Human Rights

Human rights compliance is an essential part of Alliance policy and we have never restricted this policy to the state of existing case law from the European Convention of Human Rights (ECHR). We include within our understanding of human rights all standards adopted at an international or regional level, either as binding obligations on the UK or as declarations of principle.

Expert commentators have given evidence indicating that it is unlikely that the Bill will fully meet the requirements of the Human Rights Act 1998 (HRA).

The recommendations of the Joint Committee on Human Rights (JCHR) have not been heeded in the 2004 Draft Mental Health Bill. We draw attention to their views on the status of the Code of Practice, the power to disapply principles, the lack of exclusions, the power to override advance directives and the danger of preventive detention.

Preventive detention

In the view of the JCHR, it is questionable whether the non-therapeutic detention of persons without conviction of an offence, on the grounds of *"speculation about possible future behaviour and resulting risk to identified persons",* will be compatible with the HRA. The JCHR noted in its report that explicit powers of preventive detention established by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 had been deemed compatible with the (ECHR) Article 5 by the Judicial Committee of the Privy Council, but pointed to the fact that these powers related only to restricted patients who have been convicted of serious offences and set no clear precedent for patients who have had no contact with the criminal justice system.

Definition of mental disorder

It is possible that the wide definition of mental disorder combined with the vagueness and breadth of the key concepts (for instance "appropriate", "for the protection of"," treatment"; "all the circumstances of his case") lacks sufficient certainty to comply with the requirement that loss of liberty must be in accordance with the law. A person must be able to know whether s/he falls within its ambit. We agree with the Bar Council[1] that the criteria for the imposition of detention and compulsory treatment are too vague, the threshold for such imposition is too low and the safeguards against arbitrariness too weak to comply with the provisions of Articles 5 and 8 of the ECHR.

Compulsory treatment of competent (capacious) patients without consent

Recent case law has raised squarely the rationale of the distinction in the law between physical and mental health. People with physical illness may, in all circumstances however serious, refuse treatment if they have capacity to make the decision to do so, but people with a mental disorder do not have that right. To force treatment upon a person with mental ill health can involve force and is inherently demeaning. In some

[1] Bar Council, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II,* Nov 2004. Ev. 175 para 1 and 3.

circumstances this may violate Articles 3 and/ or 8 and/ or 14 of the ECHR and is certainly contrary to international human rights standards.[2]

Criminal justice provisions

The disproportionate response to people who pose a significant risk to others (by providing that they can be detained despite their willingness to receive treatment),[3] the discriminatory impact of the law for those within the criminal justice system, the powers of the Tribunals to impose the equivalent of civil restriction orders and the power to defer release of patients for 8 weeks may in some cases breach article 5(4) and article 14 of the HRA.

Role of Home Secretary

The Home Secretary has retained the power to order leave or transfer restricted patients and this is likely to be in breach of the HRA.[4] We believe that the retention by the Home Secretary of this power is in any event undesirable. Leave and transfer to lower security accommodation are used as steps towards discharge for patients who are seen to be dangerous. Since the Act will require the legality of a detention to be subject to a judicial decision, we consider that it is only fair that this should also apply to the preliminary decisions towards discharge.

The Bar Council have commented that the Draft Mental Health Bill appears to: "*Violate core human rights values*" and "*fails to set the standards by which civilized nations should treat this vulnerable and stigmatised group*." They highlight many areas of concern including the following ones:

- The absence of any reciprocal right to treatment of a minimum standard and in appropriate conditions and to suitable aftercare is incompatible with international human rights standards and may violate Articles 5 and 8 of the ECHR.

- The absence of any power in the Mental Health Tribunal to order a patient to be transferred to another hospital or to be given leave of absence in the face of objections from the patient's doctor or (in restricted cases) the Home Secretary effectively neutralises its function where transfer to lower conditions of security or leave of absence are a necessary precondition to discharge, potentially in breach of Articles 5(4) and 8.

- Inadequate protection is given to the residual rights of detained patients in relation to issues such as seclusion, searching, visiting, access to personal possessions, computers etc, potentially in breach of Articles 3 and 8.[5]

The HRA is a "living instrument" which changes its interpretation over time. There are indications that case law may decide that if treatment is forced on people with capacity to

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[2] The issue is most comprehensively dealt with in *R on the application of b v the Secretary of State for the Department of Health* [2005] EWHC 86 (Admin)

[3] Article 5 cases such as *Litwa v. Poland* and *Pretty v UK* (both cited by Fennell in *Mental Health Law and Human Rights* CCELS, 2004) show that proportionality applies to Article 5 and Article 8 cases.

[4] We are indebted to Professor Genevra Richardson, *Mental disorder and the European Convention* Speech to the British Institute of Human Rights, December, 2002 for raising this issue.

[5] Bar Council, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II,* Nov 2004. Ev 176 para 6.

make their own decisions[6] when they do not present a serious threat to others article 3 and article 8 could also be engaged.

Recent case law from the ECHR demonstrates that early case law can not be relied upon. In *Keenan .v. UK* the court stated: "*For example, in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3. Similarly, treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though that person may not be capable of pointing to any specific ill-effects.* "7

Professor Graham Thornicroft has commented that most of the principles seen as fundamental to good practice in mental health in the relevant national and international policies are neither explicit nor implicit in the Draft Mental Health Bill:
"*In so far as the implicit principle of safety is given salience in the Bill (in relation to risk assessment and risk management), for the whole range of mental disorders, this is likely to reinforce common and stigmatising stereotypes that associate mental illness and violence. This conflicts with the principles of participation, autonomy and empowerment, and dignity. It is also in direct conflict with the policies contained in the Government's recent policy paper by the Social Exclusion Unit*"[8]

[6] *R (Wilkinson) v RMO Broadmoor Hospital* [2001] EWCA 1545; [2002] 1 WLR 419
[7] European Court of Human Rights- *Keenan v United Kingdom* (2001) 33 EHRR 38.
[8] Professor Graham Thornicroft, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II,* Nov 2004. Ev 661 para 3.8