03 May 2002

Chapter 3

HUMAN RIGHTS OF PERSONS WITH MENTAL DISABILITIES:

THE EUROPEAN CONVENTION OF HUMAN RIGHTS[1]

3.01 Introduction

[1] This chapter is an updated and revised version of an article originally published in Lawrence O Gostin 'Human Rights of Persons With Mental Disabilities' (2000) 23 Intl J L & Psychiatry 125–159, with permission of Elsevier Science.

> *It is not necessary to recount the numerous charters and declarations ... to understand human rights ... All persons are born free and equal in dignity and rights. Everyone ... is entitled to all the rights and freedoms set forth in the international human rights instruments without discrimination, such as the rights to life, liberty, security of the person, privacy, health, education, work, social security, and to marry and found a family. Yet, violations of human rights are a reality to be found in every corner of the globe.*[2]

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Peter Piot (Executive Director, UNAIDS)

Human rights law is a powerful, but often neglected, tool in advancing the rights and freedoms of persons with mental disabilities. International law may seem marginal or unimportant in developed countries with democratic and constitutional systems of their own. Yet, even democracies often resist reform of mental health law and policy, and domestic courts do not always compel changes necessary for the rights and welfare of persons with mental disabilities. Additionally, human rights are obviously important for countries without democratic and constitutional systems because they may provide the only genuine safeguard against abuse of persons with mental disabilities ostensibly based on political, social, or cultural justifications.[3]

Human rights law is important in the context of mental health because of two fundamental ideas unique to global protection of rights and freedoms. First, human rights are the only source of law that legitimises international scrutiny of mental health policies and practices within a sovereign country. The international system before World War II focussed almost solely on relations between states; human rights violations that occurred within a country's borders were generally deemed an 'internal affair'. The horrors of the war exposed the vulnerability of the individual in an international system that was based on state sovereignty, and demonstrated the

[2] Peter Piot & Jose Ayala-Lasso Foreword to Lawrence O Gostin & Zita Lazzarini (eds) *Human Rights and Public Health in the AIDS Pandemic* (OUP Oxford 1997) vii.
[3] Sidney Bloch & Peter Reddeway *Psychiatric Terror: How Soviet Psychiatry is Used to Suppress Dissent* (Basic Books New York 1977).

gross inadequacy of previous attempts to protect rights and freedoms.[4] One of the first imperatives of the postwar era was to prevent the recurrence of such egregious affronts to peace and human dignity.

The postwar human rights movement permanently altered the scope of international law. It pierced the veil of national sovereignty and elevated human rights as a matter of international import. The idea that individuals possess inherent rights and freedoms was nothing new; however, recognizing these rights under international law and holding states accountable for violations was a new development. Human rights, therefore, are not a matter simply between citizens and their government. Rather, human rights are a matter of international law enforceable against the state. This renders each country's mental health policies and practices susceptible to international monitoring and control.

The second related idea is that human rights do not rely on government beneficence. Human rights and freedoms are neither granted nor denied by governments. Persons possess rights simply because of their humanity. Thus, persons with mental disabilities need not prove that they deserve certain rights or that they can be trusted to exercise them in socially and culturally acceptable ways. Human rights law provides fundamental protections without qualification or exception.

Human rights, then, afford all persons rights and freedoms, and place duties on government to respect them. Classic understandings of human rights are limited to obligations on governments, and not on other citizens. Human rights law, strictly speaking, does not protect one individual against the harmful actions of another.[5] However, government duties may be

[4] Louis Henkin *How Nations Behave: Law and Foreign Policy* (Columbia University Press New York 1979) 320.
[5] See, eg C–91/92 *Faccini Dori v Recreb* [1994] ECR I–3325.

conceived quite broadly to include: (1) *respect*—the state's obligation not to infringe human rights; (2) *protection*—the state's obligation to prevent private violations (for instance, anti-discrimination laws); and (3) *fulfilment*—the state's obligation to promote human rights (for instance, education and services).[6]

This chapter examines the human rights of persons with mental disabilities, particularly within the European system for the protection of human rights. First, it briefly examines three important relationships between mental health and human rights: coercive mental health policies infringe human rights; invasions of human rights are harmful to mental health; and positive promotion of mental health and human rights are mutually reinforcing and synergistic.

Second, this chapter reviews sources of law within the United Nations system of human rights protection. The principal source of law within the United Nations system is the International Bill of Human Rights, which includes two treaty-based charters that are binding on states that have ratified the agreements. The chapter also examines the International Principles for the Protection of Persons with Mental Illness. These principles, while not formally binding, serve as influential aids in the interpretation of United Nations and regional treaty obligations (See Part B below.).

Third, this chapter examines in depth what is perhaps the most highly developed regional system of human rights protection—the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) within the Council of Europe. The chapter demonstrates the vast potential of human rights law in three important areas of mental health policy: (1) the right to fundamental fairness in compulsory admission and subsequent detention in mental institutions—eg legal representation, a hearing, and use of independent experts; (2) the

[6] See generally, Henry J Steiner & Philip Alston *International Human Rights in Context: Law, Politics,*

right to humane and dignified conditions of confinement—eg avoidance of neglectful or abusive conditions in mental hospitals and harmful or intrusive forms of medical treatment; and (3) protection of rights of citizenship—eg privacy, marriage, franchise, and association. Human rights law, of course, leaves government with a wide range of discretion in relation to each of these fundamental rights and freedoms. Nevertheless, this body of international law opens each of these areas to serious external scrutiny.

A. THE FUNDAMENTAL RELATIONSHIPS BETWEEN MENTAL HEALTH AND HUMAN RIGHTS

3.02 Three Relationships Between Mental Health and Human Rights

Mental health and human rights, with notable exceptions, are rarely discussed together and connected in thoughtful, systematic ways. Different philosophies, vocabularies, and social roles may explain the rarity of cross-disciplinary work. Yet, mental health and human rights are both powerful, modern approaches to advancing human well-being; by viewing these two fields together, rather than in isolation, they become mutually reinforcing. There exist three relationships between mental health and human rights: mental health policy affects human rights; human rights violations affect mental health; and positive promotion of mental health and human rights are mutually reinforcing.[7]

The first relationship means that mental health policies, programs, and practices can violate human rights. Despite its rhetoric of 'voluntarism' and non-coercion, mental health policy

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Morals (Clarendon Press Oxford 1996).

[7] This section is based on a previous article: Jonathan M Mann, Lawrence Gostin, Sofia Gruskin *et al* 'Health and Human Rights' (1994) 1 Health & Hum Rts 7 (proposing three linkages between public health and human rights). See also Lawrence O Gostin (ed) *Public Health Law and Ethics: A Reader* (University

quintessentially involves the exercise of governmental power—the power to restrain, to treat, and to deprive citizens of their basic rights, such as the right to vote, access to the courts, and control of personal and financial affairs. Although mental health powers may be exercised beneficently, for the welfare of the individual as well as of the family and society, governmental authority, by its very nature, affects a variety of personal interests—among them autonomy, bodily integrity, privacy, property, and liberty. These interests can, and do, give rise to human rights claims when mental health powers are exercised arbitrarily, in a discriminatory manner, or in the absence of a fair process.

The second relationship is that violations of human rights adversely affect mental health. The mental health effects of severe human rights violations, such as torture, rape, genocide, and inhuman and degrading treatment, are obvious and inherent. Yet, the duration and extent of mental health problems remain under-appreciated. Severe human rights abuses result in serious, life-long mental suffering—not only by the individual, but often the family, community, and even future generations.[8] Serious human rights violations usually are designed not so much to inflict physical pain, as to break the human spirit—torture may be politically motivated to discourage resistance to government, and rape and genocide may be culturally motivated to destroy ethnic identity.[9] Even less drastic human rights violations such as discrimination and invasion of privacy can have adverse effects on mental well-being by undermining dignity and self-worth.[10]

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of California Press Berkeley 2002).

[8] Anne E Goldfield, Richard F Mollica, Barbara H Pesavento *et al* 'The Physical and Psychological Sequelae of Torture, Symptomotology and Diagnosis' (1988) 259 JAMA 2725.

[9] See Ahcene Boulesbaa *The UN Convention on Torture and the Prospects for Enforcement* (Martinus Nijhoff Publishers The Hague 1999); Kelly Dawn Askin *War Crimes Against Women: Prosecution in International War Crimes Tribunals* (Martinus Nijhoff Publishers The Hague 1997).

[10] See eg Aart Hendricks 'Disabled Persons and Their Right to Treatment: Allowing Differentiation While Ending Discrimination' (1995) 1 Health & Hum Rts 152; Alfred H Neufeldt & Ruth Mathieson 'Empirical Dimensions of Discrimination Against Disabled People' (1995) 1 Health & Hum Rts 174.

The third relationship is that mental health and human rights are inextricably linked. Mental health and human rights are complementary approaches to the betterment of human beings. Some measure of mental health is indispensable for human rights, because only those who possess some reasonable level of functioning can engage in political and social life.[11] Similarly, human rights are indispensable for mental health, because they provide security from harm or unnecessary restraint and the freedom to form and express beliefs that are essential to mental well-being. Consider the importance of mental health and human rights to women in society. Without mental health, women cannot function within the family, community, and workplace or participate in the political process. If they are subjected to discrimination, enforced conditions, or violence in sexual relationships or marriage, possession or use of property, and status or livelihood, their mental health will suffer. Seen in this way, a woman's mental health may improve by safeguarding her human rights'—for instance, through the reform of laws relating to divorce, property distribution, labour and rape. Her power to secure her rights may improve if government provides services and other conditions necessary for mental health.

B. SOURCES OF HUMAN RIGHTS LAW WITHIN THE UNITED NATIONS SYSTEM OF PROTECTION OF HUMAN RIGHTS

International human rights is a complex and evolving body of law. The main source of law within the United Nations system is the International Bill of Human Rights consisting of the United Nations Charter, the Universal Declaration of Human Rights, and two International Covenants on

[11] Norman Daniels *Just Health Care* (Cambridge University Press Cambridge 1985); Dan W Brock & Norman Daniels 'Ethical Foundation of the Clinton Administration's Proposed Health Care System' (1994) 271 JAMA 1189.

human rights.[12] Additionally, the United Nations has adopted declarations on the rights of persons with mental illness[13] and learning disabilities.[14] Human rights are also protected under regional systems including those in the Americas, Europe, and Africa.[15]

3.03 The United Nations Charter

In its preamble, the United Nations Charter articulates the international community's determination 'to reaffirm faith in fundamental human rights, [and] in the dignity and worth of the human person.'[16] One of the central purposes of the United Nations is to achieve international co-operation in 'promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction'.[17] The Charter, as a binding treaty, pledges member states to

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[12] The International Bill of Human Rights also includes the Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR). The Optional Protocol empowers private persons to seek redress for Covenant violations from the Human Rights Committee, but is only available against states that have ratified it. The Optional Protocol binds approximately half of the states that are parties to the Covenant. See Hurst Hannum (ed) *Guide to International Human Rights Practice* (University of Pennsylvania Press Philadelphia 1992).

[13] UN General Assembly Resolution No 119: *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (adopted by the 75th plenary meeting of the 46th session of the General Assembly on 17 of December 1991, UN Doc A/46/119, UN GAOR 46th Sess Supp No 49 Annex 188–92 ,1991).

[14] UN General Assembly Resolution No 2856: *Declaration on the Rights of Mentally Retarded Persons* (adopted by the 26th session of the General Assembly in 1971, UN Doc A/8429, UN GAOR 26th Sess Supp No 29 at 99, 1971). See UN General Assembly Resolution No 3447: *Declaration on the Rights of Disabled Persons* (adopted by the 30th session of the General Assembly in 1975, UN Doc A/10034, UN GAOR 30th Sess Supp No 34, 92, 1975). See generally, Stanley S. Herr 'Rights of Disabled Persons: International Principles and American Experiences' (1980) 12 Colum Hum Rt L Rev 1.

[15] See eg European Convention for the Protection of Human Rights and Fundamental Freedoms (the European Human Rights Convention) (Rome, 4 November 1950; entered into force 3 September 1953, ETS 5 (1953); Cmd 8969); American Convention on Human Rights (Pact of San Jose) (San Jose, 22 November 1969, entered into force 18 July 1978, OASTS 36, OAS Off Rec OEA/Ser L/V/II 23, doc 21, rev 6 (1979)), reprinted in 9 ILM 673 (1970); African Charter on Human and Peoples' Rights (Nairobi, 28 June 1981, entered into force 21 October 1986, OAU Doc CAB/LEG/67/3 Rev 5, reprinted in 21 ILM 58 (1982)).

[16] Preamble, Charter of the United Nations (UN Charter) (San Francisco, 26 June 1945; entered into force 24 October 1945.

[17] UN Charter Art 1, para 3.

promote universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.[18]

3.04 The Universal Declaration of Human Rights

The Universal Declaration of Human Rights (Declaration), adopted in 1948, built upon the promise of the Charter by identifying specific rights and freedoms that deserve promotion and protection. The Declaration, approved by forty-eight states with eight abstentions, was the organised international community's first attempt to establish 'a common standard of achievement for all peoples and all nations' to promote human rights.[19] The document proclaims the equal significance of civil and political rights and economic, social, and cultural rights. The Declaration's 30 articles are based upon the principle that '[a]ll human beings are born free and equal in dignity and rights'.[20] The rights set forth are to be respected without discrimination, and include: the right to life, liberty, and security of person; the prohibition of slavery, torture, and cruel, inhuman, or degrading treatment; the right to an effective judicial remedy; the prohibition of arbitrary arrest, detention, and exile; freedom from arbitrary interference with privacy, family, or home; freedom of movement; freedom of conscience, religion, expression, and association; and the right to participate in government.

The Declaration characterises economic, social, and cultural rights as 'indispensable for [a person's] dignity and the free development of his personality' (Article 22). These rights include: social security; work, equal pay for equal work, and remuneration ensuring 'an existence worthy

[18] UN Charter Art 55–56.
[19] Universal Declaration of Human Rights (Declaration), adopted 10 December 1948, General Assembly resolution 217 A (III) of 10 December 1948, UN Doc A/810, preamble (1948).
[20] Declaration, Art 1.

of human dignity'; the right to education; and the right to share in the cultural life of the community and 'to share in scientific advancement and its benefits' (Articles 22-27). Article 25 of the Declaration expressly recognised an interest in health:[21]

> Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The Universal Declaration has largely fulfilled the promise of its preamble, becoming the 'common standard' for evaluating respect for human rights. Although it was not promulgated to legally bind member states, its key provisions have so often been applied and accepted that they are now widely considered to have attained the status of customary international law. The Universal Declaration embodies what is meant by 'human rights' in the international community, and has inspired successive generations of legally binding human rights instruments including the European Convention of Human Rights.

3.05 The International Covenants on Human Rights

The Declaration's adoption set the stage for a binding, treaty-based scheme to promote and protect human rights. The International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) were adopted in 1966. After ratification or accession by at least thirty-five member countries, the Covenants entered into force in 1976. The ICCPR includes most, but not all, of the civil and political rights

[21] Interestingly, during the drafting of the Declaration, the emphasis shifted from a direct focus on the right to health to its current focus on the economic necessities to achieve human health. The original draft declared that '[e]veryone, without distinction as to economic and social conditions, has the right to the preservation of his health through the appropriate standard of food, clothing, housing, and medical care.

addressed in the Declaration.[22] The ICESCR greatly expands upon the Declaration's treatment of these rights. Sections of the ICESCR form the foundation for 'positive rights', that is, those requiring affirmative duties on the state to provide services. Such positive rights include family protection, an adequate standard of living and education. Article 12 requires governments to recognise 'the right of everyone to the highest attainable standard of physical and mental health'.

The two Covenants diverge in their treatment of permissible limitations. The ICCPR recognises that certain rights are so fundamental as to be absolute and proscribes any derogation of them. Non-derogable rights include: the right to life (Article 6);[23] freedom from torture and from cruel, inhuman, or degrading treatment or punishment (Article 7); the right to recognition as a person before the law (Article 16); and freedom of thought, conscience, and religion (Article 18). The ICCPR states that other rights may be justifiably derogated from under certain conditions. Derogations may be permissible 'in time of public emergency which threatens the life of the nation' but only 'to the extent strictly required by the exigencies of the situation, provided that such measures are not applied in a discriminatory manner and are not inconsistent with their other obligations under international law' (Article 4.1). Freedom of movement may be justifiably limited where restrictions are 'provided for by law, are necessary to protect national security, public order, public health or morals or the rights and freedoms of others. …' (Article 12.3) The

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See *United Nations Yearbook* (Lake Success New York 1948).

[22] For a comparison of the ICCPR and the ECHR, see Marc-André Eissen 'The European Convention on Human Rights and the United Nations Covenant on Civil and Political Rights: Problems of Co-Existence' (1972–1973) 22 Buffalo L Rev 181–216.

[23] The European Court of Human Rights has had occasion to examine the right to life under Article 6 in the context of mental health. In *Paul and Audrey Edwards v United Kingdom*, Application no 46477/99 (14 March 2002), the Court held that the UK government breached its duty under Article 2 to protect the life of a prisoner named Christopher Edwards. Richard Linford, a cellmate who was known to be a dangerous person diagnosed with schizophrenia, murdered Mr. Edwards. The Court said that the failure of the agencies involved in this case (medical profession, police, prosecution and court) to pass on

ICESCR generally permits 'such limitations as are determined by law only in so far as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society' (Article 4). It is also subject to progressive implementation (Article 2.1)

3.06 Principles for the Protection of Persons with Mental Illness

The United Nations designated the years 1983 to 1992 to be the 'Decade for Disabled Persons.'[24] To advance the welfare and rights of one group of persons with disabilities, namely the mentally ill, the Human Rights Commission appointed two special rapporteurs, Erica-Irene Daes[25] and Leandro Despouy,[26] to report on human rights abuses. Following an extensive drafting process beginning in the late 1970s,[27] and considerable debate among mental health professionals and civil libertarians, the General Assembly adopted a detailed international statement of the rights of persons with mental illness—Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (MI Principles).[28]

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information about Mr. Linford to the prison authorities and the inadequate nature of the screening process on Linford's arrival in prison disclose a breach of the State's obligation to protect the life of Mr. Edwards.

[24] GA Res 52, UN GAOR 37th Sess (1982).

[25] United Nations, Economic and Social Council, Commission on Human Rights, Sub-Commission on Prevention of Discrimination and Protection of Minorities, Principles, Guidelines, and Guarantees for the Protection of Persons Detained on Grounds of Mental Ill-Health or Suffering from Mental Disorder, UN Doc E/CN.4/Sub.2/17 (1983).

[26] United Nations, Economic and Social Council, Commission on Human Rights, Sub-Commission on Prevention of Discrimination and Protection of Minorities, Human Rights and Disability, UN Doc E/CN.4/Sub.2/31(1991).

[27] *Human Rights and Scientific and Technological Developments*, GA Res 53, UN GAOR, 33rd Sess, Supp No 45, at 144, UN Doc A/Res/33/53 (1978). The earliest draft was prepared by a committee under the auspices of the International Association of Penal Law and the International Commission of Jurists. The Protection of Persons Suffering from Mental Disorder: Proceedings of Two Meetings of Experts Held at the International Institute of Higher Studies in Criminal Studies in Siracusa May 29–31, 1980 and December 1–4, 1980.

[28] GA Res 119, UN GAOR, 46th Sess, Supp No 49, Annex, at 188–92, UN A/RES/46/119 (1991). For an

Unlike treaties and customary international law, United Nations General Assembly resolutions are not directly binding on states. Accordingly, governments may argue that they are not obliged to conform with international resolutions, rendering them virtually meaningless as a force for influencing mental health policies. A strong argument, however, can be made that international principles do have practical importance. First, they help establish international human rights norms by creating a baseline of fair and decent treatment of persons with mental disabilities. Second, they enable fairer and more effective monitoring of psychiatric abuses because international and non-profit organisations have a standard with which to judge extant mental health policies. Finally, and most importantly, resolutions can be used as an interpretative guide to international treaty obligations.[29] The MI Principles could serve as a useful interpretative guide to United Nations and regional human rights conventions.

The MI Principles begin by enunciating fundamental freedoms and rights to: the 'best available' mental health care; respect for inherent dignity; protection from exploitation, physical abuse, and degrading treatment; non-discrimination; natural justice prior to a finding of incapacity; and, more generally, the right to exercise all rights in the International Bill of Human Rights (Principle 1).

The MI Principles recognise the inherent difficulties of protecting human rights in institutions: as far as possible, care should be in the community (Principles 3 and 7). This

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authoritative account of the MI Principles, see Eric Rosenthal & Leonard S. Rubenstein 'International Human Rights Advocacy Under the Principles for the Protection of Persons with Mental Illness' (1993) 16 Int'l JL & Psychiatry 257, 257–99.

[29] Eric Rosenthal & Leonard S Rubenstein 'International Human Rights Advocacy Under the "Principles for the Protection of Persons with Mental Illness"' (1993) 16 Int'l JL & Psychiatry 257, 268–71; see Louis Henkin *The Age of Rights* (New York: Columbia University Press 1990) 17.: resolutions provide 'a proper subject for diplomacy, international institutions and international law'.

preference for community care is reinforced by the duty to treat in the least restrictive environment and to preserve and enhance autonomy (Principle 9).

The MI principles adopt a set of legalistic standards and procedures for involuntary admission to hospital. A person may be involuntarily admitted only if: (1) he has a mental illness diagnosed under internationally accepted medical standards; and (2) there is a serious likelihood of immediate harm to the person or others; or (3) if the person is severely mentally ill and has impaired judgement, there will be a serious deterioration of his condition (Principle 16). Procedural safeguards include a fair hearing by a judicial or other independent review body, with representation, independent experts, rights to information and attendance, and reasons for the decision (Principles 17 and 18). The MI Principles offer less robust protection against mandatory treatment. Principle 11, on consent to treatment, offers a complex and detailed political compromise between autonomy and paternalism.[30]

Persons with mental illness are entitled to a number of 'negative' rights (ie freedoms from restraint and interference) including privacy and confidentiality, freedom of communication, access to information, and no enforced labour (Principles 6, 13, 19). The MI Principles also enunciate a set of 'positive' rights (entitlements to services) including the right to health and social services appropriate to health needs, an individualised treatment plan, recreational and educational services, and resources for mental health facilities comparable to other health facilities (Principles 8–10, 13, 14).

As argued above, these human rights principles, while not formally binding, can still be important in setting international mental health norms, monitoring psychiatric abuse, and serving as a constructive guide to treaty interpretation. The next part of this chapter discusses one of the

[30] Caroline Gendreau 'The Rights of Psychiatric Patients in the Light of the Principles Announced by the

most important treaty obligations in mental health—the European system for the protection of human rights.

C. EUROPEAN SYSTEM FOR THE PROTECTION OF HUMAN RIGHTS

On 10 May 1948, delegates to the Congress of Europe in the Hague declared that: 'We desire a Charter of Human Rights guaranteeing liberty of thought, assembly, and expression as well as the right to form a political opposition.'[31] The following year, Article 3 of the Statute of the Council of Europe (which formed the Council) affirmed 'the principle of the rule of law and of the enjoyment by all persons … of human rights and fundamental freedoms.' This began a process that culminated in the signing of the European Convention for the Protection of Human Rights and Fundamental Freedoms in Rome on 4 November 1950.[32] The United Kingdom was the first country to ratify the Convention on 8 March 1951 and, by 1974, all 18 then-existing States of the Council of Europe had ratified it. Today, the Council of Europe has over 40 members.

3.07 European Union Not Bound by the Convention

The European Union (which is a separate entity from the Council of Europe) is not a party to the European Convention on Human Rights, and the Union does not accede to its authority.[33] While European Union law does not provide a major vehicle for human rights adjudication, Article 6(2)

United Nations: A Recognition of the Right to Consent to Treatment' (1997) 20 Int'l JL & Psychiatry 259.

[31] Arthur Henry Robertson *Human Rights in Europe* (2nd revised and expanded edn Manchester University Press Manchester 1977) 5–17.

[32] Ben Emmerson & Andrew Ashworth *Human Rights and Criminal Justice* (Sweet & Maxwell London 2001) 3–8.

[33] Opinion 2/94 [1996] ECR I–1759.

of the Treaty on European Union (Maastricht Treaty), does contain a non-justiciable provision relevant to human rights: 'The Union shall respect fundamental rights, as guaranteed by the European Convention for the Protection of Human Rights and Fundamental Freedoms…'[34] Additionally, since the Amsterdam-amendment in 1997, the Treaty Establishing the European Communities contains provisions on discrimination and public health. Article 13 of the Treaty enables the European Community (EC) to 'take appropriate action to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age, or sexual orientation.'[35] Article 152 (formerly Article 129) states that 'a high level of human health protection shall be ensured in the definition and implementation of Community policies and activities.'[36] Consequently, European Union law, while certainly relevant, does not offer the kind of adjudicative power on mental health and human rights as does the Council of Europe.

3.08 The Institutions of the Convention

The Eleventh Protocol of the ECHR, which entered into force on 1 November 1998, merged the functions of two previous institutions of the Convention—the Commission and Court—into a single European Court of Human Rights.[37] The Court's jurisdiction extends to all matters concerning the interpretation and application of the Convention and its protocols (Article 32(1)).

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[34] Treaty of the European Union (TEU or Treaty of Maastricht) signed in 1992, entered into force 1 November 1993, 1992 OJ C191, Art F(2).
[35] Treaty of Amsterdam amending the Treaty on European Union, signed in 1997, entered into force 1 May 1999 1997 OJ C340, Art 6(2).
[36] ToA (n 34 above) Art 152.
[37] Previously, the European Commission of Human Rights received all applications, having the power to find them 'inadmissible' or 'admissible'. If the Commission found an application 'admissible' it investigated and sought a 'friendly settlement'. It also had power to report to the Committee of Ministers and to refer cases to the Court. The Court had, and continues to have, the ultimate power to adjudicate violations of the Convention.

The Court can sit in committees of 3 judges, in Chambers of 7 judges, and in a Grand Chamber of 17 judges (Article 27). In addition to its mandatory jurisdiction over inter-state cases (Article 33), the Court hears individual applications by persons, any group of individuals or non-governmental organisations who are 'victims' of a violation of human rights by a contracting party (Article 34).

The Court can consider cases only after exhaustion of all domestic remedies and within a period of six months from the date on which the final decision was taken (Article 35). The Court can hold an application 'inadmissible' if it is 'incompatible' with the Convention (for instance, the Convention does not apply), 'manifestly ill-founded' (for instance, the facts do not disclose a prima facie violation), or an 'abuse of the right of petition' (for instance, politically motivated). If the Court finds the case 'admissible', it will investigate: it can secure a 'friendly settlement' (ie a negotiated agreement) or, after a hearing, render a decision on the merits. If it finds a violation of the Convention, the Court has the power to afford 'just satisfaction' (ie damages and reimbursement of legal costs) (Article 41). A Chamber's judgement can be appealed to the Grand Chamber if it raises a serious issue affecting the interpretation of the Convention or of general importance (Article 43).

3.09 Right of Individual Application and Incorporation of the ECHR into Domestic Law: The Human Rights Act 1998

Until recently, member states of the Council of Europe were not obliged to permit individual litigants access to the Commission and Court to redress violations of rights and freedoms, although most chose to do so.[38] The United Kingdom was late in granting the right of individual petition; the UK did so in 1966, although it declined to incorporate the Convention into domestic

law. Many states, however, did incorporate the ECHR into domestic law so that citizens could present human rights claims to their own courts. France, for example, incorporated the ECHR into domestic law soon after the Convention was ratified, but the United Kingdom took no action until the close of the twentieth century.[39] Consequently, state obligations under international law were not part of domestic law or effectively justiciable by domestic courts.[40]

The Human Rights Act 1998, which came into effect on 2 October 2000, extends the ways in which the ECHR can be applied in the domestic courts—partly incorporating the Convention into domestic law and partly retaining Parliamentary sovereignty.[41] The Act creates two complementary duties—one on the judiciary and the other on public authorities.

The judiciary, whenever possible, must construe primary (statutes) and secondary (regulations) legislation in conformance with the Convention (s 3). In construing the Convention, the courts must take into account sources of Convention law (s 2).[42] Thus, judgements, decisions, and opinions of the European Commission, Court, and Committee of Ministers are persuasive, not binding authority.

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[38] By virtue of the Eleventh Protocol, the right of individual application effectively ceased to be optional for contracting parties (Art 34).

[39] Home Office *Rights Brought Home: The Human Rights Bill*, Cmnd 3782 (HMSO London 1997).

[40] As to the role of human rights law prior to the 1998 Act, see Murray Hunt *Using Human Rights Law in English Courts* (Hart Publishing Oxford 1997); Rabinder Singh *The Future of Human Rights in the United Kingdom* (Hart Publishing Oxford 1997). Since the passage of the Human Rights Act, however, the courts consider the force of the Convention on domestic disputes.

[41] There are a number of authoritative texts on the Human Rights Act 1998. See, eg John Wadham & Helen Mountfield *Blackstone's Guide to Human Rights Act 1998* (Blackstone Press London 1999); Christopher Baker (ed) *Human Rights Act 1998: A Practitioner's Guide* (Sweet & Maxwell London 1998). For a description of ministerial statements during the passage of the 1998 Act, see Francesca Klug 'The Human Rights Act 1998, Pepper v Hart and All That' [1998] Pub L 246–72.

[42] There are a number of authoritative texts on the Human Rights Act 1998. See, eg John Wadham & Helen Mountfield *Blackstone's Guide to Human Rights Act 1998* (Blackstone Press London 1999); Christopher Baker (ed) *Human Rights Act 1998: A Practitioner's Guide* (Sweet & Maxwell London 1998). For a description of ministerial statements during the passage of the 1998 Act, see Francesca Klug 'The Human Rights Act 1998, Pepper v Hart and All That' f1998] Pub L 246–72.

The Human Rights Act does not specify whether judges must construe common law by the same international human rights standards. This is important in mental health policy because restraint or detention can sometimes be accomplished under common law powers.[43] Since common law, like statute and regulation, empowers government to act coercively, logically judges should assure that common law practice conforms with human rights norms. This conclusion can also be inferred from the Act because section 6 requires public authorities, which includes the judiciary, to comply with the rights and freedoms afforded under the Convention.[44]

The Act also imposes an obligation on public authorities (eg courts and persons whose function are of a public nature, except Parliament) to comply with the rights and freedoms afforded under the Convention unless they are prevented from doing so by statute (s 6)[45] Individuals can challenge public authorities in court on grounds that their acts are incompatible with the Convention, but a person has standing only if a 'victim of that act' (s 7). Reliance on a Convention right does not restrict other existing rights and freedoms under domestic law (s 11). Convention rights, therefore, provide a 'floor,' or minimum level of protection, of rights and freedoms.

Despite the duties on the courts to construe laws in conformity with the Convention, Parliament retains its supremacy.[46] If certain higher courts find that domestic law is incompatible

[43] *R v Bournewood Community and Mental Health NHS Trust, ex p L (Secretary of State for Health and others intervening)* [1999] 1 AC 458; [1998] 3 WLR 107 (CA)
[44] John Hodgson 'Detention, Necessity, Common Law and the European Convention: Some Further Aspects of the *Bournewood* Case' [1999] J Mental Health L 23, 23–32.
[45] Nicholas Bamforth 'The Application of the Human Rights Act 1998 to Public Authorities and Private Bodies' (1999) 58 Camb LJ 159–70 (exploring the meaning of the term 'public authority' and whether the act protects one individual against the actions of another).
[46] For views on the effects of the 1998 act on Parliamentary sovereignty, see Rt Hon Lord Hoffmann 'Human Rights and the House of Lords' (1999) 62 Mod L Rev 2 159–66; K D Ewing 'The Human Rights Act and Parliamentary Democracy' (1999) 62 Mod L Rev 1 79–99.

with the Convention, they can make a declaration of incompatibility (s 4).[47] A declaration—which is discretionary, not obligatory, on the court—is a formal statement that there exists a conflict between the two systems of law. However, courts are not given the power of judicial review so that they cannot invalidate legislation as unconstitutional (s 4(6)). Ministers, in response to a declaration, are empowered in certain cases to amend legislation by a 'remedial order' to assure conformity with the Convention (s 10, Sched 2).[48] The constitutional position in the United Kingdom, therefore, is unlike that of the United States. The latter grants to the judiciary power to invalidate legislative and regulatory acts as unconstitutional, whereas the former gives the courts moral authority to declare that legislation violates human rights norms.

There exists an extensive body of case law on mental health from the European Commission and Court of Human Rights, and an impressive body of scholarship has emerged.[49] The Human Rights Act 1998 provides the domestic courts with the opportunity to refine and expand the theory and practice of human rights in the United Kingdom. The UK courts have already decided a number of cases on human rights grounds and many more are expected. The courts in Strasbourg and the UK have thus far dealt with human rights that are essentially 'negative' in character. That is, the courts place limits on governmental interference with individual rights and freedoms, rather than establishing a positive entitlement to government

[47] Where the court is considering whether to make a declaration, the Crown is entitled to notification so that it may, if it chooses, intervene in the proceedings (s 5).

[48] House of Lords and Joint Committee on Human Rights, Making of remedial orders report and proceedings of the Committee: seventh report, Session 2001/02 (general lessons drawn from first use of remedial order under 1998 Act). See Mental Health Act 1983 (Remedial) Order 2001 (HC Paper No 472).

[49] See eg Margaret G Wachenfeld *The Human Rights of the Mentally Ill in Europe* (The Danish Center for Human Rights Copenhagen 1992); Phillip Fennell 'The Third Way in Mental Health Policy' (1999) 26 J L & Society Issue 1 103–27; Oliver Thorold 'The Implications of the European Convention on Human Rights for United Kingdom Mental Health Legislation' [1996] EHRLR 619, 619–36; David Hewitt 'Mental Health Law' *in* Christopher Baker (ed) *Human Rights Act 1998: A Practitioner's Guide* (Sweet & Maxwell London 1998); T W Harding 'The Application of the European Convention of Human Rights to

services. The case law can be categorised into three primary areas: compulsory detention, conditions of confinement, and civil rights.

3.10 Involuntary Admission and Subsequent Detention in Mental Institutions

Article 5 of the ECHR guarantees the right to liberty and security of the person. Sub-paragraph 1 lists the cases in which government may justifiably deprive persons of their liberty, including the case of 'persons of unsound mind.' Sub-paragraph 2 requires government to inform persons of the reasons for their arrest (including 'psychiatric' arrest). Sub-paragraph 4 requires government to provide a 'speedy' review of the detention by an independent court or tribunal. Finally, sub-paragraph 5 requires that victims of arrest or detention in contravention of the Convention must have an enforceable right to compensation.

3.11 The Meaning of 'Detention'

The entire framework for protection of liberty and security of the person depends on whether a person with mental disability is 'detained.' If a person is not 'detained,' the considerable safeguards of Article 5 do not apply. On its face, the language of Article 5 could be read quite liberally: 'Everyone has the right to liberty and security of person.' Personal security is a concept broader than liberty, implying that Article 5 is concerned with all circumstances when a person's liberty is at all constrained by governmental action.

Despite the possible differences between liberty and security, the European Court construes Article 5 to apply only to cases of formal detention, and it appears to see detention

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the Field of Psychiatry' (1989) 12 Intl JL & Psychiatry 245.

mainly as a relatively long period of confinement within an institution. The Court separates detention,[50] which triggers Article 5 safeguards, from mere restriction of movement, which receives decidedly less protection in other parts of the Convention.[51] Determinations of detention are based on all the circumstances of the case, including the type, duration, effects, and manner of the restraint.[52] Detention is a matter of 'degree or intensity' (not 'nature or substance'), with more severe restrictions rising to the level of 'detention.'[53] In *Ashingdane v the United Kingdom*, for example, the Court held that a patient was detained in the sense that 'his liberty, and not just his freedom of movement, has been circumscribed both in fact and in law,' even though he had been permitted to leave hospital on frequent occasions.[54]

This formalistic construction of 'detention' may leave persons without substantial human rights protection even when their autonomy and liberty are significantly constrained. Two important problems in mental health are going to be considered that involve restraints that may

[50] Article 5 refers to arrests, detentions, and deprivations of liberty: Article 5(1): 'No one shall be *deprived of liberty* save in the following cases....'; Article 5(2) : 'Everyone who is *arrested* shall be informed promptly ... of the reasons....'; Article 5(4): 'Everyone who is *deprived of his liberty by arrest or detention* shall be entitled to take proceedings....'

[51] Personal restraint that does not involve deprivation of liberty is governed by Article 2 of the Protocol No 4: 'Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement...'.

[52] *Ashingdane v United Kingdom* (1985) Series A No 93, (1985) 7 EHRR 528, para 40–41. See *Engel and Others v the Netherlands* (1976) Series A No 22, (1979-80) 1 EHHRR 706, para 58–59; *Guzzardi v Italy* (1980) Series A No 39, (1981) 3 EHRR 333, para 92.

[53] See *Amuur v France* (1996) Series A 1996–III, (1996) 22 EHRR 533.

[54] *Ashingdane v United Kingdom* (see n 51 above) para 42. Ashingdane's RMO recommended his transfer from Broadmoor to a local hospital and the Home Secretary accepted the recommendation. However, the local authority refused to admit him because the trade union of nursing staff had operated a total ban on admission on restricted patients. Since the nature and conditions in the two hospitals were so fundamentally different, Ashingdane argued it amounted to a choice between detention and liberty. The Court rejected the claim stating that, although there are important differences between the regime in a special hospital and a local hospital, they are both forms of lawful detention. See also *LL v Sweden* (Application No 10801/84) (1986) 61 DR 62, 73 ('a person detained in a psychiatric hospital would clearly still be regarded as 'deprived of his liberty' even if he was occasionally allowed to leave the hospital premises').

fall outside the scope of Article 5: confinement of non-protesting patients and compulsory supervision in the community.

3.12 Detention of 'Non-Protesting' Patients

This problem involves persons who are confined in fact, but not under the force of law. This may occur in several different contexts. First, a person may succumb to a show of authority because he does not realise that he is free to resist. For example, in *Guenat v Switzerland*, police officers 'invited' an individual whom they believed was acting abnormally to come to the police station. His behaviour, in fact, was caused by medication for a neurological condition, but a psychiatrist, called in by the police, arranged for his compulsory admission to a mental hospital. The Commission decided that his confinement in the police station was not a deprivation of liberty because the police did not exert physical force, and he remained free to leave.[55] This decision fails to consider the person's true circumstances and whether, in reality, he reasonably feels that his liberty is constrained.

Another illustration of this problem occurs when incompetent patients are 'voluntarily' admitted to a mental hospital. In the United Kingdom, persons with mental disabilities can be admitted 'informally.' Informal patients do not receive any of the usual procedural and substantive safeguards to ensure they have given legally effective consent and that admission is in their best interests.[56] (The 2000 White Paper, however, announced the government's intention to introduce safeguards for patients treated without the use of compulsory powers.)[57]

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[55] Application No 24722/94 (1995), 81 DR 130, 134. His complaint that he had been wrongfully admitted to a mental hospital was not heard because he failed to exhaust his administrative remedies.
[56] Mental Health Act 1983, s 131.
[57] Department of Health *Reforming the Mental Health Act*, Cmnd. 5016–I, Chapter 6 (HMSO London

In *R v Bournewood Community and Mental Health NHS Trust, ex p L (Secretary of State for Health and others intervening),*[58] the House of Lords upheld the use of informal admission. In *Bournewood*, an adult with severe learning disabilities was informally admitted to a mental hospital after harming himself at a day centre. The House of Lords held unanimously that his initial sedation and movement was justified under the common law doctrine of necessity. The informal admission to hospital, according to the majority, did not amount to a 'detention.'[59]

There may be strong grounds for believing that, at least in some circumstances, non-protesting patients are detained within the meaning of Article 5. Recall that *Ashingdane* was 'detained' because his liberty was severely constrained 'both in fact and law.' The incompetent informal patient's liberty may be severely constrained in fact—he may not be aware of his right to leave the hospital. The patient may also feel genuinely constrained in law—if he tries to leave the hospital he may be prevented from doing so. For example, in the United Kingdom, doctors and nurses possess the power to 'hold' informal patients for a period of time necessary to accomplish an involuntary admission to hospital.[60] The European Court should have close regard to the factual and legal realities facing an individual. A failure to exercise a theoretical right to leave an institution ought not to be dispositive if the person lacks maturity, understanding of the situation, or competence. A determination of a 'detention' under the Convention should depend on all the circumstances of the case including the use of force or deception, the person's resistance to, or displeasure with, restraint and treatment, the person's mental capacity, and the

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2000). The Department of Health estimated that at any time there may be as many as 44,000 people informally admitted to hospital with serous, long-term mental incapacity (para 6.1). For a discussion of the White Paper proposals relating to informal admission see paras **10.01**, **10.04**.

[58] [1999] 1 AC 458.

[59] See John Hodgson 'Detention, Necessity, Common Law and the European Convention: Some Further Aspects of the *Bournewood* Case' [1999] J Mental Health L 23, 23–32.

[60] Mental Health Act 1983, s 5(2)(4).

place, conditions, and duration of confinement.[61] Fennell thoughtfully points out that, in *Bournewood,* the patient's family was prevented from visiting him; this deprivation of association with family should amount to an 'aggravating factor' under Article 5.[62]

3.12.1 Compulsory Supervision in the Community

There is considerable interest in mental health policy circles in compulsory supervision of persons with mental disabilities in the community. Pressure for community supervision arises from growing public perceptions that de-institutionalisation failed and that greater numbers of persons with mental disabilities in the community pose a public risk.[63] Under various national schemes, persons with mental disabilities may be required to live in specified residences, attend specified places for purposes of counselling, education or training, grant access by mental health professionals to their homes, or submit to compulsory psychiatric treatment.[64]

There is certainly a 'detention' at the point that patients in the community are actually admitted, or re-admitted, to a hospital. At that moment the full panoply of human rights under Article 5 take effect. However, only the most intrusive forms of restraint in the community are likely to be seen to be of sufficient intensity and degree to constitute a deprivation of liberty. The Commission, for example, has found that provisional discharge on condition that the patient accept medical treatment on an outpatient basis was not a 'deprivation of liberty.[65]

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[61] The Code of Practice on the Mental Health Act recommends that an incompetent person should be detained only if he 'persistently and purposefully' tries to leave the hospital. See para *.
[62] Phillip Fennell 'Doctor Knows Best: Therapeutic Detention Under Common Law: The Mental Health Act and the European Convention' (1998) 6 Med L Rev 322–353.
[63] Kate Harrison 'Patients in the Community' (1995) 145 New LJ 276; Terry Thomas 'Supervision Registers for Mentally Disordered People' (1995) 145 New LJ 565.
[64] See eg the Mental Health (Patients in the Community) Act 1995.
[65] *L.L v Sweden* Application No 10801/84 (1986) 61 DR 62, 73; para 75.

The Court's jurisprudence is still insufficiently developed to predict whether, in the more extreme cases, community control would amount to a detention. These powers adversely effect several important aspects of human dignity, including autonomy, association, and privacy. Because of the serious effects on human rights, the Court should develop effective methods to ensure that governments justify the most intrusive forms of community supervision.[66]

3.13 Justification for Detention Based on Mental Disability

Article 5(1) lists the circumstances in which governments may justifiably deprive a person of liberty: 'No one shall be deprived of liberty save in the following cases and in accordance with a procedure prescribed by law.' Sub-paragraph (e) lays down the case of the 'lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants.'[67] Persons of unsound mind, therefore, are grouped together with other individuals who are marginalized in society and subject to confinement without a criminal conviction. The state interest in prevention of infectious disease is certainly legitimate because it is framed in terms of public protection. The remaining state interests, however, are not justifications for confinement at all. Rather, they are a series of personal statuses based on health or socio–economic status. The fact that an individual is in poor health from

[66] As suggested above, the Court itself has said that restrictions of movement fall to be considered under Article 2 of the Protocol No 4: 'Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement....' Community powers might also implicate, for example, Article 8 (respect for private and family life), Article 11 (freedom of association), or Article 13 (an effective remedy for violation of Convention rights). Oliver Thorold, however, concludes that 'community controls ... appear to be treated as insufficiently invasive or serious to engage any of the relevant Articles of the Convention.' Oliver Thorold 'The Implications of the European Convention on Human Rights for United Kingdom Mental Health Legislation' [1996] EHRLR 619, 632.

[67] It should also be noted that, in addition to sub-paragraph (e), mentally disordered offenders admitted to hospital are detained on the basis of sub-paragraph (a). See further discussion of incorporated and periodic

mental illness or dependence on alcohol or drugs, or that he has no visible means of support, does not, in itself, warrant detention. These statuses justify detention only with an additional finding of dangerousness and benefit from treatment.

The section 47 of the National Assistance Act 1948 makes provision for the removal to, and detention and maintenance in, suitable premises of persons in need of care and attention. (See para **19.08**). The 1948 Act authorises confinement of persons who are suffering from a grave chronic disease or, being aged, infirm, or physically incapacitated, are living in unsanitary conditions. The person who is not receiving proper care and attention must be unable to look after himself. The removal must be necessary in his own interests or to prevent injury to the health of, or serious nuisance to, other persons. It is not at all clear that persons who have a chronic disease, are elderly, infirm, or physically disabled meet the standards of Article 5(1)(e), even if they are unable to look after themselves or pose a threat or serious nuisance to others. If individual cases did fall within Article 5(1)(e) (for example, persons with mental disabilities or infectious disease), it would be necessary to have more precise statutory criteria than those articulated in the National Assistance Act. Additionally, requiring only that the detention is in the person's 'best interests' or is necessary to prevent a 'serious nuisance' (rather than to prevent a clear 'danger' to self or others) might be too vague to meet human rights standards.[68]

Despite the Convention's failure to state clearly and precisely a rigorous justification for detention on grounds of mental disability, the Court has imposed reasonably strong standards under Article 5(1)(e). First, the detention must be 'lawful,' meaning that the government must

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review at para **3.13.5**.

[68] *See* Department of Health, The Human Rights Act, Section 47 of the National Assistance Act 1948 and Section 1 of the National Assistance (Amendment) Act 1951 (Letter to Regional Directors of Health, 16 August 2000). In addition to the human rights concerns under Article 5(1)(e) of the Convention, the letter discusses concerns under Article 5(4) (because of the absence of speedy judicial review of detention) and

follow a 'procedure prescribed by law' and cannot act arbitrarily. Second, the person must be of 'unsound mind,' meaning that he is currently suffering from a mental illness that warrants confinement for care and treatment.

3.13.1 'Lawful Detention': Duty to Conform with Domestic Law and Avoid Arbitrary Decisions

Detention of persons on grounds of mental illness must be 'lawful,' meaning that authorities must conform with a 'procedure prescribed by law' and the detention must not be 'arbitrary'. The phrase 'in accordance with a procedure prescribed by law' essentially refers back to the domestic law; it states the requirement that the detention must comply with the relevant substantive and procedural rules under that law.

An interesting human rights question was presented, but never resolved, in the *Bournewood* case where the House of Lords held that a patient's detention was justified under the common law rather than mental health legislation. Arguably, this was a violation of Article 5 (1) because mental health authorities did not follow a 'procedure prescribed by law.' By relying solely on the common law, they circumvented all the substantive and procedural safeguards intended under mental health legislation.[69]

The Court has stated more generally that 'lawful' detention must also be consistent with the purposes for which a person is confined.[70] Put another way, the government must demonstrate a reasonable relationship between the objectives (ie to provide care and treatment in the person's

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article 8 (because removal interferes with the right to a private and family life).

[69] See *Steel and Others v United Kingdom* (1998) Series A 1998–VII 2735, (1999) 28 EHRR 603, para 54. ('Given the importance of personal liberty, it is essential that the applicable national law meets the standard of 'lawfulness' set by the Convention, which requires that all law, whether written or unwritten, be sufficiently precise to allow the citizen ... to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action may entail.').

best interests) and the means used to achieve those objectives (eg reasonable procedures, criteria, and conditions of confinement). Governmental action is not reasonable if it is aimless: 'any measure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary.'[71]

The Court asserts the power to examine whether a national authority has complied with the terms of its own legislation or has otherwise acted arbitrarily, but the scope of review is limited. For example, in *Van der Leer v Netherlands*, the Court found a violation of Article 5(1) based on the arbitrary nature of the detention. The judge had failed to hear from the patient or his representative, and gave no reason for doing so.[72] Similarly, in *DSE v Netherlands*, the Commission found that the government had failed to comply with lawful procedures. A mentally disordered offender's period of confinement in hospital, due to a procedural oversight, was not formally extended: 'there had been a period of [over] two months during which there existed no court decision as the basis of the applicant's detention.[73]

'Lawful' detention may also require a minimally therapeutic environment. This follows from the need for a reasonable relationship between the detention and treatment for mental illness. Detention for the purposes of care and treatment of mentally ill persons cannot be accomplished in punitive or non-therapeutic environments. The idea that the Convention may impose an affirmative obligation to provide a minimally therapeutic environment is discussed below.

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[70] *Aerts v Belgium* (1998) Series A No 1998–V 1939, (2000) 29 EHRR 50.
[71] *Winterwerp v Netherland* (1979) Series A No 33, (1979–80) 2 EHRR 387, para 45.
[72] (1990) Series A No 170, (1990) 12 EHRR 657, para 21–24.
[73] *DSE v Netherlands* (1997) Application No 23807/94, [1998] EHRLR 99–101. For a similar case involving a violation of Article 5(1)(e) due to failure to set a hearing date to review continued detention,

3.13.2 Persons of 'Unsound Mind'

The entire foundation of mental health law rests on a reliable finding of mental disability. Absent this status, individuals would not be subject to confinement without conviction of a criminal offence.[74] Human rights norms, therefore, stress the importance of a careful and accurate diagnosis of mental disability.[75]

The Convention requires a finding of unsoundness of mind to justify confinement in a mental hospital, but offers no definition of the term. The Court has said that because of the fluidity of the term's usage, it should not be given a definitive interpretation. The Court, however, has stated that Article 5(1)(e) would not permit the detention of a person only because 'his views or behaviour deviate from the norms prevailing in a particular society.'[76]

The lawful detention of persons of unsound mind under the Convention, except in emergency cases, requires the observance of three minimal conditions.[77] First, the individual must be reliably shown to be of unsound mind on the basis of *objective medical expertise*—ie the state must establish 'a true mental disorder before a competent authority on the basis of objective expertise.'[78] The procedural requirement of objective medical evidence is important because it

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see *Erkalo v the Netherlands* (1998) Reports 1998–VI, (1999) 28 EHRR 509.

[74] But see the discussion on the detention of high-risk persons with personality disorder in para **2.02-2.03**; Richard Ford, 'Psychopaths May be Locked Up Without Trial' *The Times* 20 July 1999, 10 (floating the government's idea of preventive detention of psychopaths and paedophiles in the absence of a criminal conviction).

[75] See MI Principles, Principle 16.

[76] *Winterwerp v Netherlands* (1979) Series A No 33, (1979–80) 2 EHRR 387, para 37.

[77] *Winterwerp v Netherlands* (n 75 above) para 39 ('In the Courts'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.')

[78] *X v United Kingdom* (1981) Series A No 46, (1982) 4 EHRR 188, para 40; *Winterwerp v Netherlands* (n 75 above) para 39; *Luberti v Italy* (1984) Series A No 75, (1984) 6 EHRR 440.

adds legitimacy to the state's claim that detention is truly necessary for treatment of a person with a mental illness. The medical evidence, according to the Commission, may come from a general practitioner rather than a psychiatrist,[79] although psychiatrists are more likely to meet the MI Principle of an 'internationally accepted medical standard.'[80]

The second criterion for lawful detention is that the mental illness must be of a *kind or degree warranting compulsory confinement*. Since 'unsoundness of mind' under the Convention is not defined, persons with relatively minor mental health problems conceivably could be subject to detention. The Court has made clear, however, that the mental disability must be of sufficient seriousness to justify deprivation of liberty.

It is interesting to speculate whether the phrase "mental illness of a kind or degree warranting compulsory confinement" could be read to require the patient to be amenable to treatment. If his condition were untreatable, arguably, he ought not to be confined in a mental hospital. Yet, United Kingdom Courts have rejected this argument, reasoning that the language in *Winterwerp* could justify confinement necessary for public protection, even if the mental illness were untreatable.[81] In *R (on the application of H) v Mental Health Review Tribunal, North and East London Region and Another,*[82] Lord Phillips MR, *obiter*, observed that a person's mental illness does not have to be treatable to be lawful under the Convention: 'Detention cannot be justified under Article 5(1)(e) unless the patient is "of unsound mind", but once that is established we do not consider that the Convention restricts the right to detain a patient in hospital, as does section 3, to circumstances where medical treatment is likely to alleviate or prevent a deterioration of the condition. Nor is it necessary under

[79] *Schuurs v Netherlands* Application No 10518/83 (1985) 41 DR 186, 188–89.
[80] See MI Principles, Principle 16.
[81] *A v Scottish Ministers* 2001 SLT 1331 (PC(Sc)); [2002] HRLR 6. See Commentary 'Detention of Untreatable Psychopaths and Article 5 of the European Convention on Human Rights ' [2002] Medical LR 10, 92 (The question of whether a person deprived of liberty on grounds of mental illness should be susceptible to treatment is a matter of domestic law).

the Convention to demonstrate that such treatment cannot be provided unless the patient is detained in hospital.' Thus, the Court of Appeal is suggesting that the Convention does require a mental disorder as a precondition for confinement, but not that the mental disorder is treatable or that it is only treatable while detained in hospital.

The third criterion is that the validity of *continued confinement depends upon the persistence of such a disorder*.[83] This means that even if the person at the time of admission had a sufficiently serious form of mental disability, he must be discharged when he achieves a state of mental health that no longer warrants confinement. Logically, the government must have in place a mechanism for ongoing review of a person's mental status.

The judicial mechanism in place in England and Wales, of course, is a Mental Health Review Tribunal. To be compatible with the Convention, the Tribunal must have a duty to discharge if it cannot reliably be shown that the patient suffers from a mental disorder sufficiently serious to warrant detention. However, the criteria under section 73 of the Act for the discharge of restricted patients appear to place the burden of proof on the patient, not the state.[84] Thus, a restricted patient has the burden to demonstrate that he is no longer suffering from a mental disorder warranting detention in order to receive a discharge. The Court of Appeal in *R (on the*

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[82] [2001] EWCA Civ 415; [2001] 3 WLR 512.

[83] *Winterwerp v Netherlands* (1979) Series A No 33, (1979–80) 2 EHRR 387, para 39; *Ashingdane v United Kingdom* (1985) Series A No 93, (1985) 7 EHRR 528, para 37; *X v United Kingdom* (n 77 above) para 40. See also Lawrence O Gostin 'Human Rights, Judicial Review and the Mentally Disordered Offender' [1982] Crim L Rev 779.

[84] See *Reid v Secretary of State for Scotland* [1999] 2 AC 512, 533, per Lord Clyde ('...the decision is not one which is left to the discretion of the sheriff once he is satisfied on the particular criteria. If he is satisfied, he is obliged to grant a discharge. Secondly, the burden of establishing the particular propositions to the satisfaction of the sheriff will lie on the patient, although in practice it may well be that questions of the burden of proof will not often arise.'); *Perkins v Bath District Health Authority* (1989) 4 BMLR 145, per Lord Donaldson MR ('If a tribunal is to make an order under s 72(1)(a)(i), clearly they have to be satisfied, and should state that they are satisfied, that he is not then suffering from mental disorder. That is not the same thing as saying the tribunal is not satisfied that he is so suffering); *R. v London and South Western Mental Health Review Tribunal ex p M* [2000] Lloyd's LR Med 143, 150, per

application of H) v Mental Health Review Tribunal, North and East London Region and Another[85] made a declaration that placing the burden of proof on the patient is incompatible with the Convention:[86]

> [I]t is contrary to the Convention compulsorily to detain a patient unless it can be shown that the patient is suffering from a mental disorder that warrants detention. Inasmuch as Sections 72 and 73 do not require the tribunal to discharge a patient if this cannot be shown we have concluded that they are incompatible with both Article 5(1) and Article 5(4).

The government has accepted the court's declaration of incompatibility and issued a remedial order.[87]

The European Court of Human Rights has held that patients do not necessarily have to be released immediately and unconditionally as soon as they cease to be suffering from a mental disorder. However, safeguards must be in place to assure that discharge is not unreasonably delayed. In *Johnson v United Kingdom*, a Mental Health Review Tribunal found that Johnson no longer suffered from a mental illness, but deferred his conditional discharge until arrangements could be made for suitable hostel accommodation.[88] However, a suitable hostel could not be found, and Johnson remained in hospital for an additional 3 years. The Court held that, although a deferral of conditional discharge was justified in principle, Johnson's detention was not permitted

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Latham J (referring to the 'reversed burden of proof').

[85] [2001] EWCA Civ 415; [2001] 3 WLR 512. See Oliver Thorold 'The Implications of the European Convention on Human Rights for United Kingdom Mental Health Legislation' [1996] EHRLR 619, 629.

[86] Lord Phillips MR, *obiter*, observed that a person's mental illness does not have to be treatable to be lawful under the Convention. See para *.

[87] Mental Health Act 1983 (Remedial) Order 2001 (SI 2001/3712). See House of Lords and Joint committee on Human Rights, Mental Health Act 1983 (Remedial Order) 2001 report, together with the proceedings of the Committee relating to the report and appendices: sixth report, Session 2001/02.

[88] *Johnson v United Kingdom* (1997) 1997–VII 2391, (1999) 27 EHRR 296. See also *R (on the application of C) v. Secretary of State for the Home Department* [2001] EWHC Admin 501 (QBD) (finding that before referring a case to a tribunal, the Home Secretary should have considered whether the patient's continued detention was necessary given the fact that the Home Secretary had the burden of proof).

under Article 5(1)(e) because of the lack of safeguards to ensure that the applicant's release was not unreasonably delayed.

Notably, the Court found that, simply because an expert authority determines the applicant is no longer suffering from mental disorder, it does not require his immediate and unconditional release into the community.[89] Such a rigid approach would constrain the exercise of judgement whether the interests of the patient and the community into which he is to be released would in fact be best served by an immediate and unconditional discharge.[90] The Court acknowledged that a responsible authority should be able to 'retain some measure of supervision over the progress of the person once he is released into the community and ... to make his discharge subject to conditions.'

The Court of Appeal in *R v Camden and Islington Health Authority ex p K*[91] further considered the applicability of Article 5 to a Tribunal's decision to discharge a patient subject to conditions. The Court of Appeal distinguished between two kinds of cases. The first is a case, like *Johnson*, where the Tribunal finds the patient is no longer suffering from a mental disorder, but needs to be discharged into a controlled environment as part of a structured period of rehabilitation. In such a case, Article 5(1)(e) requires that the conditions, as well as the period of time needed to comply with the conditions, must be proportionate to the objectives and cannot become indefinite. For example, if the Tribunal imposes a condition which proves inordinately difficult and time-consuming to perform, there may be a violation of the Convention.

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[89] The court in *R (on the application of IH) v Nottinghamshire Healthcare NHS Trust* [2001] EWHC Admin 1037, came to a similar conclusion. Where a MHRT made a deferred direction for conditional discharge, the power to monitor attempts to comply with reasonable conditions and to make amendments to a deferred conditional discharge order was sufficient to ensure compatibility with Article 5.

[90] *Luberti v Italy* (1984) Series A No 75, (1984) 6 EHRR 440.

[91] [2001] EWCA Civ 240; [2001] 3 WLR 553 (CA)

The second is a case, like in *R v Camden and Islington Health Authority ex p K*, where the Tribunal concludes that the patient is mentally ill, but could be treated appropriately in the community. Lord Phillips MR said, 'If a Health Authority is unable, despite the exercise of all reasonable endeavours, to procure for a patient the level of care and treatment in the community that a Tribunal considers to be a prerequisite to the discharge of the patient from hospital, I do not consider that the continued detention of the patient in hospital will violate the right to liberty conferred by Article 5.' He explained that:

> Whether or not it is necessary to detain a patient in hospital for treatment may well depend upon the level of facilities available for treatment with the community. Neither Article 5 nor Strasbourg jurisprudence lays down any criteria as to the extent to which member States must provide facilities for the care of those of unsound mind in the community, thereby avoiding the necessity for them to be detained for treatment in hospital.

It is important to note that the three standards for compliance under Article 5(1)(e) (ie, reliable evidence of mental disorder, the disorder warrants detention in hospital, and continued confinement depends upon the persistence of the disorder) may not apply in emergency situations. The Court has stated that objective medical expertise may not be required in advance of detention in all conceivable cases. If domestic law authorizes emergency admission to hospital, the Convention would not always require a thorough medical examination prior to arrest or detention if it were impracticable. In the Court's view, 'a wide discretion must in the nature of things be enjoyed by the national authority empowered to order such emergency confinements.'[92] Where there exists a risk that a patient will pose a public threat or will suffer a serious deterioration of his mental health, the expert evaluation may take place after admission. In such circumstances the public's safety or the patient's best interests may prevail over the individual's right to liberty by justifying emergency confinement in the absence of the usual guarantees in

Article 5(1)(e).[93] Nevertheless, a thorough medical examination must, in all cases, occur promptly after emergency admission.

3.13.3 Power to Recall Patients to Hospital without Evidence of Mental Disability

The Home Secretary's broad discretion to recall to hospital conditionally discharged restricted patients may violate Article 5 (1) because recall does not require proof of mental disability. In *R v Secretary of State for the Home Department, ex p K*,[94] the Court of Appeal held that section 42(3) does not require the Home Secretary to have medical evidence that the patient is mentally disordered before issuing a warrant for his recall to hospital. The appellant argued that the recall of a person to hospital who was of sound mind violated Article 5(1)(e). However, the Court of Appeal, citing *R v Secretary of State for the Home Department ex p Brind*,[95] held that since section 42(3) was plain and unambiguous on its face, the courts would not look to the European Convention for assistance in its interpretation.

The position taken in *Brind*, of course, is explicitly overridden by the 1998 Act; the domestic courts will now construe the Convention and have regard to cases decided in Strasbourg. In *Kay v United Kingdom*, the Committee of Ministers held that recall powers exercised without regard to medical evidence of mental illness violated Articles 5(1) and 5(4). Thus, it is difficult to reconcile section 42(3) with decisions of the Committee of Ministers and the Court concerning the importance of objective mental evidence of mental disability.

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[92] *X v United Kingdom* (1981) Series A No 46, (1982) 4 EHRR 188, para 41.
[93] See eg *A (A Mental Patient) v Scottish Ministers* 2001 SC 1; [2000] EHRLR 450 (the detention of a person of unsound mind in order to protect the public from serious harm did not violate Article 5(1)(e) or Article 5(4). The right to liberty is not absolute and must be balanced against the duty of the government to protect life under Article 2).
[94] [1990] 3 All ER 562 (CA). The other aspects of *ex p K* are discussed in para *.

3.13.4 Summary of Article 5(1)(e)

In summary, Article 5(1)(e) places the following limitations on involuntary detention of persons on grounds of mental illness. First, government must comply with domestic law by following all democratically imposed criteria and procedures. Second, government must act consistently with the purposes of confinement which are to provide care and treatment in the person's best interests. This means that authorities may not act arbitrarily and that the circumstances and conditions of confinement must be compatible with treatment rather than punishment. Finally, the person must be suffering from a mental illness sufficient to justify confinement and must continue to suffer from such a mental illness. Government, moreover, must produce independent evidence that reliably diagnoses the person as mentally ill within internationally accepted medical standards.

3.14 The Right to a Review of Detention by a Court

Article 5(4) states that 'Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.' Article 5(4) affords fundamental rights to: (1) a review of the lawfulness of detention, (2) by a court, (3) in a reasonably prompt manner, and (4) with the power to release a patient who is unlawfully detained.

[95] [1990] 2 WLR 787 (CA).

3.14.1 Review the 'Lawfulness of Detention'

Persons who have been deprived of their liberty on grounds of mental disability must have the right 'to take proceedings at reasonable intervals to put in issue the lawfulness of his detention, whether that detention was ordered by a civil or criminal court or by some other authority.'[96] The Court has construed expansively the phrase 'proceedings by which the lawfulness of his detention shall be decided.' The independent review of detention must achieve two clear purposes.[97] First, the review must examine whether authorities have complied fully with domestic law. The authorities must have acted in accordance with the applicable procedures and criteria set forth under domestic law. Second, the review must examine whether authorities have complied fully with the Convention. The authorities must have followed all of the standards in Article 5(1)(e) including the proscription against arbitrary detention and the requirement of independent medical evidence demonstrating that the person is, and continues to be, of unsound mind. The Court, therefore, has insisted that the independent review of detention must not be a mere formality, but must provide a serious examination of the merits of the case. While the review body need not substitute its decision for that of the decision-making authority, it must nevertheless assure that the person is, in fact, mentally disabled to the extent necessary to justify involuntary confinement.[98]

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[96] *X v United Kingdom* (1981) Series A No 46, (1982) 4 EHRR 188, para 52. See *De Wilde, Ooms & Versyp v Belgium* (1971) Series A No 12, (1979–80) 1 EHRR 373, para 76 ('Where a decision depriving a person of his liberty is one taken by an administrative body, there is no doubt that Article 5(4) obliges the Contracting States to make available to the person detained a right of recourse to a court.').

[97] The first purpose (conformity with domestic law) can be reviewed by the courts by means of judicial review and habeas corpus, while the second purpose (the merits of the case) can be reviewed by a Mental Health Review Tribunal.

[98] *X v United Kingdom* (n 95 above) para 58 (the scope of judicial review must be sufficient to enable enquiry whether the reasons which initially justified the detention continue to subsist).

3.14.2 Review by a 'Court'

The Convention requires that the review of detention be conducted by a 'court.' The word 'court' in Article 5(4) does not signify a court of law of the classic kind, integrated within the judicial machinery of the country. Rather it requires a body with a judicial character and which affords procedural guarantees to the parties. The most important characteristic of a court is independence from the executive and the parties to the case. This is a critically important safeguard since it assures that the review body does not have a conflict of interest. Since the detaining authority technically rests within the executive branch of government, the European Court insists that the court reside within a different branch. Thus, the review body could reside within the judicial branch, with a formal court of law, or it might be independent of the executive and judicial branches, as with a Mental Health Review Tribunal.

A 'court' must also follow a procedure of a judicial character, giving the individual fundamental guarantees of natural justice[99] Judicial proceedings for the purposes of Article 5(4) need not always be attended by the same guarantees as those required under Article 6 (see below), but the person must have the opportunity to present his own case, either in person or, where necessary, through a representative, and to challenge the medical and social evidence adduced in support of the detention.[100] Mental disability may entail restricting or modifying the manner of exercise of natural justice, but it cannot justify impairing the very essence of the right. Indeed, special procedural safeguards may be necessary to protect the interests of persons who, on account of mental disability, are not fully capable of acting for themselves.[101] Indeed, the importance of what is at stake for the individual (personal liberty) together with the nature of the

[99] *De Wilde, Oooms & Versyp v Belgium* (n 95 above) para 76.
[100] *Winterwerp v Netherlands* (1979) Series A No 33, (1979–80) 2 EHRR 387, paras 58, 60.

person's mental state (diminished mental capacity) may require the government to provide legal representation.[102] The United Kingdom instituted public financing of MHRT representation in response to a case brought by MIND (the National Association of Mental Health) in the early 1980s.[103]

3.14.3 Review in a 'Speedy' Manner

Article 5(4), in guaranteeing a right to institute proceedings, also affords a right to a 'speedy' determination terminating detention if it proves to be unlawful. The relevant time period for calculating a delay in judicial review runs from when the application for release was filed.[104] The Court has found that delays of four[105] or five[106] months violated the Convention. The Court, however, went considerably further in *E v Norway*, holding that a delay of 8 weeks violated the mandate for a speedy review.[107] The European Court has acknowledged that the government may, in exceptional cases, have a sufficient justification for delays. However, primary responsibility for delay rests on the government. Moreover, the complexity of a medical case does not absolve national authorities from the essential obligation to afford a prompt review of detention.[108]

The domestic courts have followed the European Court's jurisprudence in this area. For example, *in R (on the application of C) v Mental Health Review Tribunal London and Southwest*

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[101] *Winterwerp* (n 99 above) para 60.
[102] *Megyeri v Germany* (1992) Series A No 237–A, (1993) 15 EHRR 584, para 23; *Winterwerp* (n 99 above) para 60–61, 101–02; *X v Belgium* (1975) 3 DR 13.
[103] *Collins v United Kingdom,* Application No 9729/82 (withdrawn due to change in law). Mr. Collins was a patient at Broadmoor Hospital whose solicitor would not represent him at the tribunal hearing because there was no legal aid to pay for a representative. The Commission found the case admissible.
[104] *Van der Leer v Netherlands* Series A No 170, (1990) 12 EHHR 567, para 35.
[105] *Koendjbiharie v Netherlands* (1990) Series A 185-B (1991) EHHR 820, para 29.
[106] *Van der Leer v Netherlands* (n 99 above), para 36.
[107] *E v Norway* (1990) Series No 181-A, (1994) 17 EHRR 30, para 63–67.

Region,[109] the Court of Appeal held that the denial of a request for an early hearing date by a solicitor experienced in mental health was incompatible with the Convention. The practice of listing hearings eight weeks after an application stemmed from convenience rather than necessity; the authorities made no attempt to ensure that individual applications were heard as soon as reasonably practicable.

The High Court in *R (on the application of KB, MK, JR, GM, LB, PD, and TB) v Mental Health Review Tribunal*,[110] similarly held that patients detained under s. 3 were entitled to a Tribunal hearing within eight weeks of the date of their application. Where, in the absence of any reasoned justification, a hearing did not take place within that timescale there had been a breach of the Human Rights Act 1998. Although isolated delays in holding hearings do not necessarily violate Convention rights, systematic delays do. As the European Court itself has observed: 'The Convention places a duty on Contracting States to organise their legal systems so as to allow the courts to comply with the requirements of [a speedy hearing].'[111] This case is particularly interesting because the High Court took into account the resource limitations and administrative problems in the Tribunal system, particularly the large workload and the shortage of medical members. By holding that lack of resources provides an insufficient justification for Tribunal delays, the Court implicitly required additional government expenditures to assure competent and speedy hearings for persons detained under the Act.

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[108] *Musial v Poland* (1999) Application No 24557/94, Reports of Judgements and Decisions 1999–II.
[109] [2001] EWCA Civ 1110, [2002] 1 WLR 176 (CA). See Commentary 'Mental Health Review Tribunals: Time Limits and the ECHR' [2002] Medical LR 10, 89.
[110] (QBD (Admin Ct) [2002] EWHC 639, 2002 WL 498854.
[111] Zimmermann and Steiner v Switzerland (1983) 6 EHRR 17.

3.14.4 The Power to Release Unlawfully Detained Patients

Article 5(4) provides that a court must have the power to order the patient's release if the detention is not lawful. Consequently, the court must be vested with the ultimate power to discharge the patient, and may not act merely as an advisory body.[112]

3.14.5 Incorporated and Periodic Review: Mentally Disordered Offenders

Mentally disordered offenders admitted to hospital are detained not only on the basis of Article 5(1)(e), but also Article 5(1)(a): 'the lawful detention of a person after conviction by a competent court.'[113] Presumably, the justification for detention under sub-paragraph (a) ceases once the person has been confined for a period of time that is proportional to the gravity of the offence.[114]

Mentally disordered offenders are admitted to hospital by order of a court, as opposed to patients who are admitted under civil powers. Provided the court finds, on the facts, that the person has a mental disability warranting hospital admission, this is precisely the judicial review required by Article 5(4). The European Court has repeatedly found that where a court initially orders detention, the judicial review required by the Convention is incorporated in that decision.[115]

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[112] *X v United Kingdom* (1981) Series A No 46, (1982) 4 EHRR 188, para 61. See also *Curley v United Kingdom* (2000) Application No 32340/96 (2001) 31 EHRR 14. (finding that the UK Parole Board system, which did not grant the Parole Board the power to order the release of the prisoner, violated Article 5(4)); *Oldham v United Kingdom* (2000) Application No 36273/97 (2001) 31 EHRR 34) (finding that a two year delay between Parole Board hearings was not reasonable under Article 5(4)).

[113] *X v United Kingdom* (n 109 above) para 39.

[114] *X v United Kingdom* (n 109 above) para 39 ('The particular circumstances of this case, and notably the fact that X was conditionally released and enjoyed a lengthy period of liberty before being re-detained, may give rise to some doubts as to be the continued applicability of sub-paragraph (a)'). But authorities cannot rely on sub-paragraph (a) alone to justify detention in a mental hospital; the Court retains the power to verify, at all times, that the person is of unsound mind under sub-paragraph (e). See para **3.12**.

[115] *De Wilde, Ooms & Versyp v Belgium* (1971) Series A No 12, (1979–80) 1 EHRR 373, para 76;

The initial court order, however, lasts only for a period of time that is proportional to the gravity of the offence. For example, in *Silva Rocha v Portugal*, the European Court found that a person found not guilty by reason of insanity could be detained under sub-paragraph (a) for three years given the seriousness of the offence and the risk to the public; for that period, the review required by Article 5(4) was incorporated in the sentencing court's decision. However, once this 'tariff' of three years expired, the applicant had the right to further judicial review.[116]

In the case of confinement of mentally disabled persons, the European Court requires a periodic review of the lawfulness of detention. Since mental illness is subject to amelioration and cure, subsequent reviews at reasonable intervals are necessary to ensure that the person's mental state continues to require detention in a mental hospital.[117]

3.14.6 X v United Kingdom: A Landmark in Mental Health Law Reform

X v United Kingdom, one of several test cases brought by MIND in the mid-1970s, is one of the most pivotal mental health decisions made by the European Court of Human Rights.[118] The case involved section 65 of the Mental Health Act 1959 (now section 41 of the 1983 Act) which gave the Secretary of State for the Home Department (the Home Secretary) the exclusive authority to

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Winterwerp v Netherlands (1979) Series A No 33, (1979–80) 2 EHRR 387, paras 55, 60; *Luberti v Italy* (1984) Series A No 75, (1984) 6 EHRR 440, para 31.

[116] *Silva Rocha v Portugal* (1994) Series A 1996–V para 29–30. (2001) 32 EHRR 16

[117] *Luberti v Italy* (n 112 above); *Winterwerp v Netherlands* (n 107 above) para 55. The Court has also required periodic review in certain circumstances after 'conviction by a competent court' under Article 5(1)(a). See *Weeks v United Kingdom* (1987) Series A 114, (1988) 10 EHRR293 (indeterminate life sentence made on grounds of social protection and rehabilitation; since the grounds for this detention are subject to change, applicant is entitled to a periodic review); *Thynne, Wilson and Gunnell v United Kingdom* Series A No 190 para 69; (1991) 13 EHRR 666.

[118] See Lawrence O Gostin 'Human Rights, Judicial Review and the Mentally Disordered Offender' [1982] Crim L Rev 779, 779–93; Nigel Walker 'X. v United Kingdom' (1982) 22 Brit J Crim 315, 315–17.

discharge patients detained under a hospital order with restrictions on discharge. A restricted patient was conditionally discharged from Broadmoor Hospital (a maximum security hospital) and was subsequently recalled by the Home Secretary to that hospital following a matrimonial dispute not involving physical violence. The applicant had at all times complied with the conditions of discharge; there was no medical recommendation sought and no investigation of the facts giving rise to the recall. The Court held that section 65 of the 1959 Act violated Article 5 of the Convention in the following respects.

First, since mental illness is subject to amelioration and cure, any person detained on grounds of 'unsoundness of mind' under Article 5(1)(e) must have a right to *periodic judicial review*. As explained above, this review must examine not merely whether the detention is in conformity with the domestic law, but whether it is justified on its merits. The applicant did have a forum in which to challenge the domestic lawfulness of his detention. On an application for judicial review or habeas corpus, the domestic courts examine the facial lawfulness of the detention. However, since the law granted the Home Secretary virtually unfettered discretion, patients could not demonstrate that he acted contrary to law, in bad faith, or in an arbitrary manner; the remedies available to the patient went only to the legal validity of the detention, not its merits. The European Court, therefore, found that habeas corpus did not provide a form of judicial review sufficiently wide in scope to substantively examine the justification of the detention.

Second, neither of the two bodies charged with the duty to review the merits of the case were 'courts' with the power to order discharge. The Home Secretary, who made the ultimate decision, was not a court within the meaning of the term because he was not independent of the

executive and the parties to the case and did not act judicially. Indeed, the Home Secretary was both a party to the case, because he was the detaining authority, and a member of the executive branch. The Mental Health Review Tribunal (MHRT), on the other hand, was a court in the sense that it was independent and acted judicially, but it did not have the power to discharge.[119] The MHRT under the 1959 Act only advised the Home Secretary as to the exercise of his powers; the Home Secretary rejected more than 40 per cent of all positive recommendations made by the tribunal.[120]

The government complied with the European Court's decision in *X v United Kingdom* by enacting the Mental Health (Amendment) Act 1982 to give restricted patients the right to a binding Mental Health Review Tribunal review.

3.15 The Right to be Informed of the Reasons for Arrest

Article 5(2) states that 'Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charges against him.' This provision extends beyond the realm of criminal law, to any detention under mental health law.[121] A relationship exists between sub-paragraphs (2) and (4) in Article 5. Sub-paragraph (4) provides a right to take proceedings by which the lawfulness of a person's detention can be decided

[119] *R (on the application of B) v East London and the City Mental Health NHS Trust* [2001] 3 WLR 588, raised the interesting issue of whether a tribunal was deprived of its status as a "court" if, having discharged the patient, he was immediately readmitted to hospital under a fresh application. The Court held that professionals making an application were not bound by an earlier tribunal decision as mental illness can fluctuate. Where, however, an application was made only days after a tribunal's decision to discharge, if there was no change of circumstances, the tribunal's opinion prevailed unless there were material facts which the tribunal had not been made aware.

[120] See Larry Gostin *A Human Condition, Vol. 2* (MIND London 1977), 167–74.

[121] *X v United Kingdom* (1981) Series A No 46; (1982) 4 EHRR 188, para 28; *Van der Leer v Netherlands* Series A No 170, (1990) 12 EHHR 567, para 28.

speedily by a court. A person subject to detention in a mental hospital could not make effective use of the right to a hearing unless he was promptly and adequately informed of the reasons for the deprivation of his liberty.

The circumstances in which the power to recall a restricted patient was exercised in *X v United Kingdom* led the European Commission to find a violation of Article 5(2). The authorities had not promptly informed the applicant of the reasons for his recall. As a result, the government introduced a detailed procedure for informing restricted patients of the reasons for their recall.[122]

3.16 The Conditions of Confinement

Convention rights for persons with mental disability focus primarily on liberty and security—eg, ensuring adequate standards and procedures for involuntary admission to hospital and the opportunity for meaningful periodic review by a court or tribunal. But human rights do not stop at the hospital door, but rather set minimal standards for a therapeutic environment and prevention of neglect and abuse of patients.[123] These minimal standards can be derived from several sources of human rights law: (1) Article 3 of the ECHR prohibiting inhuman and degrading treatment; (2) Article 5(1) of the ECHR prohibiting arbitrary detention; and (3) the European Torture Convention providing a mechanism for monitoring the conditions of confinement.[124]

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[122] Home Office Circular No. 117/1980; DHHS Circular LASSL (80)7. For a more detailed description of this procedure, see para **15.16***.

[123] See eg Larry Gostin 'Human Rights in Mental Health: A Proposal for Five International Standards Based on the Japanese Experience' (1987) 10 *Int'l J Law & Psychiatry* 583.

[124] The Court of Appeal in *R v Drew (Anthony James)* [2001] EWCA Crim 2861; The Times 14 January 2002, held that the imposition of a life sentence on a person with mental illness was not a violation of the prisoner's rights under Articles 3 and 5 of the Convention. It is open to Parliament to stipulate that in defined cases an offender poses such a serious and continuing danger that a hospital order would provide

3.17 Torture or Inhuman and Degrading Treatment or Punishment

Article 3 of the Convention states that 'No one shall be subjected to torture or to inhuman and degrading treatment or punishment.' Unlike most human rights, there can be no derogation from Article 3 even if it is necessary for the public's health or safety or national security.[125] The European Commission[126] and Court[127] have both found that torture must involve an unlawful or invidious purpose, a point confirmed in the United Nations Torture Declaration.[128] As a result, the torture prohibition is unlikely to apply to mental health cases unless there is some anti-therapeutic or unethical motive such as political oppression.

Inhuman and degrading treatment, unlike torture, does not require a malevolent intent. The United Nations Detention Principles explain that inhuman and degrading treatment 'should be interpreted so as to extend to the widest possible protection against abuses, whether physical or mental...'[129] Mental health professionals who seclude or restrain patients may violate Article 3 even if their purpose is to provide therapy for the patient or security for the institution.[130] Article 3, therefore, applies to patients in mental hospitals who claim they have been neglected, abused, or placed in conditions that are unsanitary or unsafe. Since patients are vulnerable by virtue of

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insufficient protection to the public.

[125] *Ribitsch v Austria* (1995) Series A No 336; (1996) 21 EHRR 573, para 32.

[126] *The Greek Case* (1969) 12 YB Eur Conv on HR 186 (torture is inhuman treatment that has a purpose such as obtaining information or confession or the infliction of punishment).

[127] *Ireland v United Kingdom* (1978) Series A No 25, (1979-80) 2 EHRR 25, para 66–67 (torture has a special stigma involving deliberate inhuman treatment causing very serious and cruel suffering).

[128] *United Nations Declaration on the Protection of All Persons from being Subjected to Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, Art. 1*, GA Res 3452, UN GAOR, 30th Sess, Supp No 34, 91, UN Doc A/10034 (1975) (providing detailed definition of torture with detailed discussion of intent requirement).

[129] *United Nations Body of Principles for the Protection of All Persons Under Any form of Detention or Imprisonment*, GA Res 173, UN GAOR, 43rd Sess, Supp No 49, 297, UN Doc A/43/49 (1988).

[130] See eg *McFeeley v United Kingdom* (1981) Application No 8317/78, (1981) 3 EHRR 161, 199 (denial of facilities for exercise may violate Article 3).

their mental state and their dependence on the government to meet their needs, special scrutiny of their conditions of confinement is required:[131]

> 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 was for medical authorities to decide, ... patients nevertheless remain under the protection of Article 3.

The standard for inhuman and degrading treatment was set in *Ireland v United Kingdom*: 'Treatment will be inhuman only if it reaches a level of gravity involving considerable mental or physical suffering, and degrading if the person has undergone humiliation or debasement involving a minimum level of severity.'[132] Inhuman and degrading treatment depends on all the circumstances of the case, including its nature and context, the manner and method of its execution, its duration, its physical and mental effects and, in some instances, the victim's sex, age, and state of health.[133]

Article 3, in theory, can be used to scrutinise both the patients' conditions of confinement and treatment (including compulsory medical treatment).[134] Nevertheless, the Court's jurisprudence on Article 3 has been highly deferential to mental health authorities. The Court in *Herczegfalvy v Austria* said that, while the Court would make the ultimate determination under

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[131] *Herczegfalvy v Austria* (1992) Series A No 242–B (1993) 15 EHRR 437, para 82.

[132] *Ireland v United Kingdom* (1978) Series A No 25, (1979-80) 2 EHRR 25, para 162. See, eg *Tomasi v France* Series A, No. 241–A (1993) 15 EHRR 1 (finding violation of Article 3 when prisoner sustained blows of such intensity to meet the *Ireland v United Kingdom* standard). See *Kudla v. Poland* 10 BHRC 269 where the European Court found no violation of Article 3 because ill-treatment had to reach a minimum level of severity.

[133] *Ireland v United Kingdom* (n 129 above) para 162; *Tyrer v United Kingdom* (1978) Series A No 26, (1979–80) 2 EHRR 1 para 29–30; *Costello-Roberts v United Kingdom* Series A No 247–C, (1995) 19 EHRR 112, para 30.

[134] In *R (on the application of Wilkinson) v. Responsible Medical Officer Broadmoor Hospital and another)* 2001 EWCA Civ 1545 (Transcript) 77, the Court of Appeals applied Aricle 3 of the Convention to section 63 of the Mental Health Act, which permits treatment without consent in certain circumstances. The court held that "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."

Article 3, 'it was for medical authorities to decide, on the basis of 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....'[135] The applicant had been admitted to a psychiatric hospital in a weakened state following a hunger strike. He was force-fed and given strong doses of sedatives against his will. He was also at different times attached to a security bed by a net and straps and was handcuffed and a belt placed around his ankles because of his aggressive behaviour. Although the Court found worrying the prolonged use of handcuffs and the security bed, it determined that the restraint was medically justified.

The Court, therefore, has adopted a medically-oriented standard that requires the government to demonstrate that the treatment was prescribed under internationally recognised mental health standards. The Commission and the Court, in applying this medically-based standard, have been highly deferential to mental health professionals—in one case finding no violation even though a mentally disturbed prisoner was reduced to a state 'like an animal.[136] Consider the permissive view taken in *B v United Kingdom*, *Dhoest v Belgium*, and *Aerts v Belgium*.

B v United Kingdom[137] was another test case brought by MIND in the mid-1970s. In that case, a patient at Broadmoor Hospital complained that he was detained in grossly overcrowded

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[135] *Herczegfalvy v Austria* (n 128 above) para 82. See Eric Rosenthal & Leonard S Rubenstein (1993) 'International Human Rights Advocacy Under the "Principles for the Protection of Persons with Mental Illness"' 16 *Int'l JL & Psychiatry* 257, 275.

[136] *Hilton v United Kingdom* (1978) Application No 5613/72, (1981) 3 EHRR 104, 126 (inmate in Liverpool prison came to feel 'he was like an animal, to such an extent that he would roll in his own excrement'). But see *Keenan v. United Kingdom* (2001) 33 EHRR 38 where the European Court found a violation of Article 3 in a case where a prisoner had committed suicide. The prisoner, who had been taking anti-psychotic medication, was placed in segregation. Taking into account the prisoner's vulnerability and the authorities' obligation to protect his health, the punishment threatened his physical and moral resistance and adversely affected his personality.

[137] Application No 6780/75; (1977) 10 DR 37 (Second Partial Decision of the Commission as to

conditions, lacking in adequate sanitary (eg toilet and washing) facilities, and in a constant atmosphere of violence. He alleged that dormitory beds were only six to twelve inches apart, and there was no privacy and little fresh air or exercise. The applicant claimed he had received no treatment whatsoever and almost never saw his doctor. The European Commission determined his complaint to be admissible for the following reasons:

> The physical conditions in Broadmoor Hospital are admittedly unsatisfactory and have been criticized by different official bodies over a number of years. While the hospital staff may ... do their best to cope with these inadequacies, this does not exclude the possibility that the physical conditions of detention could in themselves give rise to a question under Article 3. The Commission considers that the applicant's different allegations concerning the conditions of his detention and the question of his medical treatment must be looked at together and, if so examined, raise issues under Article 3 which require investigation and examination on the merits.

The Commission subsequently ruled against the applicant on the merits because of the absence of a single incident which was so grave as to warrant a finding of inhuman and degrading treatment. The Commission's decision leaves in doubt whether Article 3 would take cognizance of the totality of conditions in the absence of a single factor that was so gross as to shock the conscience. The Commission's position, however, is not consistent with the Court's Article 3 jurisprudence, which stresses that inhuman and degrading treatment depends on *all* the circumstances of the case. Indeed, many forms of torture and inhuman and degrading treatment do not involve merely one horrific act, but rather a regime that is unconscionably cruel in all its totality. The vote in *B v United Kingdom*, however, was very close, thus suggesting that in the future Strasbourg authorities might return to Article 3 as an important source of Convention law in matters of mental health.

Admissibility). See also Larry Gostin *Observation on the Merits of the Application No. 6780/75 Under Article 3 of the European Convention on Human Rights* (MIND London 1978).

In *Dhoest v Belgium*, the Commission found no violation of Article 3 where a patient was tied down to his bed overnight and forcibly administered tranquillisers. The Commission said that, although a person's revolt or non-cooperation does not excuse inhuman and degrading treatment, having regard to all the circumstances, and in particular his hostility toward treatment, the conditions of detention did not attain the seriousness of inhuman and degrading treatment.[138]

Finally, in *Aerts v Belgium*, the Court found no violation of Article 3 despite the fact that a mentally ill person was detained in the psychiatric wing of Lantin Prison that had been harshly criticised by the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment. The conditions in the Lantin psychiatric wing fell below minimum acceptable ethical and humanitarian standards. Yet, the Court held that the living conditions 'do not seem to have had such serious effects on his mental health as would bring them within the scope of Article 3…. it has not been conclusively established that the applicant suffered treatment that could be classified as inhuman and degrading.'[139]

The Strasbourg authorities have been so deferential in their Article 3 jurisprudence that the Commission or Court has never found that the conditions in a mental hospital were so inhuman and degrading as to breach Article 3. Yet, patients' severe maltreatment, neglect, humiliation, or placement in punitive or unsafe environments should give rise to an Article 3 claim. While therapeutic intent is important, the Court's responsibility is to protect patients from serious forms of maltreatment even if administered ostensibly under the guise of medical expertise. In another Article 3 case brought by MIND during the mid-1970s, *A v United Kingdom,* the Commission secured a friendly settlement that implicitly recognised that certain forms of seclusion, even if ordered by medical authority, could be inhumane.

[138] *Dhoest v Belgium* (1987) Application No 10448/83, (1988) 55 DR 5, para 129.

3.17.1 Seclusion Procedure in Maximum Security Hospitals

In July 1980, the European Commission of Human Rights adopted a report accepting a friendly settlement (under Article 28 of the Convention) in the case of *A v United Kingdom.*[140] A patient at Broadmoor Hospital complained under Article 3 that he had been subjected to inhuman and degrading treatment during a period of seclusion which lasted for five weeks following his suspected involvement in an arson on one of the hospital wards. The patient had only very limited opportunities for exercise or association, was deprived of adequate furnishings and clothing, and the conditions in the room were unsanitary, inadequately lit, and poorly ventilated.[141]

The friendly settlement included an *ex gratia* payment to the applicant and a requirement that new working guidelines for the seclusion of patients at Broadmoor Hospital be introduced. Rooms used for seclusion have to be at least 4.7 square meters and have natural lighting; an individual programme of care must be drawn up; patients must have suitable clothing and footwear, mattresses and bedding, and reading matter. Unless a patient's condition precludes it, he has to be allowed out of his room for toilet purposes, have at least 30 minutes of exercise each morning and afternoon, and have access to visitors. Patients in seclusion are to be observed at irregular intervals not exceeding 15 minutes. A special record book should be maintained recording, *inter alia*, the starting and ending time of seclusion, the reason for it, details of clothing, bedding, etc., and observations and reviews made. *A v United Kingdom* demonstrates that, although Strasbourg authorities have not been highly sympathetic to claims of inhuman and

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[139] *Aerts v Belgium* (1998) Series A No 1998–V 1939, (2000) 29 EHRR 50, para 66.
[140] Application No 6840/74, (1978) 10 DR 5.
[141] See Larry Gostin *Observations on the Merits of Application No. 6840/74, European Commission of Human Rights* (MIND London 1978)).

degrading treatment, Article 3 can still be an important source of law to improve the most deplorable conditions in mental hospitals.

3.18 An Anti-Therapeutic Environment as 'Arbitrary' Detention

Article 5(1)(e) provides another possible route for finding that the conditions of confinement are so anti-therapeutic that they violate the Convention. As explained above, the European Court has held that the term 'lawfulness' under Article 5(1) requires conformity with the domestic law and with the purposes of deprivation of liberty permitted by Article 5(1). In theory, a reasonable relationship must exist between the ground of permitted deprivation of liberty relied upon and the place and conditions of detention. Under this theory, since the purpose of detention on grounds of unsoundness of mind is therapeutic, it can be accomplished only in a place equipped to provide minimally adequate care and treatment.

Initially, in *Ashingdane*[142] and *Dhoest*,[143] Strasbourg institutions disclaimed a connection between the actual detention (which was naturally a matter for consideration under Article 5) and the conditions of confinement (which were naturally a matter for consideration under Article 3). Still, the Court has hinted that Article 5(1)(e) is relevant for reviewing a patient's conditions of confinement. The first sign of this was in the *Ashingdane* case where the Court found that detention of a person is 'lawful' for the purposes of Article 5(1)(e) only if effected in a hospital, clinic, or other appropriate institution.[144]

The Court appeared to go further in *Aerts v Belgium* by suggesting that persons with mental illness must be confined in a minimally therapeutic environment:

[142] *Ashingdane v United Kingdom* Series A, No. 93, (1985) 7 EHRR528, para 78.
[143] *Dhoest v Belgium* (1987) Application No 10448/83, (1988) 55 DR 5, para 143–146.

> Article 5(1) should be 'lawful' and there should be some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention. In principle the 'detention' of a person as a mental health patient would only be lawful for the purposes of sub-paragraph (e) if effected in an appropriate institution.[145]

According to the Court, the Lantin psychiatric wing could not be regarded as an institution appropriate for the detention of persons of unsound mind, because it did not provide regular medical attention or a therapeutic environment. 'The proper relationship between the aim of the detention and the conditions in which it took place was therefore deficient.'[146]

The Court's jurisprudence is still too undeveloped to predict whether it will formulate robust criteria for ensuring that mental health facilities provide minimum standards of treatment, care, and protection from abuse. It is not difficult to form a theory supporting a 'right to therapeutic conditions' under Article 5. Minimally adequate care and treatment should be a necessary pre-condition to detention on grounds of unsoundness of mind; otherwise it would be difficult to justify detention on those grounds alone. In other words, if a person is to be deprived of liberty not as a punishment for a criminal offence but because of the need for therapy, then government should have a duty to provide minimally adequate treatment. Minimally adequate standards of treatment would help assure that a person's mental health does not deteriorate, but can actually improve.[147]

3.19 Monitoring of Torture and Inhuman or Degrading Treatment or Punishment

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[144] *Ashingdane v United Kingdom* (1985) Series A No 93, (1985) 7 EHRR 528, 44.
[145] *Aerts v Belgium* (1998) Series A No 1998–V 1939, (2000) 29 EHRR 50, para 46.
[146] *Aerts v Belgium* (n 141 above), para 49.
[147] The United States Supreme Court, for example, has found that persons with mental illness who are not dangerous cannot be detained unless they are afforded minimally adequate levels of treatment. *O'Connor v Donaldson*, 422 US 563 (1975).

The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment is designed to strengthen the protection of persons deprived of their liberty by non-judicial means. The Convention does not establish international human rights standards for torture and inhuman and degrading treatment. Rather, it provides a mechanism for monitoring and enforcement through the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.

The European Committee examines the treatment of persons deprived of their liberty by making visits to places where persons are deprived of their liberty by a public authority, including prisons and hospitals. The Committee, in cooperation with member states, organizes its own visits, carried out by at least two members with the assistance of experts and interpreters. In addition to periodic visits, the Committee may organize such other visits as appear to it to be required in the circumstances. The Committee must notify the Government concerned of its intention to carry out a visit, after which it can visit at any time. The Government must provide the Committee with unlimited access to the place of detention, full information necessary to carry out the task, including the right to interview detained persons in private, and the right to communicate freely with any relevant person.

The Government may make representations to the Committee against a visit. This can occur only in exceptional circumstances on grounds of national defense, public safety, serious disorder in places where persons are deprived of their liberty, the medical condition of a person, or that an urgent interrogation to a serious crime is in progress.

After each visit, the Committee must draw up a report on the facts found, and transmit its report to the Government with any recommendations. If the Government fails to cooperate or

refuses to improve the situation, the Committee may decide by a majority of two-thirds of its members to make a public statement on the matter.

The Committee's report is confidential, but can be published whenever requested by the Government. However, no personal data can be published without the express consent of the person concerned. Subject to these rules of confidentiality, the Committee must submit a public report to the Committee of Ministers annually.

The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, in many respects, works outside of the conventional human rights framework. Human rights law, by its nature, is publicly visible and binding on governments. The Convention, however, often operates without public scrutiny, uses the power of moral persuasion, and relies on government cooperation. Still, its systematic monitoring of places of detention helps assure compliance with standards set in Article 3 of the European Convention of Human Rights. Additionally, as in *Aerts v Belgium*, the European Court can use a finding of fact by the European Committee to help adjudicate a human rights case.

3.20 Civil Rights

Human rights norms extend to the exercise of a wide array of civil rights both within and outside of institutions. Simply because a person has a mental disability, or is subject to confinement, does not mean he is incapable of exercising rights of citizenship. The ECHR contains many provisions that can be helpful in securing civil rights for persons with mental disabilities, including the right of access to the courts, privacy, marriage, and procreation.

3.20.1 The Right to a Fair and Public Hearing in the Determination of Civil Rights

Article 6(1) of the Convention states: 'In the determination of his civil rights and obligations ..., everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law....' The European Court in the *Golder* case held that Article 6 secures to everyone the right to have any claim relating to his civil rights and obligations brought before a court or tribunal.[148] The Article, therefore, embodies the right of access to a court. The court, moreover, must follow a procedure that is fundamentally fair, including affording a right to representation so that litigants can present their case 'properly and satisfactorily.'[149] For example, in *R (on the application of W) Broadmoor Hospital*,[150] Hale, LJ ruled that a mental patient had the right to cross-examine medical witnesses relating to his claim that forcible treatment violated his Convention rights.

The rights in Article 6 may be subject to limitations, but the limitations must be based on a legitimate aim, be proportionate to that aim, and not restrict judicial access to such an extent that the very essence of the right is impaired.[151] In *Winterwerp*, the Court held that 'while mental illness may render legitimate certain limitations upon the exercise of the 'right to a court,' it cannot warrant the total absence of that right as embodied in Article 6(1).'[152]

Persons with mental disability, therefore, have rights guaranteed under the Convention to judicial determinations to secure their full entitlement to civil rights. The Court has found violations of Article 6 in a number of cases where persons with mental disabilities were either refused adequate access to a court or there were unreasonable delays: denial of a detained

[148] *Golder v United Kingdom* (1975) Series A No 18 (1979–80) 1 EHRR 524, para 37.
[149] *Airey v Republic of Ireland* Series A No. 32 (1979–80) 2 EHRR 305 para 24.
[150] [2001] EWCA Civ 1545.
[151] *Osman v United Kingdom* Application No 23452/94, (2000) 29 EHRR 245, para 147.
[152] Winterwerp v Netherlands Series A No 33 (1979–80) 2 EHRR 387, para 75.

patient's right to control property;[153] a finding of mental incapacity to acquire rights and undertake obligations;[154] placement of a person into guardianship;[155] and denial of a mentally ill parent's right of access to his child.[156]

However, in a remarkable case, the Commission and the Court held that the ECHR did not prevent the United Kingdom from requiring persons to obtain permission of the court before instituting judicial proceedings in securing their rights under mental health legislation. The Government asserted that persons with mental disabilities are prone to pursuing vexatious litigation, although there was no evidence to support this assumption. The European Court agreed that United Kingdom law did place a hindrance on the applicant's recourse to the national courts and insisted that it was not generally approving the statute. Nevertheless, in the particular facts of the case, the applicant was unlikely to prevail on the merits and, therefore, in all the circumstances, the Court found no violation of Article 6.[157] The Court's decision implies that because a person's claim may fail, for that reason he can be barred from access to a court to determine the merits. The very essence of Article 6, however, is that citizens have rights of access to the judicial system to pursue their claims; if they are meritless, the domestic courts are free to dismiss them after hearing the evidence.

3.20.2 The Right to a Private and Family Life and the Right to Marry and Found a Family

[153] Winterwerp v the Netherlands (n 148 above), para 75.
[154] *Matter v Slovakia* (1999) Application No 31534/96, (2001) 31 EHRR 32, para 51.
[155] *Bock v Germany* Series A No 150, (1990) 12 EHRR 247.
[156] *B v United Kingdom* Series A No 121, (1988) 10 EHRR 87; *H v United Kingdom* Series A No 136–B (1991) 13 EHRR 449.
[157] *Ashingdane v United Kingdom* Series A, No. 93, (1985) 7 EHRR528, para 58–60.

Article 8 prohibits public authorities from interfering with a person's right 'to respect for his private and family life, his home and his correspondence.' The right is broad enough to encompass an entitlement 'to establish and to develop relationships with other human beings, especially in the emotional field for the development and fulfilment of one's own personality.'[158] The primary objective is to protect the individual against arbitrary interference by public authorities, but Article 8 also imposes a positive obligation on government to respect private and family life.[159] The state, for example, may have to adopt policies affirmatively designed to secure a private life even in the sphere of relationships among private citizens.[160]

Limitations on Article 8 rights are permitted only in accordance with law and where necessary in a democratic society in the interests, *inter alia*, of public safety or the protection of health, morals, or the rights and freedoms of others (Article 8(2)). Government limitations, moreover, must be proportionate to one of these legitimate governmental interests.[161]

The European Court has found a violation of Article 8 in a case involving the freedom of correspondence of a detained patient. The hospital and the patient's guardian had screened all outgoing post and determined which pieces should be forwarded to the addressees, including letters of complaint about his medical treatment.[162] However, a domestic court upheld a special hospital policy of random recording and listening in to ten percent of patient phone calls. This was regarded as a justified infringement of Article 8 because it was a proportionate measure

[158] *X v Iceland* (1976) 5 DR 86–87.
[159] Several of the major cases involving Article 8 concern the custody and care of minors. See eg *TP and KM v. United Kingdom*, Application Number 00028945/95, October 5, 2001; *K v Finland* [2001] 2 FLR 707.
[160] *X & Y v Netherlands* Series A, No 91, (1986) 8 EHRR235 para 23.
[161] *Nasri v France* Series A, No 324, (1996) 21 EHRR458, para 46.
[162] *Herczegfalvy v Austria* Series A, Volume 242-B, (1993) 15 EHRR 437, para 268 (the Court also found a violation of the right to receive and impart information under Article 10).

necessary to achieve the legitimate aim of maintaining high security for potentially dangerous persons.[163]

Similarly, the Court accepted a settlement of a case involving the possible violation of the right of a patient to informational privacy.[164] In the latter case, the detained patient had a troubled relationship with her mother and she had also been sexually abused by her adoptive father. Given that the mother was the nearest relative under the Act, she and the stepfather had access to highly confidential information and the Act did not afford the patient a procedure by which she could change the nearest relative (see para **9.04**). The parties agreed to a settlement based on a proposed change in the Mental Health Act that would allow detained patients to apply to the court to have the nearest relative replaced where a patient reasonably objects. The amendment would also provide for the exclusion of certain persons from acting as a 'nearest relative.' The settlement also included a small amount of monetary compensation.

The right to a private life under Article 8 applies to sexual life,[165] suggesting that unreasonable interference with sexual relationships of persons in institutions would be proscribed. Yet, it is likely that reasonable rules restricting sexual activities would be upheld. For example, the Commission found no violation of Article 8 when a prisoner was denied unsupervised visits with his spouse.[166]

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[163] *R v Ashworth Special Hospital Authority ex p N* [2001] HRLR 46 (QB) (upholding Safety and Security in Ashworth, Broadmoor and Rampton Hospitals Directions 2000).
[164] *JT v United Kingdom* [2000] 1 FLR 909. About the admissibility decision of the Ejuropean Commission of Human Rights see [1997] EHRLR 436.
[165] *Dudgeon v United Kingdom* (No 2) (1982) Series A No 45 (1982) 4 EHRR149.
[166] See Council of Europe (1981) Human Rights File No 5. The Commission declined an application by a Swiss married couple claiming a violation of Article 8 when they were detained in prison for two months without being allowed unsupervised visits. The Commission and the prison authority actions were justified on the grounds of prevention of disorder in prison.

Under the Human Rights Act 1998, courts in the United Kingdom have been reluctant to interpret the Article 8 right to private and family life broadly. Restrictions on visitation rights of patients in high security hospitals,[167] donation of sperm to a wife for the purposes of artificial inseminatation,[168] and possession of condoms[169] have all been declared compatible with the Convention. In an unusual case, a domestic court found that the refusal of a hospital authority to allow a male patient to dress as a woman amounted to an interference with the patient's right to a private life. However, the interference was justified under Article 8(2) because the restrictions imposed were necessary for the patient's detention and treatment.[170]

Article 12 guarantees a particular aspect of the right to a private life—the entitlement of adults to marry and to found a family. Government violates the right to marry and found a family if it prohibits or unreasonably delays the marriage of a competent adult. The Commission said that the right to marry is, in essence, a right to forge a legally binding association between a man and a woman. This right should not be denied on grounds that, as one of the partners was detained, the couple would not be able to live together.[171] This principle undoubtedly also applies to persons with mental disabilities detained for substantial periods of time.

Apart from these instances, surprisingly few mental health cases under Articles 8 and 12 have been litigated in Strasbourg despite the relevance of private and family life to persons with mental disabilities. It is not difficult to think of other potential claims under Articles 8 and 12—

[167] *R v Secretary of State for Health ex p L (M)* [2001] 1 FLR 406 (QB), 2000 WL 1480057 (refusing to allow visitation by a niece and nephew of a patient in a high security hospital).
[168] *R. v Secretary of State for the Home Department ex p Mellor* [2000] 2 FLR 951 (QB), [2000] HRLR 846 (refusing to find a right to artificial insemination of spouse under Article 8).
[169] *R (on the application of H) v Ashworth Hospital Authority* [2001] EWHC Admin 872 (QB).
[170] *R (on the application of E) v. Ashworth Hospital Authority* [2001] EWHC Admin 1098, The Times January 17, 2001.
[171] *Hamer v United Kingdom* Application No 7114/75 (1981) 24 DR 5, (1982) 4 EHRR 139; *Draper v United Kingdom* Application No 8186/78 (1981) 24 DR 72.

eg the right to privacy and confidentiality, solitude in one's home, and relationships with children, parents, and other family members.[172] Consider a person's claim that certain compulsory powers either restricting or forcing associations with family violate the right to family and private life. If mental health authorities forbid visits with family or deprive patients of their autonomy or liberty in spite of family objections, genuine issues may arise under Article 8.

In summary, the ECHR has defended the civil rights of persons with mental disabilities in a variety of contexts. The Court has afforded individuals the right of access to the national judicial system, the right to a private and family life including the freedom to communicate, and the right to a sexual life and marriage.

3.21 Conclusion: The Right to Mental Health

As the discussion of European Court jurisprudence suggests, human rights law holds promise for advancing the fundamental rights and freedoms of persons with mental disabilities. The European Court has defended a set of negative rights to personal autonomy, privacy, and liberty. The Convention, however, does not expressly grant affirmative entitlements to services, and the Court has been reluctant to find government obligations to afford minimal conditions of confinement, services, and treatment.[173]

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[172] See eg *B v United Kingdom* (1977) 10 DR, para 59–70 (finding that parent's relationship with child is a fundamental element of family life). But see *Re F* [2000] 2 FLR 481, in which the High Court found no violation of Article 8 in a case involving termination of parental rights of a person with a mental disability.

[173] The European Court and domestic courts have addressed the issue of whether the Convention prohibits removal or deportation of a person with mental illness to a country that does not offer adequate care. In *Bensaid v United Kingdom* (2001) 33 EHRR 10, the European Court upheld a Home Office decision to remove a person with schizophrenia to his home State of Algeria on grounds that his marriage in England was one of convenience. There was no violation of Article 3 even though treatment for his mental illness would be more difficult in Algeria. Article 3, the Court said, includes situations where the source of the treatment complained of is beyond the State's control, but a high threshold is needed where the State is not

Earlier scholarly analysis has explored an 'ideology of entitlement'—the idea that international human rights law affords a right to mental health.[174] The conceptualisation of mental health as a human right, and not simply a moral claim, suggests that states are under binding obligations to respect, defend, and promote that entitlement. Considerable disagreement, however, exists as to whether 'mental health' is a meaningful, identifiable, operational, and enforceable right, or whether it is merely aspirational or rhetorical. A right to mental health that is too broadly defined lacks clear content and is less likely to have a meaningful effect. For example, if health is, in the World Health Organization's words, truly 'a state of complete physical, mental and social well-being,' then it can never be achieved.[175] Even if this definition were construed as a reasonable, as opposed to an absolute standard, it remains difficult to implement, and is unlikely to be justiciable.

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directly responsible for the harm. The patient could obtain treatment in Algeria at a hospital 75 kilometres from his home. The fact that it would be harder to obtain than in the UK was not conclusive for the purposes of Article 3. The UK courts, however, have quashed deportation orders by the Secretary of State, finding that, if the removal of an individual to a country with inadequate mental health services would severely affect his health, then the deportation order contravenes Article 3 of the ECHR. *R v Secretary of State for the Home Department, ex p Kebbeth*, (QB 30 April 1999); *R v Secretary of State for the Home Department, ex p B*, (QB 24 June 1999). But see *R v Secretary of State for the Home Department, ex p Kilic*, (QB 28 June 1999) (upholding deportation order because the deportation would not result in serious psychological harms to the person).

[174] Lawrence O Gostin 'The Ideology of Entitlement' in Phillip Bean (ed), *Mental Illness: Changes and Trends* (Wiley New York 1985). See also Lawrence O Gostin 'The Mentally Ill and the Power of the State' in Richard Hoggart (ed) *Liberty and Legislation* (Cass London 1989); Lawrence O Gostin 'Human Rights in Mental Health' in Martin Roth & Robert Bluglass (edd), *Psychiatry, Human Rights, and the Law* (Cambridge University Press Cambridge 1985).

[175] WHO's Declaration of Alma Ata in 1978 reaffirms that: 'health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.' (Declaration adopted by the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978; **Para I.)**

The notion that human beings are entitled to health, including mental health, is derived from numerous international documents.[176] Notably, the ICESCR recognizes 'the right of everyone to the highest attainable standard of physical and mental health.' Yet, human rights bodies have not developed a clear definition that helps clarify state obligations, identify violations, and establish criteria and procedures for enforcement. The following proposed definition achieves several of these purposes, but also harbours a number of weaknesses:

> The duty of the state, within the limits of its available resources, to ensure the conditions necessary for the mental health of individuals and populations.

This proposed definition places explicit obligations on the state, and recognises that a claim to a right to mental health imposes a correlating duty. By acknowledging that states possess varying capabilities, this definition also requires a state to act only within the limits of its resources to secure the right to mental health. The definition does not impose an absolute standard because mental health results from many factors outside of government's control (eg genetics, behaviour, and stressful conditions). However, it requires the state to ensure the conditions under which people can be mentally healthy. Governments can do a great deal to improve the mental health of individuals and populations, including providing decent economic conditions, social and welfare services, primary and secondary mental health care, community mental health services, and hospital-based treatment and services. Government obligations, then, go beyond the provision of discrete psychiatric medication to the assurance of a broad array of services that are necessary for populations to maintain mental health. The definition does not, however, ensure a minimal

[176] World Health Organisation's Constitution, preamble (1946) ('enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.'); UN Charter, Art 55 (dedicates UN to promoting solutions for international health); Universal Declaration of Human Rights, Art 25 (right to 'a standard of living adequate for the health and well-being of individuals and their families.'); Convention on the Rights of the Child, Art 24(1) ('highest attainable standard of health'). See also Stephen D Jamar 'The International Human Right to Health' (1994) 22 Southern Univ L Rev 1; Virginia

standard of mental health because, given widely disparate resource levels, a single international standard would be unworkable.

Vast scholarship and litigation in international fora were required to define and enforce civil and political rights. This chapter has demonstrated the systematic defence of negative rights by the European Court of Human Rights. The international human rights community, on the other hand, has largely neglected positive rights. However, social and economic rights, notably the right to mental health, deserve the same rigorous and sustained attention that has been given to civil and political rights.