawfulness of the detention. The detention was considered lawful by the High Court. The Court of Appeal allowed the appeal finding the detention unlawful. The House of Lords allowed the appeal finding the detention lawful. (Dissenting judgments were delivered by Lords Steyn and Nolan.)

The European Court held that the detention was unlawful and contrary to Articles 5(1) and 5(4) of the European Convention on Human Rights. Of particular relevance is the finding that detention under the common law doctrine of necessity was unlawful: the court holding that the lack of a regulatory framework, and in particular adequate procedural safeguards, rendered the detention arbitrary and contrary to the Convention. It is useful to set out below the relevant part of this important decision:

116. The Court considers it clear that the domestic legal basis for the applicant's detention between 22 July and 29 October 1997 was the common-law doctrine of necessity: the House of Lords may have differed on whether his admission and stay in hospital amounted to detention, but it was unanimous in finding that he had been admitted to hospital pursuant to that doctrine. In addition, the Court considers that, when the doctrine of necessity was applied in the area of mental

health, it accommodated the minimum conditions for the lawful detention of those of unsound mind outlined in paragraph 98 above.

117. In this connection, the Court has noted that as early as 1772 the common law permitted detention of those who were a potential danger to themselves in so far as this was shown to be necessary. In the early 1990s necessity was the recognised legal basis for the consideration of authorisations for certain medical treatment (sterilisation and artificial nutrition and hydration) of incapacitated individuals (see paragraph 57 above). *Re S. (Hospital Patient: Court's Jurisdiction)* and *Re S. (Hospital Patient: Foreign Curator)* together with *Re C. (Mental Patient: Contact)*, reported in 1993 and 1996, resulted in declarations being made as to the best interests of incapacitated individuals pursuant to the doctrine of necessity where there was a conflict over certain welfare issues (see, in particular, the judgment of Lady Justice Butler-Sloss in *Re F. (Adult: Court's Jurisdiction)*, paragraphs 59-61 above).

In addition, all the judges of the House of Lords in the present case relied on *Re F. (Mental Patient: Sterilisation)* in unanimously concluding that the admission and treatment of an incapacitated compliant patient could be justified on the basis of the doctrine of necessity. Lord Goff, delivering the main judgment, had "no doubt" about this conclusion. Moreover, all counsel before the House of Lords were in agreement as to the precise elements of the doctrine of necessity to be applied (Lord Steyn, paragraph 47 above). These were "simply" that: (i) there must be a necessity to act when it is not practicable to communicate with the assisted person, and (ii) that the action taken must be such as a reasonable person would in all circumstances take, acting in the best interests of the assisted person. Furthermore, as is clear from the statistics provided by the Mental Health Act Commission to the House of Lords, the applicant was one of thousands of compliant incapacitated patients detained each year on the basis of the doctrine of necessity. Finally, the Court does not consider that the lack of a definition of "compliant" rendered the applicant's detention unforeseeable: the majority of the House of Lords expressed no particular difficulty in applying the notion of compliance in the present case.

118. It is true that, at the time of the applicant's detention, the doctrine of necessity and, in particular, the "best interests" test were still developing. Clinical assessments of best interests began to be subjected to a double test (the Bolam "not negligent" test together with a separate duty to act in a patient's best interests). Broader welfare matters were also introduced in the "best interests" assessment (see *Re F. (Adult: Court's Jurisdiction)* and *R.-B. (A Patient) v. Official Solicitor, sub nom Re A. (Male Sterilisation)* – paragraphs 59-62 above). It is therefore true that each element of the doctrine might not have been fully defined in 1997. This is reflected in, for example, the conflict between the views of Lady Justice Butler-Sloss in *R.-B. (A Patient)*, cited above, and paragraph 15.21 of the Mental Health Act Code of Practice 1999 (see paragraphs 62 and 72 above).

119. Whether or not the above allows the conclusion that the applicant could, with appropriate advice, have reasonably foreseen his detention on the basis of the doctrine of necessity (see *The Sunday Times v. the United Kingdom* (no. 1), judgment of 26 April 1979, Series A no. 30, pp. 31-33, §§ 49 and 52), the Court considers that the further element of lawfulness, the aim of avoiding arbitrariness, has not been satisfied.

120. In this latter respect, the Court finds striking the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted. The contrast between this dearth of regulation and the extensive network of safeguards applicable to psychiatric committals covered by the 1983 Act (see paragraphs 36 and 54 above) is, in the Court's view, significant.

In particular and most obviously, the Court notes the lack of any formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions. There is no requirement to fix the exact purpose of admission (for example, for assessment or for treatment) and, consistently, no limits in terms of time, treatment or care attach to that admission. Nor is there any specific provision requiring a continuing clinical assessment of the persistence of a disorder warranting detention. The appointment of a representative of a patient who could make certain objections and applications on his or her behalf is a procedural protection accorded to those committed involuntarily under the 1983 Act and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities.

121. The Court observes that, as a result of the lack of procedural regulation and limits, the hospital's health care professionals assumed full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit: as Lord Steyn remarked, this left "effective and unqualified control" in their hands. While the Court does not question the good faith of those professionals or that they acted in what they considered to be the applicant's best interests, the very purpose of procedural safeguards is to protect individuals against any "misjudgments and professional lapses" (Lord Steyn, paragraph 49 above).

122. The Court notes, on the one hand, the concerns regarding the lack of regulation in this area expressed by Lord Steyn (see paragraph 47 above), Lady Justice Butler-Sloss (see paragraph 61 above) and the Law Commission in 1995 (see paragraphs 66-68 above). On the other hand, it has also noted the Government's understandable concern (outlined in paragraph 80 above) to avoid the full, formal and inflexible impact of the 1983 Act. However, the current reform proposals set out to answer the above-mentioned concerns of the Government while at the same time making provision for detailed procedural regulation of the detention of incapacitated individuals (see, in particular, the Mental Capacity Bill described in paragraphs 77-78 above).

123. The Government's submission that detention could not be arbitrary within the meaning of Article 5 § 1 because of the possibility of a later review of its lawfulness disregards the distinctive and cumulative protections offered by paragraphs 1 and 4 of Article 5; the former strictly regulates the circumstances in which one's liberty can be taken away, whereas the latter requires a review of its legality thereafter.

124. The Court therefore finds that this absence of procedural safeguards fails to protect against arbitrary deprivations of liberty on grounds of necessity and, consequently, to comply with the essential purpose of Article 5 § 1. On this basis, the Court finds that there has been a violation of Article 5 § 1 of the Convention.

Law

The law governing capacity is mainly contained in the common law and the Mental Health Order. Part VIII of the Order provides for regulation of the property and affairs of patients (i.e. persons without the capacity to act for themselves). Part IV regulates the provision of treatment for patients. (The law in relation to capacity is considered in more detail in section 5 in relation to treatment and consent.)

It is notable that in England and Wales the Mental Capacity Act 2005 has adopted a principles-based approach. The principles are set out at section 1:

1. *The following principles apply for the purposes of this Act.*
2. *A person must be assumed to have capacity unless it is established that he lacks capacity.*
3. *A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.*
4. *A person is not to be treated as unable to make a decision merely because he makes an unwise decision.*
5. *An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.*
6. *Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.*

Apart from the Mental Health Order (NI) 1986 and the Article 37 and Schedule 6 of the Health and Personal Social Services Order (Northern Ireland) 1972, there is no statutory framework currently in place to regulate and safeguard the detention, care and/or treatment of persons without capacity. The informal nature of health care for many people without capacity raises profound human rights issues as demonstrated by the European Court decision in *HL*. It is notable that the Mental Health Bill currently before Parliament contains a new statutory framework of authorisation to facilitate the detention of persons without capacity, intended to fill the HL vacuum.⁹

Recommendations and Action

1. The development of a set of human rights standards to assist health authorities, policy makers and legislators;
2. The retention of a low threshold for the determination of capacity;
3. The urgent need for a statutory framework in Northern Ireland for the detention of persons without capacity following the decision of the European Court in *HL*; and,
4. The adoption in any new legislation of a principles-based approach.

3.2 Detention (including non-consensual intervention)

Detention (including non-consensual intervention) is one of the most controversial issues in mental health law. It includes the detention of people who have not or are not

⁹ The Mental Health Bill at Schedule 6 proposes a statutory framework which would be inserted as a new schedule to the Mental Capacity Act 2005.

suspected of having committed a crime. From a human rights perspective, detention flies in the face of the concepts or principles of autonomy and liberty.

There are two separate but overlapping aspects to non-consensual intervention: detention and treatment.

It is important from a human rights perspective to consider detention and treatment separately as well as together.

Issues

1. On what basis or bases should it be lawful to compulsorily detain capable persons?
2. Should mental health legislation perform a social control function?
3. Should any type of mental disorder (e.g. personality disorder) be excluded from the reach of the legislation?
4. How should legislation be drafted to ensure compliance with human rights law?

Standards

Principle 16 of the Mental Health Care Principles provides for compulsory detention for either the prevention of harm or to preserve the health of the individual where the judgment of the individual is impaired. (Principles 16(1)(a) and (b)) The bases for intervention are separate. In particular, intervention on the ground of harm is not dependent upon a treatment or treat-ability requirement.

Under the European Convention, a person of “unsound mind” can be involuntary detained. The European Court in *Winterwerp v Netherlands* [1979] 2 EHRR 387 stated that unsoundness of mind was a term that could not be given a definitive interpretation. That it was:

a term whose meaning is continually evolving as research in psychiatry progresses an increasing flexibility in treatment is developing, and society's attitude to mental illness changes, in particular so that greater understanding of the problems of mental patients is becoming more widespread.(Paragraph 37)

Under Article 5(1)(e) of the Convention, detention in a psychiatric hospital cannot be justified, unless a number of criteria are satisfied, as set out in the case of *Winterwerp v Netherlands* [1979] 2 EHRR 387 at 403:

In the Court's opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind'. The very nature of what has to be established before the competent national authority – that is, a true mental disorder – calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder.

The criteria can be isolated as follows:

- (a) establishment of mental disorder by an expert;
- (b) the mental disorder warrants compulsory confinement; and,

(c) the detention can only continue for as long as the disorder continues.

It is notable that under the Convention a person can be detained simply if his or her disorder 'warrants' confinement. No additional requirement is specified in relation to treatment, treat-ability or harm.

Moreover, it appears that the Convention contemplates the detention of persons with mental disorder to prevent harm and/or administer medical treatment. In *Litwa v Poland* [2001] 22 EHRR 53, the European Court stated as follows:

60. The Court observes that the word "alcoholics", in its common usage, denotes persons who are addicted to alcohol. On the other hand, in Article 5 § 1 of the Convention this term is found in a context that includes a reference to several other categories of individuals, that is, persons spreading infectious diseases, persons of unsound mind, drug addicts and vagrants. There is a link between all those persons in that they may be deprived of their liberty either in order to be given medical treatment or because of considerations dictated by social policy, or on both medical and social grounds. It is therefore legitimate to conclude from this context that a predominant reason why the Convention allows the persons mentioned in paragraph 1 (e) of Article 5 to be deprived of their liberty is not only that they are dangerous for public safety but also that their own interests may necessitate their detention.¹⁰

Law

In relation to detention, Part II of the Order permits compulsory detention in hospital of capable and incapable persons where:

- (a) there is a specific form of mental disorder;
- (b) the nature and degree of the mental disorder "warrants" in-patient care; and,
- (c) failure to detain "*would create a substantial likelihood of serious physical harm to himself or to other persons*" [sic]. (Article 12)

The drafting is conjunctive: all three factors are required. This is a very different approach to that developed by the European Court on Human Rights.

The nature of the criteria and the combination of the three requirements in the one test raises a number of human rights issues. It fails to contemplate treatment in such situations as:

- a patient has a personality disorder and detention is necessary to prevent harm;
- detention is necessary to prevent serious *mental* harm to the patient or others; and/or,

¹⁰ See the *Guzzardi v. Italy* judgment of 6 November 1980, Series A no. 39, pp. 36-37.

- a patient without capacity requires treatment: but there is no imminent risk of harm. (This is a particular omission given the implications of *HL v UK* (or *Bournewood* as it is known); i.e. that common law detention is unlawful as there are inadequate safeguards in place.)

The conjunctive approach considered

A marked feature of the legislation is the dual basis for detention: to treat the patient and to prevent harm. There appears no requirement in human rights law for detention to serve both purposes. Rather, the Mental Health Care Principles carefully distinguishes between detention for the purpose of preventing harm; and, detention of a person with impaired judgement for the purposes of medical treatment. An even broader approach has been taken by the European Convention, which apparently conceives of detention for the purpose of medical treatment, irrespective of in capacity or impairment of judgement.

In relation to the basis for detention, the clear position in European Convention jurisprudence is that a person can be detained in hospital either to provide medication or treatment or simply to prevent harm to himself or others. The European Court in *Hutchinson and Reid v UK* [2003] 37 EHRR 211 stated:

Confinement may be necessary not only where a person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons. (Para 51)

By adopting a dual basis for detention, domestic legislation mixes the objectives of detention.

Bartlett and Sandford identify the “twin strands” in domestic legislation of desirability of treatment and the need for protective custody and state:

The current English legislation is a conjunction of a variety of approaches. For example, a prerequisite for most confinements refers to ‘the health or safety of the patient or for the protection of other persons’ Criteria relating to dangerousness and therapeutic benevolence are expressly included, even in the space of a single paragraph of the statute. Defenders of the English statute would claim a triumph of English pragmatism and compromise. The rationales of the approaches are markedly different, however, and they do not necessarily sit easily together. Detractors would call the statute incoherent [and] tensions between the various approaches [are] ... apparent...”¹¹

By conjoining the objective of treatment with the objective of social control or harm prevention, the legislation is serving different masters. From a human rights perspective this raises concerns as different human rights considerations apply to different situations.

The Mental Health Bill currently before Parliament

¹¹ Page 122.

The draft mental health bill currently before Parliament, and as amended by the House of Lords, would change the law in England and Wales in relation to involuntary detention. A person could only be admitted or detained if the following criteria were fulfilled:

- (a) he or she has a mental disorder; (mental disorder is defined as “any disorder or disability of the mind”); and,
- (b) his or her ability to make decisions about the provision of medical treatment is significantly impaired.

Additionally, it is proposed that a person could only be detained for treatment under section 3 of the Act if ‘appropriate medical treatment’ was available.¹² Thus the Bill retains a treatability requirement, but in an amended form. ‘Appropriate medical treatment’ is defined as “medical treatment which is likely to alleviate or prevent a deterioration in [a patient’s] condition”.(Clause 5) The definition of ‘medical treatment’ is to be extended to include ‘psychological intervention and specialist mental health habilitation, rehabilitation and care.’(Clause 9) This is in part intended to bring personality disorders within the purview of the provision.

The Bamford Review

The premise of the Bamford Review appears to be the introduction of capacity-based legislation. Involuntary intervention to prevent harm is contemplated only in circumstances where the person concerned falls within a definition of incapacity or impairment.(A similar approach has been adopted in the Mental Health Bill currently before Parliament.)

At Paragraph 7.21 of its report entitled “A Comprehensive Legislative Framework”, the Review states as follows:

Where a person is determined not to have impaired decision-making capacity the Framework does not apply to that person and any decision that he/she makes, even if it appears to be unwise and even if, ultimately, it might bring about his/her death, must be respected.

Where the person concerned falls outside the Bamford concepts of incapacity or impairment, the Review recommends a criminal justice solution. (See paragraph 7.24)

Concerns from a human rights perspective which flow from the Bamford proposals include the following:

- That persons who present a risk of harm to themselves or others, but who fall without the definition of incapacity or impairment, cannot be detained in the public interest and/or the interests of the person concerned. Such a position

¹² Much case-law has been generated over the years by the treat-ability requirement. It has raised particular difficulties in Scotland as well as in other parts of the United Kingdom in relation to personality disorder. (*Reid v Secretary of State for Scotland* [1999] 1 AER 481; A, D and R v Scottish Ministers [2002] UKHRR 1; *Hutchinson and Reid v UK* [2003] 37 EHRR 211; see generally Bartlett and Sandland *Mental Health Law, Policy and Practice*, at pages 399 to 504)

could be contrary to human rights law including: Article 2 (the right to life); and, Article 3 (freedom from inhuman and degrading treatment). Arguably, if a person with a mental disorder (including a severe personality disorder) presents a serious and imminent threat to other persons, the authorities should be able to intervene whether or not the individual in question falls within a statutory definition of impairment or incapacity. The object of the intervention is the prevention of harm. The patient's autonomy should not automatically take precedence over other human rights considerations including his or her right to life or the right to life of other persons.

- That the proposals, if implemented, could create a dangerous lacuna in the law. In the absence of a crime, it is difficult to identify a 'criminal justice' solution.
- That the threshold for capacity and/or impairment might in practice be stretched to bring persons within the legislation. The raising of such thresholds undermines the concept of autonomy (self government) which is fundamental to the human rights of mental patients.

Recommendations / Action

1. That legislation is quickly enacted providing a framework for the detention of persons without capacity who require care and treatment. And that the legislation contains sufficient safeguards to protect the human rights of such persons.
2. That the exclusion of personality disorder from Northern Ireland Mental Health legislation is removed and soon.
3. That the Bamford Review proposals are subjected to scrutiny pursuant to human rights law and standards.
4. That the legislation is rationalised to enable intervention when appropriate commensurate with human rights law and standards.

3.3 Treatment (including non-consensual intervention)

The issue of non-consensual treatment is closely related to the issues discussed in the preceding two sub-sections: capacity and detention. It raises obvious and important human rights issues. In particular, a person can be treated against his or her will in hospital, subject to a few, though significant limitations.

Two overlapping issues will be addressed in this sub-section: the protection of autonomy in relation to treatment for detained patients; and, the import of the 'detention and treatment package' which underpins prevailing domestic legislation.

It is submitted that issues raised in this sub-section are of particular human rights concern and the Commission should take steps to subject law, policy and practice in this area to scrutiny in early course.

Issues

Some of the main issues are as follows:

1. The determination of capacity;
2. In what circumstances, if any, should it be justifiable to treat a capable person without their consent?
3. If non consensual treatment is permitted, what safeguards should be in place to protect capable detained patients from treatment which they do not consent to?
4. Are there any particular forms of treatment warranting special safeguards? If so what should those safeguards be?

Standards

In Ontario, Canada, legislation guaranteed capable mental patients the right to make their own treatment decisions. (See *Health Care Consent Act 1996*) In *Scott Starson v Swayze* [2003] 1 SCR 722, the Supreme Court of Canada upheld a finding that the patient was capable and therefore could not be treated against his will. An extract from the head-note of the law report summarises the relevant issues for our purposes:

The Health Care Consent Act 1996 presumes a person is capable to decide to accept or reject medical treatment; therefore patients with mental disorders are presumptively entitled to make their own treatment decisions. The presumption of capacity can be displaced only by evidence that a patient lacks the requisite elements of capacity provided by the Act. Capacity involves two criteria, first a person must be able to understand the information that is relevant to making a treatment decision and second a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. The legislative mandate of the Consent and Capacity Board is to adjudicate solely upon a patient's capacity and the Board's conception of the patient's best interests is irrelevant to that determination.

The Mental Health Care Principles at Principles 11 and 16 provide for non-consensual treatment of persons involuntarily detained. However, intervention is subject to a range of requirements and safeguards to protect a person's human rights.

6. Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 below, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:

(a) The patient is, at the relevant time, held as an involuntary patient;

(b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent; and

(c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.

7. Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 below, treatment may be given to such a patient without his or her informed consent if the personal

representative, having been given the information described in paragraph 2 above, consents on the patient's behalf.

8. Except as provided in paragraphs 12, 13, 14 and 15 below, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.

9. Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.

10. All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.

11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

12. Sterilization shall never be carried out as a treatment for mental illness.

13. A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.

14. Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.

15. Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.

16. *In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 above, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.*

One question which has not been properly considered in Northern Ireland is whether the Mental Health Care Principles permit the non-consensual use of all forms of treatment currently utilised in mental hospitals, including electro convulsive therapy (ECT). Arguably, ECT constitutes an “intrusive and irreversible treatment” pursuant to Principle 11(14).

European Convention Law is embryonic in relation to mental health and medical treatment. Patients enjoy the protection of Article 3: ‘freedom from inhuman and degrading treatment’ and Article 8 which protects ‘physical integrity’. The leading case on Article 3 is *Herczegfalvy v Austria* [1995] 30 EHRR 121 in which the European Court laid down a general principle that if it can be established that treatment proposed or pursued is a medical necessity, it is unlikely that it can constitute inhuman or degrading treatment. Consequently the level of protection afforded by the European Convention to mental patients in relation to medical treatment is relatively minimalistic, akin to a floor of rights.

Finally, the Commission, in its report *Connecting Mental Health and Human Rights* (2003), set out standards to protect patients in such circumstances, which are worthy of consideration.

Law

Until 1986, in general terms, detained patients could be treated against their will and no safeguards were in place. Since then, Part IV of the *Mental Health Order (NI) 1986* has governed the treatment of mental patients and in particular patients detained under the order.

Article 69 permits the non-consensual treatment of detained patients but is subject to Articles 63-64. Article 69 applies to most but not all patients detained under the Mental Health Order (NI) 1986. (See Article 62)

Article 64

Electro-convulsive therapy (ECT) and the administration of medicine can be given without a patient’s consent so long as the safeguards in Part IV are complied with. Except in relation to ECT, said safeguards do not become applicable until the patient has been detained for three months. (Article 64(1))

The main safeguard is the certification requirement:

(a) In relation to a patient who consents to proposed treatment, the responsible medical officer or a psychiatrist appointed by the Mental Health Commission for Northern Ireland must certify that:

the patient is capable of understanding its nature, purpose and likely effects and has consented to it. (Article 64(3)(a))

(b) In all other cases, treatment is only lawful where a psychiatrist appointed by the Mental Health Commission for Northern Ireland (not being the responsible medical officer) certifies that:

the patient is not capable of understanding the nature, purpose and likely effects of that treatment or has not consented to it but that, having regard to the likelihood of its alleviating or preventing a deterioration of his condition, the treatment should be given. (Article 64(3)(b))

These provisions are subject to Article 68 which permits non-consensual intervention in an emergency.

Article 63

Except in an emergency, psychosurgery can only be given if the patient consents and a psychiatrist appointed by the Mental Health Commission for Northern Ireland certifies that the patient has capacity to provide a valid consent and the treatment should be given *“having regard to the likelihood of the treatment alleviating or preventing a deterioration of the patients condition”*.(See Articles 63 and 68) Certification of the patient’s capacity is also required by two non-medical Commission appointees.(See Article 63(2)(a))

Concerns in relation to existing mental health law have been flagged by the Commission in the publication *Connecting Mental Health and Human Rights*.¹³ Said concerns are premised upon the principles of liberty and autonomy.

Discernibly different approaches to the legislation have been adopted by the English Court of Appeal in two important cases: *R (on the application of Wilkinson) v Broadmoor Special Hospital Authority*; and, *R (on the application of B) v S and others*. The approach in the first case is more human rights friendly: the approach in the second markedly less so.

*R (on the application of Wilkinson) v Broadmoor Special Hospital Authority*¹⁴

The case concerned proposed treatment involving anti-psychotic medication for a patient classified as suffering from a psychopathic disorder, i.e. a personality disorder resulting in abnormally aggressive conduct. The Responsible Medical Officer (Dr Horne) regarded the patient as incapable of consenting to treatment. He also had formed the view that the patient had a psychotic illness and the proposed treatment was appropriate. Dr Grounds took a different view: that the patient did not have a psychotic illness, that he was capable of consenting and that the prospects of the proposed treatment improving his personality characteristics were low.

Simon Brown LJ stated as follows:

The scheme for compulsory treatment under the 1983 Act seems to me plain. Detention under the Act does not of itself authorise treatment without consent..... Compulsory treatment must be authorised if at all under Part IV of the Act... (Paragraph 9)

¹³ Pages 52-60.

¹⁴ [2002] 1 WLR 419

Paul Bowen for the Appellant argued that Part IV had to be interpreted, subject to the Human Rights Act, and in particular Articles 2, 3, 6 and 8 of the Convention, and that non-consensual treatment was permissible only in “tightly circumscribed circumstances”. (Paragraph 15)

Simon Brown LJ appeared to be sympathetic to the arguments presented by Mr Bowen, stating that the “impact [of non consensual treatment] on the appellant’s rights above all to autonomy and bodily inviolability is immense”. He continued:

if the appellant is incompetent, the court will need to be satisfied (in the language of the ECHR in Herczegfalvy) that the medical necessity has been convincingly shown to exist according to the psychiatric principles generally accepted at the time. (Paragraph 30)

Hale LJ similarly stated that detention did not automatically confer the right to treat and that treatment must be directed at the mental disorder the patient is suffering from. She referenced the European Court decision in Herczegfalvy:

82. The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3 (art. 3), whose requirements permit of no derogation.

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

She then stated:

“79 One can at least conclude from this that forcible measures inflicted upon an incapacitated patient which are not a medical necessity may indeed be inhuman or degrading. The same must apply to forcible measures inflicted upon a capacitated patient. I would hesitate to say which was worse: the degradation of an incapacitated person shames us all even if that person is unable to appreciate it, but in fact most people are able to appreciate that they are being forced to do something against their will even if they are not able to make the decision that it should or should not be done. The Court understood how vulnerable such patients can be and how much in need of the protection of the world outside the closed world of the psychiatric institution however well meaning. The Court was properly respectful of ‘therapeutic necessity’ and ‘the psychiatric principles generally accepted at that time’. ...

80 I do not take the view that detained patients who have the capacity to decide for themselves can never be treated against their will. Our threshold of capacity is rightly a low one. It is better to keep it that way and allow some non-

consensual treatment of those who have capacity than to set such a high threshold for capacity that many would never qualify. Whether the criteria for non-consensual treatment of the capacitated should be limited to treatment which is for their own safety (as opposed to their health) is a difficult and complex question. Mr Bowen tried to persuade us that there was a developing consensus to that effect. There are indeed indications that the issue of capacity is assuming greater importance in the context of psychiatric treatment. But we have not yet reached the point where it is an accepted norm that detained patients who fulfil the Re MB criteria for capacity can only be treated against their will for the protection of others or for their own safety.”

*R (on the application of B) v S and others*¹⁵

This case involved a detained patient who was not consenting to proposed anti-psychotic medication. At first instance, Charles J found that the patient lacked capacity and the treatment was a therapeutic or medical necessity. The Court of Appeal upheld the decision of the lower court. However the court undertook a wide ranging consideration of the issues raised by the application.

In his judgment, Lord Phillips the Lord Chief Justice tackled *inter alia* the issue of the compatibility of the statutory detention and treatment package with human rights law, and the lawfulness of non-consensual intervention.

In summary, his argument runs as follows:

- compulsory detention is conceived as necessary “for the health or safety of the patient or for the protection of others”;
- detention can be justified where there are “grounds for concluding that the public is at risk from the patient”;
- detention will necessarily interfere with a number of human rights;
- the Mental Health Act 1983 provides for an integral package of detention and treatment and contains safeguards designed to ensure that individual treatment is justified. It is not, however, logical to consider consent to treatment in isolation from the overall objective of the package;
- the most important question is likely to be whether the package is justified, and that is a question for the Mental Health Review Tribunal.

Paragraphs 41- 58 of his judgment are set out below:

Will Compulsory Treatment Of A Patient With Capacity Violate Art 3, 8 And 14, Or Any Of Them, Unless It Satisfies The Threshold Requirement?

[41] *Mr Bowen submits that the three Articles of the Convention will be violated if a competent patient is subjected to invasive treatment to which he does not consent unless the treatment is necessary for the protection of the public or to prevent the patient from suffering serious harm. Mr Bowen's submissions have, implicitly, been founded on two premises, each of which we believe to be unsound. Mr Bowen's first premise is that compliance with the threshold*

¹⁵ [2006] AER (D) 200

requirement has to be demonstrated at the stage when it is proposed to administer the treatment. Thus the question is posed in relation to a patient who is detained in a mental hospital and whose capacity for harming the public or experiencing harm himself is mitigated by the security and the access to care that is implicit in that situation. As we shall show this premise is at odds with the overall scheme of the MHA, a scheme which we do not believe to be incompatible with the Convention.

[42] Mr Bowen's second premise is that autonomy, and thus capacity, is of critical importance in deciding whether a particular treatment can be imposed upon the detained patient. In a case such as that of Mr B this produces the following result. Mr B suffers from a disease whose effect is intermittent. There are spells of remission when he is without symptoms and spells when the illness produces symptoms which can vary from depression to hypomania. Anti-psychotic medication helps to produce or prolong the periods of remission. For this reason it is, objectively, in Mr B's own interest that he should accept the medication. When he is in remission and has capacity those caring for him cannot subject him to medication against his will, notwithstanding that the consequence is that he is rendered more likely to relapse into a condition where he loses capacity. Once he loses capacity, however, the medication can be administered, even though he does not consent to it. This scenario borders on the absurd. It also conflicts with the position that prevails in relation to treatment of physical illness, where doctors must have regard to the wishes of the patient expressed when he has capacity in relation to his treatment should he lose capacity. We have concluded that Charles J was correct to hold that capacity is not the critical factor in determining whether treatment can be administered without consent.

[43] The MHA is primarily concerned with the compulsory detention of patients suffering from mental disorders in order that they may receive treatment for those disorders. The compulsory detention is justified because it is necessary in order to ensure that the patient receives the treatment. Ensuring that the patient receives the treatment is justified because this is necessary for the health or safety of the patient or for the protection of others.

[44] The initial justification for detaining Mr B for treatment is demonstrated by the gravity of the crime that he committed. This was at one end of the wide spectrum of anti-social behaviour that can justify detention for the protection of the public. Where the offender is of sound mind the detention will be imprisonment. Where, however, the anti-social behaviour is attributable to treatable mental illness, the preferable alternative is likely to be detention for treatment in a mental hospital. And such detention can be justified both where criminal conduct has demonstrated the need to protect the public and where there are other grounds for concluding that the public is at risk from the patient.

[45] Whether detention is in prison or in hospital it will necessarily interfere with a number of human rights. It will interfere with the right to liberty (art 5). It will interfere with family life (art 8). It may interfere with the right to teach or practise one's religion (art 9). It may interfere with freedom of assembly (art 11). It may interfere with the right of enjoyment of one's possessions, or with education (arts 1 and 2 of the First Protocol).

[46] The MHA makes lawful further interference with art 8 rights in permitting treatment without consent. As Baroness Hale pointed out in *B v Ashworth*, until 1983 the legislation dealt expressly only with the right to detain for treatment, taking it for granted that it would be lawful compulsorily to treat those detained. Part IV of the MHA now deals expressly with the power compulsorily to treat

where that is the object of the detention. A distinction is drawn between the most invasive treatment, which can only be administered with the capacitated consent of the patient (s 57), medical treatment for mental disorder, which requires capacitated consent or the opinions of two medical officers that the treatment should be given having regard to the likelihood that it will alleviate or prevent a deterioration of the patient's condition (s 58) and other medical treatment for the patient's mental condition, which can be administered without consent (s 63).

[47] Thus the MHA provides for an integral package of detention and treatment and imposes restrictions designed to ensure that individual treatment is justified. It is not logical to consider the latter question in isolation from the overall objective of the package. The most important question is likely to be whether the package is justified, and that is a question that falls within the remit of the Mental Health Review Tribunal under Pt V of the MHA. If detention of a patient for treatment pursuant to s 3 is justified on the ground that the treatment is necessary for the protection of others, it is illogical to contend that a higher standard has to be applied to justify the administration of the treatment itself. We endorse the comment made by Baroness Hale in *R(B) v Ashworth* at para 31:

“Once the state has taken away a person's liberty and detained him in a hospital with a view to medical treatment, the state should be able (some would say obliged) to provide him with the treatment which he needs.”

[48] In *R (PS) v Dr G* [2003] EWHC 2335 (Admin), [2004] 1 MHLR 1 at para 134 Silber J accepted the submission that:

“the decision to administer anti-psychotic medication has to be considered in the context that the medication is likely to lead to the Claimant being rehabilitated rather than remaining subject to long-term incarceration.”

We agree that this submission was sound. The overall objective of detention of a dangerous patient ought to be that the patient should be rehabilitated and able to return to society. This of itself militates against an approach that ignores the overall object of the MHA package, looks at the patient in detention, and imposes a threshold requirement that treatment without consent can only be justified if that treatment is necessary to stop the patient causing harm to others or to protect the patient from serious harm.

[49] As for the significance of capacity, this is an important, but by no means straightforward concept under English law. Thus in *In re T* [1993] Fam 95 at 113, [1992] 4 All ER 649, [1992] 3 WLR 782 Lord Donaldson MR remarked that the capacity must be commensurate with the gravity of the decision purported to be made. “The more serious the decision, the greater the capacity required”. The test is particularly difficult in the present context. Where it is common ground that a patient has a mental disorder, that treatment would alleviate that disorder, that it would be in his interest to consent to that treatment and that he refuses to do so, the question of whether he has capacity is bound to be problematic.

[50] The concept of capacity is not developed in the Strasbourg jurisprudence. We are here concerned with whether compulsory medical treatment infringes arts 3, 8 and 14 of the Convention. We think that Charles J was correct to conclude that, when considering the severity of treatment the fact that it is imposed by compulsion is more significant than the question of whether the patient has or has not capacity to consent to the treatment.

[51] With these general observations we turn to consider whether the authorities lend support to Mr Bowen's submission. We shall start with domestic authority. It is sparse on this point. Wilkinson was concerned with procedure, and we will

return to it in that context. The facts were very close to those of the present case. The Claimant, a convicted mental patient compulsorily detained in Broadmoor challenged the decision compulsorily to administer anti-psychotic medication. In the course of his judgment Simon Brown LJ made the following observations:

“28. One document usefully brought to our attention on the adjourned hearing of the appeal was a report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment in August 2000, 8th General Report (CPT/Inf (98) 12), paragraph 41 of which reads:

'Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.'

29. That gives some indication of modern thinking on this sensitive subject. The precise equivalence under section 58(3)(b) between incompetent patients and competent but non-consenting patients seems to me increasingly difficult to justify.

30. If in truth this Claimant has the capacity to refuse consent to the treatment proposed here, it is difficult to suppose that he should nevertheless be forcibly subjected to it.”

[52] Hale LJ, who has great experience in this field, commented at para 80:

*“80. I do not take the view that detained patients who have the capacity to decide for themselves can never be treated against their will. Our threshold of capacity is rightly a low one. It is better to keep it that way and allow some non-consensual treatment of those who have capacity than to set such a high threshold for capacity that many would never qualify. Whether the criteria for non-consensual treatment of the capacitated should be limited to treatment which is for their own safety (as opposed to their health) is a difficult and complex question. Mr Bowen tried to persuade us that there was a developing consensus to that effect. There are indeed indications that the issue of capacity is assuming greater importance in the context of psychiatric treatment. But we have not yet reached the point where it is an accepted norm that detained patients who fulfil the *In re MB* [1997] 2 FLR 426 criteria for capacity can only be treated against their will for the protection of others or for their own safety.*

81. This is well illustrated by the report of the expert committee chaired by Professor Geneva Richardson, “The Review of the Mental Health Act 1983” (Department of Health, November 1999). This discusses the treatment of the detained patient with capacity in paras 7.19 to 7.24. There was considerable support on consultation both for detention without forced treatment and for detention with enforced treatment. The dilemma could only be resolved by a moral judgment which it was ultimately for politicians to make.”

[53] Mr Bowen has referred us to international material which was, no doubt, what Hale LJ referred to as “indications that the issue of capacity is assuming greater importance”. The Council of Europe “White Paper” on the Protection of the Human Rights and Dignity of People Suffering from Mental Disorder, 3 January 2000, recommends an absolute embargo on imposing compulsory treatment on patients who have capacity. Thus this does not accept the threshold requirement for which Mr Bowen contends – it goes further than his position.

[54] United Nations General Assembly Resolution 46/119 of 17 December 1991 “Principles for the Protection of Persons with Mental Illness” contains the following relevant principles:

“PRINCIPLE 9: TREATMENT

9.4: The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

PRINCIPLE 11: CONSENT TO TREATMENT

1. No treatment shall be given to a patient without his or her informed consent, except as provided for by paragraphs 6, 7, 8, 13 and 15 of the present principle.

11. Except as provided . . . (b) . . . the patient lacks capacity . . . or, if domestic legislation so provides, that, having regards to the patient's own safety or the safety of others, the patient unreasonably withholds such consent.”

This comes closer to the propositions advanced by Mr Bowen.

[55] Further support for Mr Bowen's submissions can be derived from art 7 of the Council of Europe's Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (1997):

“ARTICLE 7 PROTECTION OF PERSONS WHO HAVE A MENTAL DISORDER

Subject to protective conditions prescribed by law, including supervisory, control and appeal procedures, a person who has a mental disorder of a serious nature may be subjected, without his or her consent, to an intervention aimed at treating his or her mental disorder only where, without such treatment, serious harm is likely to result to his or her health.”

In Glass v United Kingdom (2004) 39 EHRR 15 the ECtHR referred to these principles under the heading of “Relevant international materials”. That was a case concerning medical treatment of a child and we do not consider that the ECtHR can be taken to have endorsed, without discussion, the entirety of that Convention.

[56] *We are concerned with whether the express provisions of the MHA are compatible with the Human Rights Convention, not with other international instruments which are not directly binding on this court. We turn, therefore, to the Strasbourg jurisprudence.*

[57] *The leading authority is Herczegfalvy v Austria (1992) 15 EHRR 437, 18 BMLR 48. The Applicant was detained in an institution for “mentally deranged offenders”. While detained he was subjected to the forcible administration of food and neuroleptics and to handcuffing to a security bed. He complained of violation of his art 3 and 8 rights. In dismissing these complaints, the court held:*

“82. The court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3, the requirements of which permit of no derogation.

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

83. In this case it is above all the length of time during which the handcuffs and security bed were used which appears worrying. However, the evidence before the court is not sufficient to disprove the Government's argument that, according to the psychiatric principles generally accepted at the time, medical necessity justified the treatment in issue."

*[58] These general principles were advanced in relation to a patient who lacked capacity. It is significant, however, that the ECtHR recently applied these principles to a complaint by an applicant, who was not mentally ill, that he had been force-fed while in criminal detention and that this had infringed art 3. In *Nevmerzhitsky v Ukraine* (decision of 12 October 2005) the court was referred to international materials that advocated that patients or prisoners who had capacity should not be subjected to compulsory treatment or force-feeding. Nonetheless it rejected the complaint, holding:*

*"94. The court reiterates that a measure which is of therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading. The same can be said about force-feeding that is aimed at saving the life of a particular detainee who consciously refuses to take food. The Convention organs must nevertheless satisfy themselves that the medical necessity has been convincingly shown to exist (see *Herczegfalvy v Austria*)."*

The danger in a broad-brush approach

As highlighted in the previous section, by conjoining reasons for detention (i.e. treatment and harm) standards, criteria and safeguards applicable to different interventions can be diluted thereby undermining the rights of the patient.

From a human rights perspective the problem is magnified where the treatment of the patient is premised on the detainment. The problem is illustrated at paragraph 47 of the judgment where Lord Phillips advocates an uncertain dual-based rationale for detention and combines this with a consequential impact on the standards to be applied in relation to treatment:

If detention of a person for treatment pursuant to section 3 is justified on the ground that the treatment is necessary for the protection of others, it is illogical to contend that a higher standard has to be applied to justify the administration of the treatment itself.

Where a person with a mental disorder poses a threat to the safety of another, the detention of that person will address the concern. The question of treatment is a separate matter raising different human rights issues. Particularly where the reason for the detention is to protect others, why is the attempt to apply different, but arguably appropriate standards to the treatment issue illogical, as stated by Lord Phillips? From a human rights perspective surely the reverse is the case: i.e. that appropriate criteria should be applied to the treatment issue separate from the fact of detention. Moreover, such an approach appears out of step with the standards articulated by the Court of Appeal in *Wilkinson*.

A broad-brush system of detention and treatment pays insufficient regard to specific human rights standards (particularly in relation to treatment), and by its very nature jeopardises human rights standards.

From a human rights perspective, it is submitted that the above analysis illustrates:

- (1) the mish-mash of concepts at the heart of domestic mental health law, i.e. in relation to the 'detention and treatment package'. By conjoining different social and medical objectives in a statutory framework, human rights standards can be seriously undermined; and,
- (2) a broad-brush legislative and judicial approach to detention and treatment, which fails to properly contemplate the different human rights standards that apply to different forms of state intervention such as detention and treatment.

Human rights concerns

A number of potential concerns can be identified:

- the safeguards contained in Part IV arguably do not adequately protect patients; and,
- the 'detention and treatment package' - at the heart of the legislation - has an underlying presumption that detained patients can be compulsorily treated: this serves to undermine human rights, and in particular, the rights of capable detained patients.

Recommendations and action

1. That separate provisions govern detention and treatment, as set out in the Mental Health Care Principles;
2. That a set of human rights standards in relation to treatment and capacity is developed;
3. That autonomy is adequately respected in future legislation and the threshold not expressly or implicitly raised.

4.0 Seclusion: a case study on *Munjaz*

This section focuses upon the use of seclusion in the *management* of detained patients. For the purposes of this paper, the subject of seclusion can be usefully considered for two reasons: first, its inappropriate use abrogates human rights; and second and pragmatically, the recent case of *Mungaz* provides a perfect case study highlighting the issues discussed in this paper about the relationship between human rights standards and the law.

Standards

Mental Health Care Principle 11 states:

Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility

and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

The European Convention provides for protection of detained patients as follows:

- Article 3 is a non-derogable right which states:

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

- Article 8 is a derogable right protecting inter alia the right to private life. It permits interference, *inter alia*, "for the prevention of disorder or crime, for the protection of health or morals or for the protection of the rights and freedoms of others".

Article 8 extends to protection of a person's bodily integrity, and is capable of protecting individuals against forms of ill-treatment which do not reach the higher Article 3 threshold.

The statutory Code of Practice to the Mental Health (Northern Ireland) Order 1986 (1992) sets out policies and procedures in relation to 'patient management', including seclusion, restraint, locked wards, time out, etc.

Mungaz: a case study

The courts in England recently considered the law in relation to patient management by seclusion in *R (on the application of Mungaz) v Mersey Care NHS Trust* [2006] 4 All ER 736. Mr Munjaz had been secluded on a number of occasions for the protection of others. The Trust drew up a policy on seclusion which drew from the statutory code of practice. The main point of distinction involved medical reviews: under the Code medical reviews were required every 4 hours as long as seclusion continued. The Trust policy provided for less frequent medical reviews: 4 on the first day, two on days 2 to 7 and thereafter 3 per week.

The use of seclusion by the Trust was challenged on the grounds, *inter alia*, that it contravened domestic law and Articles 3 and 8 of the European Convention.

The Judge at first instance held that the Trust's policy was lawful.

The Court of Appeal held that the Trust's policy was unlawful. It further held that the statutory code of practice should be followed, unless there was a good reason to depart from it in relation to an individual patient.

The House of Lords held by a majority that the Trust had not contravened Articles 3 or 8. They held that the Trusts were not obliged to follow the Code of Practice and could exercise their discretion in deciding how far their policies and practices adhered to the Code of Practice, as long as the procedures adopted did not expose the patient to a significant risk of treatment prohibited by Articles 3 or 8. The Lords held by a majority that the hospital's policy was human rights compatible. Lords Steyn and Lord Brown dissented.

Human rights, standard setting and the law

The *Munjaz* litigation provides an example of the relationship between human rights standards and the law.

The Court of Appeal, having carefully considered the law in relation to Articles 3, 5 and 8 of the Convention, concluded at paragraph 74 as follows:

74. The judges in both these appeals proceeded on the basis that, having considered the Code, a hospital was free not to follow it unless to do so would be Wednesbury perverse. There is a considerable difference between this approach and the Rixon approach in which the Code should be followed unless there is a good reason to the contrary. It would fly in the face of the original purposes of the Code if hospitals or professionals were in fact free not to follow it without a good reason. It is clear that section 118(2) (see para 4 above) cannot have been intended as a 'take it or leave it' provision. In relation to those matters where a patient's human rights are or may be engaged, the arguments for according the Code the greater status are compelling. Where there is a risk that agents of the state will treat its patients in a way which contravenes Article 3, the state should take steps to avoid this through the publication of a Code of Practice which its agents are obliged to follow unless they have good reason to depart from it. Where there is an interference with the rights protected by Article 8, the requirement of legality is met through adherence to a Code of Practice again unless there is good reason to depart from it. The same will apply where the Code deals with the deprivation of liberty within the meaning of Article 5.

Lord Phillips, the current Lord Chief Justice gave the judgment. Lady Hale, formerly Brenda Hoggett (author of *Mental Health Law* (1996) Sweet and Maxwell) was also in the court. This was an authoritative decision.

The decision provided for a higher level of human rights protection for patients, requiring Trusts to conform with the Statutory Code of Practice, except where departure was justified. Specifically it would have ensured 4 medical reviews of detention per day for as long as detention continued.

The House of Lords rolled back on the level of protection: rejecting the argument that conformity with the Code of Practice was necessary to prevent a breach of human rights. The majority held that adherence to the Trust's policy was sufficient to prevent a breach of human rights.

Lord Bingham held:

The Trust must not adopt a policy which exposes patients to a significant risk of treatment prohibited by article 3. I agree with the judge that the policy must be

considered as a whole, that the policy, properly operated, will be sufficient to prevent any possible breach of the article 3 rights of a patient secluded for more than seven days and that there is no evidence to support the proposition that the frequency of medical review provided in the policy risks any breach of those rights. (Paragraph 29)

On Article 8 he stated:

32. It is obvious that seclusion, improperly used, may violate a patient's article 8 right in a serious and damaging way and may found a claim for relief. This appeal, however, is directed to the compatibility of the Ashworth policy with the Convention, assuming it to be followed. I have, for my part, some difficulty in appreciating how seclusion can be said to show any lack of respect for a patient's private and family life, home or correspondence, if it is used as the only means of protecting others from violence or intimidation and for the shortest period necessary to that end. A detained patient, when in his right mind or during lucid intervals, would not wish to be free to act in such a way and would recognise that his best interests were served by his being prevented from doing so.

33. If, however, it is accepted that seclusion, properly used in accordance with the policy, involves an interference by a public authority with the exercise of the patient's right under article 8(1), it is necessary to consider justification under article 8(2). Seclusion under the policy is plainly necessary for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others. Properly used, the seclusion will not be disproportionate because it will match the necessity giving rise to it.

Lord Steyn's dissenting judgment is a seminal example of a judicial attempt to properly enshrine human rights standards in the law. It is worth reading in full and can be found in the Appendices. The paragraphs of particular relevance to this section are 44-48:

44. In relation to the status of the Code, I am in full agreement with the reasoning of the Court of Appeal. The Code was plainly issued under section 118(1)(a) and (b) of the Mental Health Act 1983. It is a very special type of soft law. It derives its status from the legislative context and the extreme vulnerability of the patients which it serves to protect. In the context of the Code the Court of Appeal explained, and I accept, that the concern about seclusion lies "in the combination of the potentially harmful or degrading effects of seclusion upon the patient and its potential for misuse by those looking after him": para 11. This is the contextual scene of section 118(1). It is wrong to focus exclusively or even primarily on the dictionary meaning of "guidance". In a careful analysis Mr Fleming QC relied in addition to the reasons given by the Court of Appeal on the fact that section 118(2) provides that "the Code shall, in particular, specify forms of medical treatment" which "should accordingly not be given by a registered medical practitioner unless the patient has consented to the treatment." He pointed out that the preceding White Paper of November 1981 observed that the Code "might include references to treatments such as electro-convulsive therapy when used in particular circumstances, long acting drugs, and behaviour therapies": Reform of the Mental Health Legislation, para 39. These examples reveal that in section 118(1) Parliament had authorised a Code with some minimum safeguards and a modicum of centralised protection for vulnerable patients. This is inconsistent with a free-for-all in which hospitals are at liberty to depart from the published Code as they consider right. Indeed, it seems unlikely that Parliament would have authorised a regime in which hospitals may as a matter of policy depart from the Code. After all that would result in mentally disordered

patients being treated about seclusion in a discriminatory manner, depending on the policy adopted by the managers and clinicians in particular hospitals.

45. Another internal aid to the interpretation of section 118 mentioned by Mr Fleming is section 121 which deals with the Mental Health Act Commission. Section 121(4) provides:

"The Secretary of State may, at the request of or after consultation with the Commission and after consulting such other bodies as appear to him to be concerned, direct the Commission to keep under review the care and treatment, or any aspect of the care and treatment, in hospitals and mental nursing homes of patients who are not liable to be detained under this Act."

This provision is in line with the idea of centralised minimum safeguards. It throws light on the dynamic role that a Code issued under section 118 was intended to play.

46. The Court of Appeal applied the dictum of Sedley J in *R v Islington London Borough Council, ex p Rixon* [1997] ELR 66, at 71, that local authorities may only depart from the Secretary of State's guidance for good reason. The Court of Appeal observed that there is a considerable difference between the Wednesbury approach and the Rixon approach. Counsel for the Secretary of State and the Trust challenged this approach. They were mistaken. In the present case fundamental rights are at stake and even before the Human Rights Act 1998 an intense review on principles of proportionality was appropriate: *R v Secretary of State for the Home Department, Ex p Leech* [1994] QB 198, which was affirmed in *R v Home Secretary, Ex p Simms* [2000] 2 AC 115 and in *R (Daly) v Secretary of State for the Home Department* [2001] 2 AC 532. The concrete differences between the Wednesbury and proportionality approaches was concretely described in *R (Daly) v Secretary of State for the Home Department* [2001] 2 AC 532. In a speech made with the approval of the House I observed [547 E-F]:

"First, the doctrine of proportionality may require the reviewing court to assess the balance which the decision maker has struck, not merely whether it is within the range of rational or reasonable decisions. Secondly, the proportionality test may go further than the traditional grounds of review inasmuch as it may require attention to be directed to the relative weight accorded to interests and considerations."

The application of these established principles, wholly appropriate to the context of fundamental rights, reinforces the conclusion of the Court of Appeal. That conclusion was stated with precision in para 76 as follows:

"Hence we conclude that the Code should be observed by all hospitals unless they have a good reason for departing from it in relation to an individual patient. They may identify good reasons for particular departures in relation to groups of patients who share particular well-defined characteristics, so that if the patient falls within that category there will be a good reason for departing from the Code in his case. But they cannot depart from it as a matter of policy and in relation to an arbitrary dividing line which is not properly related to the Code's definition of seclusion and its requirements."

Given the manifest dangers inherent in seclusion, and the extremely vulnerability of the patients, I regard this conclusion as sound. It is a corner of mental health law in which a dilution of minimum centrally imposed safeguards, by pragmatic policy decisions from hospital to hospital, is not appropriate.

47. In paragraph 40 of the printed case of Mr **Munjaz** the resultant picture and implications are graphically illustrated:

*". . . Ashworth, and any detaining hospital, can now substitute 3 (or 4) medical reviews for the 42 required by the Code of Practice during days 8 to 14. [Mr **Munjaz's**] complaint is not that he can be secluded for one or two more hours without a Code of Practice medical review, but that he could be secluded for 72 hours without such a review. If such wholesale departures from the Code can be made on the basis of the views of the hospital managers, there is no logical reason why Ashworth should not reduce its medical reviews yet further, depending only on its rational view of its needs and its resources. Why not a medical review every week, every month? Certainly, Ashworth cites approvingly [in para 95 of its printed case] in support of its position, cases where monthly review of segregated prisoners has been held to be lawful. A national Code of Practice provides the necessary checks and balances for this otherwise unregulated activity."*

This is a disturbing picture.

48. If Ashworth Hospital is permitted in its discretion to reject the Code, lock, stock, and barrel, regarding seclusion, it will be open to other hospitals to do so too. The Code would then be seriously undermined. For my part the endorsement of the Code by the Secretary of State makes his virtual disowning of the Code in these proceedings difficult to understand. Compared to the judgment of the Court of Appeal the judgment of the majority of the House permits a lowering of the protection offered by the law to mentally disordered patients. If that is the law, so be it. How society treats mentally disordered people detained in high security hospitals is, however, a measure of how far we have come since the dreadful ways in which such persons were treated in earlier times. For my part, the decision today is a setback for a modern and just mental health law.

One can see that Lord Steyn is attempting to ensure that those human rights standards necessary to protect 'the extreme vulnerability of patients' are protected by law. He is creatively attempting to strengthen the legal protection for patients by combining the broad principles of European Convention Law, with the Code of Practice, which he describes as 'soft law'. He relies upon fundamental human rights principles such as anxious or intense scrutiny when fundamental rights are at stake; and, proportionality. (Paragraph 46) His judgment is a strenuous attempt to maximise the protection of human rights for mentally disordered people detained in high security hospitals.

Lord Steyn was not alone. Lord Brown, albeit on the basis of different reasoning, came to the same conclusion, namely that for seclusion to be compliant with the European Convention, it must be given a higher status akin to the force of law, disentitling individual hospitals departing from it on policy grounds. (Paragraph 124) The basis for his reasoning was based on Article 8 of the Convention:

119. To my mind ... the case turns on article 8(2), and above all on the requirement that any interference with private life involved in the practice of seclusion be effected "in accordance with the law". Nobody could dispute that seclusion as a practice is necessary. It can, indeed, be justified under several of the specified grounds provided for by article 8(2): "in the interests of... public safety," "for the prevention of disorder or crime," "for the protection of health," and "for the protection of the rights and freedoms of others."

120. *But that is not a sufficient answer to the complaint of interference with article 8 rights. This is illustrated by in Malone v United Kingdom (1984) 7 EHRR 14, a complaint about telephone-tapping. Nobody doubted the justification of the practice but it was held to be contrary to article 8 for not being "in accordance with the law"—a deficiency in the legislation cured by the Interception of Communications Act 1985.*

121. *Hewitt and Harman v United Kingdom (1991) 14 EHRR 657 provides another illustration of the principle in the context of secret surveillance activities carried out by the Security Service. These activities, an undoubted interference with the applicants' private lives, were based on a non-binding and unpublished directive from the Home Secretary to the Director-General of the Security Service. The directive did not have the force of the law, nor did its contents constitute legally enforceable rules governing the operation of the Security Service. In those circumstances the European Commission of Human Rights concluded that the directive did not provide a framework indicating with the requisite degree of certainty the scope and manner of the exercise of discretion by the authorities in the carrying out of their activities. This want of legal support for the practice in turn had to be cured by further legislation, the Security Service Act 1989.*

122. *What is clear from these and other Strasbourg authorities is that more is required by way of legal justification for an interference with private rights merely than that there exists a sufficient basis for the practice in domestic law. In paragraph 39 of its judgment in Hewitt and Harman the Commission referred back to the Court's judgment in Malone as having "elucidated the concept of foreseeability and highlighted its importance as a safeguard against the arbitrary application of measures of secret surveillance", quoting from the Court's judgment in Malone:*

"The Court would reiterate its opinion that the phrase 'in accordance with the law' does not merely refer back to domestic law but also relates to the quality of the law, requiring it to be compatible with the rule of law..."

"The quality of the law" there referred to encompasses notions of transparency, accessibility, predictability and consistency, features of a legal regime designed to guard against the arbitrary use of power and to afford sufficient legal protection to those at risk of its abuse.

123. *It was just such considerations which recently led the European Court of Human Rights in H L v United Kingdom (2004) App No 45508/99 (the complaint to Strasbourg which followed on from your Lordships' decision in R v Bournewood Community and Mental Health NHS Trust ex p L [1999] AC 458) to hold that the absence of procedural safeguards to protect informal mental patients against the arbitrary deprivation of liberty on grounds of necessity violates article 5(1): the Court was struck by the lack of any fixed procedural rules governing the admission and detention of compliant incapacitated persons, contrasting this dearth of regulation with the extensive network of safeguards applicable to psychiatric committals under the 1983 Act.*

124. *What view then should be taken of the seclusion of mental patients? Is this a form of control where regulation can satisfactorily be left to the individual hospitals who practise it or must it be subject to more constraining central direction? In short, for the practice to be compliant with the Convention, must the Secretary of State's Code have something akin to the force of law? Must it therefore be given the status for which the appellants contend, a status disempowering individual hospitals to depart*

from it on policy grounds (rather than on the ground that it would be unreasonable to apply the Code to particular patients or groups of patients)?

125. Not without some considerable hesitation I have reached the conclusion that the Code must indeed be given this higher status. Without such a Code the legal position would be this. The only authority for seclusion would be, in the case of patients detained under the 1983 Act, the implied power of control over those lawfully detained; in the case of informal patients, the common law doctrines of necessity and self-defence. The actual use of seclusion in individual cases would not be regulated save insofar as each hospital practising it would be required to adopt, publish and practise a rational policy of its own. That, of course, is precisely what Ashworth does. But by the same token that Ashworth is permitted to adopt its own policy, so too may other hospitals. Much of the factual focus of the appeal was upon those of Ashworth's patients who are detained for over seven days. But Ashworth's policy departs from the Code much earlier than this: only for the first 12 hours does Ashworth conduct medical reviews at 4 hourly intervals as specified by the Code; from then until the end of the seventh day such reviews occur twice (rather than six times) a day. Other hospitals too may think it unnecessary to conduct reviews as frequently as provided for by the Code. And of course there is nothing to stop Ashworth altering its policy whenever it thinks it right to do so. The policy of an individual hospital can be changed with infinitely greater ease than the Code itself.

126. Under Ashworth's approach, moreover, seclusion as a concept loses something of its clarity. Although Ashworth ostensibly adopts the Code's definition of seclusion—"the supervised confinement of a patient in a room, which may be locked to provide others from significant harm"—Dr Finnegan's evidence is that "at most times about 75% of the long-term secluded patients are being nursed in extended association, despite being defined as 'secluded'". These patients are said to be "up in the public areas of the ward interacting with staff and patients." Small wonder that this different attitude to the very concept of seclusion results in what seem to be widely differing approaches to the practice. A startling example of this appears from the written intervention helpfully submitted to the House by the Mental Health Act Commission. In October 2002 one particular patient was transferred from Ashworth to Rampton having been in seclusion at Ashworth for the best part of nine years. At Rampton his long-term seclusion ceased and although from time to time since he has been subject to seclusion this has never been for as long as eight hours (or a total of twelve hours within any forty-eight hour period) such as to trigger Rampton's independent review process (the process provided for by para 19.21 of the Code).

127. The Secretary of State's Foreword to the 1999 issue of the Code stated that: "the Code should be followed" until necessary new legislation came into force. It ended:

"The Code provides essential reference guidance for those who apply the Act. Patients and their carers are entitled to expect professionals to use it."

Under the ruling proposed by the majority of your Lordships, patients and their carers must be reconciled instead to substantial departures from the Code on the part of individual hospitals who may prefer to follow a different policy of their own. It is my reluctant conclusion that not only will these patients and carers be disappointed in their expectations but that the practices in the event adopted by any such hospital (rational though I acknowledge they must certainly be) will not have the necessary legal quality to render them compatible with the rule of law. Unless it is to the Code that one can look for regulation carrying the force of law it is not in my opinion to be found elsewhere. Hospital policies themselves provide too

insubstantial a foundation for a practice so potentially harmful and open to abuse as the seclusion of vulnerable mental patients.

Conclusion

What does this fleeting analysis of the *Munjaz* case reveal? That there is great scope for inventiveness in human rights jurisprudence. That the Human Rights Commission and lawyers acting for patients can be creative in developing standards and constructing legal arguments designed to enhance the legal protection of patients' rights. Most starkly, it demonstrates that different courts will be more or less sympathetic to human rights arguments. In this case, ironically the majority of the Appellate Judges were in favour of according the Code of Practice special legal status, in order to provide greater protection for the rights of patients.

5.0 Tribunal discharge and the immediate use of statutory power to detain

One issue that has recently exercised the courts in England and Northern Ireland is the lawfulness of detentions on the heels of a Mental Health Review Tribunal directing the discharge of a patient. (*R (on the application of H) v Oxfordshire Mental Healthcare NHS Trust* [2002] EWHC Admin 465; [2002] MHLR 282; *R (Von Brandenburg) v East London and The City Mental Health NHS Trust* [2002] QB 235; and. *R v Ashworth Hospital Authority* [2003] 1 WLR 127; *R (Von Brandenburg) v East London and The City Mental Health NHS Trust* [2004] 1 AER 400; and, the recent Northern Ireland decision: *Brian McGee judicial review*. Reported on Bailii at [2006] NIQB 78 (Appendix 4))

A number of important human rights issues are raised:

- the effectiveness of independent judicial proceedings;
- the right to liberty; and,
- the prevention of harm to the patient and/or others.

Clearly public authorities must respect the decisions of judicial bodies appointed to independently review and adjudicate upon the decisions of their servants and agents. To undermine the efficacy of judicial determinations is to fundamentally undermine the rule of law. On the other hand, circumstances can change in mental health and what might be an appropriate determination one day can become entirely contrary to common sense the next.

The issue also raises the tension between the perception of health professionals including psychiatrists and social workers and the different perceptions of lawyers, courts and tribunals, discussed earlier in the paper.

Probably the most authoritative statement of law is derived from Lord Bingham's judgement in *R (Von Brandenburg) v East London and The City Mental Health NHS Trust* [2004] 1 AER 400:

The governing principles

6. The differences between the parties to this appeal do not lack practical importance for those charged with the difficult and sensitive task of administering

the mental health regime established by the 1983 Act. But the differences are relatively narrow, and it is convenient to begin by rehearsing certain familiar overriding principles, not in themselves controversial. First, the common law respects and protects the personal freedom of the individual, which may not be curtailed save for a reason and in circumstances sanctioned by the law of the land. This principle is reflected in, but does not depend on, article 5(1) of the European Convention on Human Rights. It can be traced back to chapter 29 of Magna Carta 1297 and before that to chapter 39 of Magna Carta 1215. But, secondly, the law may properly provide for the compulsory detention in hospital of those who suffer from mental disorder if detention is judged to be necessary for the health or safety of the patient or the protection of others. The necessity for such detention in appropriate cases is recognised by article 5(1)(e) of the Convention, and has long been given effect in domestic law. Under the legislation now current, it is a pre-condition of an emergency application under section 4 of the 1983 Act, and an application for admission for assessment under section 2, and an application for admission for treatment under section 3, that the subject should be judged to be suffering from a mental disorder of a kind which warrants his detention in a hospital or makes it appropriate for him to receive treatment in a hospital and that detention is necessary for the health or safety of the patient or the protection of others. Thus the personal freedom of the individual may be lawfully curtailed in such cases, provided the strict statutory conditions are observed.

*7. The third relevant principle is of more recent vintage. It is that a person compulsorily detained on mental health grounds should have the right to take proceedings by which the lawfulness of his detention may be decided by a court and his release ordered if the detention is not lawful. This right is expressed in article 5(4) of the Convention, but was not adequately protected in the case of patients subject to restriction by the Mental Health Act 1959, which gave a mental health review tribunal no more than an advisory role in such cases. In *X v United Kingdom* (1981) 4 EHRR 188, which concerned a restricted patient, a violation of article 5(4) was found because the mental health review tribunal enjoyed a power to advise only and not the power which a court would have to direct the discharge of a detained person. This deficiency was remedied by the Mental Health (Amendment) Act 1982 and now by the 1983 Act. In the case of patients who are not restricted, the tribunal's powers (so far as relevant) were laid down in section 72(1) of the 1983 Act. Before amendment in 2001, the subsection read:*

“Powers of tribunals

72 - (1) Where application is made to a Mental Health Review Tribunal by or in respect of a patient who is liable to be detained under this Act, the tribunal may in any case direct that the patient be discharged, and -

(a) the tribunal shall direct the discharge of a patient liable to be detained under section 2 above if they are satisfied -

(i) that he is not then suffering from mental disorder or from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; or

(ii) that his detention as aforesaid is not justified in the interests of his own health or safety or with a view to the protection of other persons;

(b) the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 above if they are satisfied -

(i) that he is not then suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment or from any of those forms of disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or

(ii) that it is not necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment; or

(iii) in the case of an application by virtue of paragraph (g) of section 66(1) above, that the patient, if released, would not be likely to act in a manner dangerous to other persons or to himself."

By subsection (3) the tribunal was empowered, as it did in this case, to direct the discharge of a patient on a future date specified in the direction.

*8. Fourthly, the rule of law requires that effect should be loyally given to the decisions of legally-constituted tribunals in accordance with what is decided. It was clearly established by the House in *Pickering v Liverpool Daily Post and Echo Newspapers plc* [1991] 2 AC 370 that a mental health review tribunal is a court to which the law of contempt applies. It follows that no one may knowingly act in a way which has the object of nullifying or setting at nought the decision of such a tribunal. The regime prescribed by Part V of the 1983 Act would plainly be stultified if proper effect were not given to tribunal decisions for what they decide, so long as they remain in force, by those making application for the admission of a patient under the Act. It is not therefore open to the nearest relative of a patient or an ASW to apply for the admission of the patient, even with the support of the required medical recommendations, simply because he or she or they disagree with a tribunal's decision to discharge. That would make a mockery of the decision.*

9. In applying these principles, account must be taken of certain important considerations:

*(1) While doctors may be expected to exercise their best professional judgment in diagnosing the condition and assessing the cases of those suffering from mental disorder, and prescribing treatment, their conclusions will rarely be capable of scientific verification. There will often be room for a bona fide difference of professional opinion. In *Johnson v United Kingdom* (1997) 27 EHRR 296, paragraph 61, the European Court of Human Rights said:*

"It must also be observed that in the field of mental illness the assessment as to whether the disappearance of the symptoms of the illness is confirmation of complete recovery is not an exact science."

(2) As the Master of the Rolls pointed out in paragraph 30 of his judgment quoted above, the condition of many of those suffering from mental disorder will not be static. Episodes of acute illness may be followed by episodes of remission. Thus it does not follow that a tribunal decision, however sound when made, will remain so. Other things being equal, the longer the period since the decision was made the greater the chance that the patient's mental condition may have altered, whether for better or worse.

(3) *It is plain from the language of sub-paragraphs (a)(i) and (b)(i) of section 72(1), quoted above, that the focus of the tribunal's enquiry into the mental health of the patient is on whether he is not "then suffering" from mental disorder or mental illness. "Then" refers to the time of the tribunal's review and the tribunal has no power to consider the validity of the admission which gave rise to the liability to be detained: see Ex parte Waldron [1986] QB 824, 846. The tribunal will doubtless endeavour to assess a patient's condition in the round, and in considering issues of health, safety and public protection under sub-paragraphs (a)(ii) and (b)(ii) of section 72(1) it cannot ignore the foreseeable future consequences of discharge, but the temporal reference of "then" is clear and the tribunal is not called upon to make an assessment which will remain accurate indefinitely or for any given period of time.*

(4) *If an unrestricted patient, compulsorily detained, seeks to be discharged, and the responsible doctors (including the current RMO) agree that the conditions for detaining him are no longer satisfied, he may be discharged and there will be no occasion for a tribunal hearing. Thus hearings will take place where (as here) a patient seeks to be discharged and the responsible doctors, or some of them, judge that he should not be discharged. Where an order for discharge is made by the tribunal, it will (unless the resisting doctors revise their opinion during the hearing) indicate that the tribunal has not accepted their judgment. A conscientious doctor whose opinion has not been accepted by the tribunal will doubtless ask himself whether the tribunal's view is to be preferred and whether his own opinion should be revised. But if, having done so, he adheres to his original opinion he cannot be obliged to suppress or alter it. His professional duty to his patient, and his wider duty to the public, require him to form, and if called upon express, the best professional judgment he can, whether or not that coincides with the judgment of the tribunal.*

(5) *Account must be taken of section 13 of the 1983 Act, which so far as relevant provides:*

"(1) It shall be the duty of an approved social worker to make an application for admission to hospital or a guardianship application in respect of a patient within the area of the local social services authority by which that officer is appointed in any case where he is satisfied that such an application ought to be made and is of the opinion, having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made by him.

(2) Before making an application for the admission of a patient to hospital an approved social worker shall interview the patient in a suitable manner and satisfy himself that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need."

It is plainly of importance that the ASW is subject to a statutory duty to apply for the admission of a patient where he is satisfied that such an application ought to be made and is of the opinion specified.

Conclusion

10. The problem at the heart of this case is to accommodate the statutory duty imposed on ASWs (by whom, in practice, most applications for admission are made) within the principles referred to in paragraphs 6, 7 and 8 above. The correct solution

is in my opinion that proposed by the Master of the Rolls, although I would express it in slightly different terms. In doing so, I do not find it necessary to make detailed reference to the European Convention. Consistently with the principle identified in paragraph 8 above, an ASW may not lawfully apply for the admission of a patient whose discharge has been ordered by the decision of a mental health review tribunal of which the ASW is aware unless the ASW has formed the reasonable and bona fide opinion that he has information not known to the tribunal which puts a significantly different complexion on the case as compared with that which was before the tribunal. It is impossible and undesirable to attempt to describe in advance the information which might justify such an opinion. I give three hypothetical examples by way of illustration only:

- (1) The issue at the tribunal is whether the patient, if discharged, might cause harm to himself. The tribunal, on the evidence presented, discounts that possibility and directs the discharge of the patient. After the hearing, the ASW learns of a fact previously unknown to him, the doctors attending the patient and the tribunal: that the patient had at an earlier date made a determined attempt on his life. Having taken medical advice, the ASW judges that this information significantly alters the risk as assessed by the tribunal.*
- (2) At the tribunal hearing the patient's mental condition is said to have been stabilised by the taking of appropriate medication. The continuing stability of the patient's mental condition is said to depend on his continuing to take that medication. The patient assures the tribunal of his willingness to continue to take medication and, on the basis of that assurance, the tribunal directs the discharge of the patient. Before or after discharge the patient refuses to take the medication or communicates his intention to refuse. Having taken medical advice, the ASW perceives a real risk to the patient or others if the medication is not taken.*
- (3) After the tribunal hearing, and whether before or after discharge, the patient's mental condition significantly deteriorates so as to present a degree of risk or require treatment or supervision not evident at the hearing.*

In cases such as these the ASW may properly apply for the admission of a patient, subject of course to obtaining the required medical support, notwithstanding a tribunal decision directing discharge. The position of the patient's nearest relative, in those cases where he or she makes the application with knowledge of the tribunal decision, does not differ in principle from that of the ASW, although the nearest relative could not in many cases be expected to be familiar with the evidence or appreciate the grounds on which the tribunal had based its decision.

In short order, where a discharge direction has been made by a Tribunal, health care professionals should be particularly circumspect in utilising the powers contained in the *Mental Health Order (Northern Ireland) 1986* to detain the patient shortly thereafter. A detention, however, may be appropriate where, *inter alia*, there has been a material change in circumstances.

There is a recent Northern Ireland decision on this issue: Brian McGee (judicial review). (Reported on Bailii at [2006] NIQB 78; Appendix 4.) It is currently on appeal to the Court of Appeal.

6.0 Legislative reform in Northern Ireland

It is important to recognise the importance of the Bamford Review and the range of contributions made therein. However, it is more important to subject any proposals to appropriate scrutiny, and to put forward a constructive, if not uncritical human rights response.

Some of the main human rights concerns raised by the recent Bamford Report have been identified in the course of this paper. Such concerns focus on the Report's 'incapacity-based' approach, which fails to make provision for intervention where it may be required, but the person concerned falls without the definition of incapacity or impairment. As identified above, the proposals raise a number of concerns, including the raising of the threshold of incapacity, thereby undermining autonomy, and exposing vulnerable persons or others to injury or death in circumstances where human rights law arguably requires intervention.

There is little doubt that the Northern Ireland Human Rights Commission will continue to play a constructive role in relation to the Bamford Review, and more generally in relation to the reform of mental health legislation in Northern Ireland. The Commission's objective will be to ensure that any new legislation is fully compatible with human rights law and appropriately informed by human rights standards such as the Mental Health Care Principles.

7.0 Discharging the Commission's statutory duty in the mental health field

The Commission has an onerous task given the resources of the organisation and the range of human rights issues requiring its attention. Nonetheless, as regards the field of mental health, the following practices could facilitate the Commission in fulfilling its statutory duty and in protecting the rights of mental patients:

1. Keeping the field of mental health under review;
2. Remaining cognizant of applicable human rights standards, particularly international human rights standards;
3. Remaining cognizant of developing European Convention jurisprudence;
4. Scrutinising mental health law, policy and practice in Northern Ireland; and,
5. Seeking to identify specific issues which require particular attention.

Holding conferences is one effective way of keeping abreast of developments in specific areas and identifying issues which need to be addressed. Another way of staying alert to human rights issues in the field is by working with other organisations, including statutory bodies (such as the Mental Health Commission for Northern Ireland) and non-government organisations (such as the Northern Ireland Mental Health Association or the Law Centre (NI)).

In particular, the Law Centre has recently appointed two mental health lawyers: whose role is the provision of legal assistance and representation for people with mental health difficulties, including mental patients.

The Commission is charged with an important statutory duty, and already has made a significant contribution in the mental health field. Hopefully the Commission will build on the work it already has undertaken, and continue to discharge its statutory duty and protect the rights of mental patients in Northern Ireland.

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