

IRISH LAW REFORM COMMISSION ANNUAL CONFERENCE

CAPACITY IN THE CONTEXT OF HUMAN RIGHTS

Rt Hon Baroness Hale of Richmond

The dilemma

Although I listen to lawyers' arguments about human rights almost every day, I sometimes wonder whether we can recognise a real abuse of human rights when we see one. Here are a couple which seem obvious to me but would they seem obvious to the law?

“An agency worker told us about going into a home at breakfast time. She was instructed to get the residents up and onto their commode. She was then told to feed them breakfast. When she started to get the residents off their commodes first she was stopped. The routine of the home was that residents ate their breakfast while sitting on the commode and the ordinary men and women who worked there had come to accept this as normal.”

“ . . . a man in his 80s, in a nursing home, . . . needs assistance to get dressed and uses a catheter. That man was made to sit with absolutely no clothes on in a double room with 5 members of staff, a mixture of male and female staff, for over 25 minutes whilst they took turns to do the bits that they needed to do, with the door wide open leading into the corridor. . . . One was coming in to wash him, another one was coming in to change his catheter bag, another one was coming in to change his medication, and he was just left sitting with

absolutely no clothes on whatsoever in the middle of this congregation taking place around him, with people walking past the door. . . .”

Those extracts come from the research done by Jenny Watson for the British Institute of Human Rights, published in December 2002.¹ She found a lamentable ignorance of human rights values amongst the providers of public services for vulnerable people. The Human Rights Act was seen as something for the lawyers, rather than ‘something for everyone . . . for the good of the people.’ Perhaps this is the result of the generally negative image of the Act portrayed in our media, who seem to see it as a vehicle for stopping the Government doing things that it wants and the people want it to do. We lawyers, on the other hand, see it as a vehicle for protecting and enhancing the core values of human dignity as well as human freedom for everyone, including the most vulnerable or unpopular members of our society. As the European Court of Human Rights said in *Pretty v United Kingdom* (2002) 35 EHRR 1, paragraph 65:

“The very essence of the Convention is respect for human dignity and human freedom.”

But this presents us with a dilemma when thinking about people who may lack the capacity to make decisions for themselves. Freedom is all about making choices but they may be unable to do this. Yet they are still entitled to respect for their essential identity and dignity as human beings. This dilemma is particularly acute when we consider the central issue of any legal system in catering for people who cannot make their own decisions: at what point should the law step in to regulate the people who

¹ *Something for Everyone – The impact of the Human Rights Act and the need for a Human Rights Commission*, 2002, British Institute of Human Rights.

perforce are making decisions daily on their behalf – whether family, informal carers, or professionals?

The common law and the genesis of our Mental Capacity Act 2005

The dilemma is very well illustrated in the story of our attempts to reform the law of mental incapacity in England and Wales. Before one can begin to reform the law, one has first to have clear idea of what it already says. This became clear for us in 1989 with the House of Lords' decision in *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1. This exposed not only what the common law did say, but also what it did not. Thereafter the pressure on us to promote reform of the law became irresistible. My guess, although of course I do not know, is that the common law of Ireland will be similar to ours.

Where we may differ is in our statute law relating to the care and treatment of mentally disordered and disabled people. Our law was fundamentally recast by the Mental Health Act 1959. This replaced the old laws on mental treatment (descended from the lunacy laws) and mental deficiency with a single coherent code, which has since been updated in the Mental Health Act 1983. The underlying assumption of both Acts was that people, whether or not they had the capacity to decide, could be looked after without the legal formalities of certification or guardianship as long as they did not object. They did not need the stigma and they did not need to be compelled. Nobody then thought that parents who were looking after their mentally handicapped adult offspring, or adult offspring who were looking after their elderly parents, in their own homes needed to get any formal approval for physical care and treatment, so why should they have to do so for anything else? In the 1950s that approach was extended

to care and treatment in mental hospitals and other institutions. This was reflected in what is now section 131(1) of the Mental Health Act 1983:

“Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or registered establishment in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act . . .”

Thus the statutory procedures were designed for the compulsory detention and care of people who objected and with decisions about an incapacitated person’s property and affairs (where it retained the cumbersome edifice of the Court of Protection assuming control over all the patient’s property and appointing someone else as receiver). When the 1959 Act came into force, the Royal Warrant under the sign manual, which had delegated the monarch’s so called ‘*parens patriae*’ jurisdiction over other matters of care and welfare to the court, was revoked. This meant that there was no recognised procedure for deciding disputes, for example between family and health care professionals, or between family members, about where a mentally incapacitated person should live, who he might see, and what medical treatment he should be given. Nor was there any formal mechanism for deciding whether the person did indeed lack the capacity to decide for himself or for protecting him against particularly serious or controversial decisions. Here again, we may be different from you, if you have retained the equivalent of wardship for incapacitated adults.

The gap in our law was revealed and then partially filled by the House of Lords in *Re F (Mental Patient: Sterilisation)*. This decided two things. First, treatment and care which might otherwise be an assault upon a person who lacked the capacity to agree to it was lawful under the common law doctrine of necessity if it was in the best interests of that person. This meant that by and large the assumption upon which the mental health legislation was based was correct – that compliant but incapacitated people could be cared for without formality. But – as was later to emerge – there was nothing in the logic of the case which distinguished between compliant and non-compliant people.

Second, the court could make a declaration that a particular proposal was or was not lawful under the necessity principle. The House advised that particularly controversial decisions, such as sterilisation, should be submitted to the court for its approval; but it could not require this because the theory was that the court was merely declaring what would or would not be lawful. The same procedure was followed in *Airedale NHS Trust v Bland* [1993] AC 789 when the House of Lords decided that it would be lawful to cease providing artificial hydration and nutrition to a patient in a persistent vegetative state. In practice, the declaration procedure has developed into something very like the old wardship jurisdiction over children: see *Re F (An Adult: Court's Jurisdiction)* [2001] Fam 38. In that case, Lady Justice Butler-Sloss made it clear that this did not detract from the obvious need expressed by the Law Commission for ‘a well-structured and clearly defined framework of protection of vulnerable, mentally incapacitated adults’.

The Law Commission's project was designed to replace these common law principles with hopefully clearer rules, better procedures and better safeguards. We published an overview consultation paper in 1991,² followed in 1993 by detailed consultation papers on new procedures for making decisions on behalf of people who were unable to make them for themselves,³ on medical treatment and research,⁴ and on social workers' powers to protect mentally incapacitated and other vulnerable adults from possible abuse.⁵ We had a great many written responses from interested professional and voluntary organisations and individuals. We also held a series of discussion meetings with what would now be called focus groups – one representative of medical, psychiatric, psychological and social work professionals; another representative of courts and legal professionals; and another representative of the voluntary organisations concerned with the interests of people who may lack capacity, their carers and their families. In 1995 the Commission published a Report⁶ proposing a new scheme for making all kinds of decision on behalf of people who are unable to make them for themselves. I am happy to say that ten years later a Mental Capacity Act which is closely modelled on our scheme has reached the statute book.

Our work was long before the Human Rights Act 1998 'brought home' the rights guaranteed under the European Convention on Human Rights to the United Kingdom, using techniques which are very similar to those in your own European Convention on Human Rights Act 2003. We drew on experience elsewhere in the common law world, as well as the most relevant international human rights instruments, to discern

² *Mentally Incapacitated Adults and Decision-Making: An Overview*, LCCP No 119, 1991.

³ *Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction*, LCCP No 128, 1993.

⁴ *Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research*, LCCP No 129, 1993.

the core principles: of normalisation (sometimes known as mainstreaming), the presumption of competence, the least restrictive intervention (which we would probably now call proportionality), providing safeguards without stigma, and respecting what the person himself might have wanted rather than what others thought best for him – the so-called substituted judgment test. We summarised those principles in our overview paper like this:

- (i) that people are enabled and encouraged to take for themselves those decisions which they are able to take;
- (ii) that where it is necessary in their own interests or for the protection of others that someone else should take decisions on their behalf, the intervention should be as limited as possible and should be concerned to achieve what the person himself would have wanted;
- (iii) that proper safeguards should be provided against exploitation and neglect, and against physical, sexual or psychological abuse.⁷

These aims received very wide support on consultation. They remained the aims of the final Report, with one exception: there was no place in the scheme we recommended for making decisions which would protect other people but not be in the best interests of the person without capacity.⁸ Protecting other people was the province of the mental health rather than the mental capacity legislation.

⁵ *Mentally Incapacitated and other Vulnerable Adults: Public Law Protection*, LCCP No 130, 1993.

⁶ Law Commission, *Report on Mental Incapacity*, 1995, Law Com No 231.

⁷ LCCP No 119, para 4.27.

⁸ Law Com No 231, para 2.46.

Our Report dealt with such controversial topics as advance refusals of medical treatment, safeguards for particularly controversial treatments, and with research. Understandably the Government proceeded with some caution. The Lord Chancellor's Department conducted a further round of consultation, largely duplicating ours. There was a Green Paper, *Who Decides?*,⁹ published in December 1997, followed by a Policy Statement, *Making Decisions*,¹⁰ published in October 1999. After a long gap, the Secretary of State for Constitutional Affairs (as the Lord Chancellor had now become) published a draft Mental Incapacity Bill in June 2003.¹¹ This was scrutinised by a Joint Committee of the House of Lords and House of Commons which gave the Bill a 'cautious welcome' in November 2003.¹² The Bill was revised in the light of this and introduced into the House of Commons, now renamed the Mental Capacity Bill, in June 2004. It was also scrutinised by the Joint Committee on Human Rights, which took the view that it should be broadly welcomed on human rights grounds, though it raised certain concerns.¹³ As the Bill had undergone pre-legislative scrutiny it could be carried over from the 2003-4 to the 2004-5 Parliamentary session. The Joint Human Rights Committee¹⁴ repeated its broad welcome but maintained some concerns. But by then other Parliamentarians had become concerned about whether respecting an advance refusal of treatment might amount to euthanasia. The Bill passed all its remaining stages in the House of Commons with some drama on 14

⁹ Lord Chancellor's Department, *Who Decides? Making Decisions on behalf of Mentally Incapacitated Adults*, December 1997.

¹⁰ Lord Chancellor's Department, *Making Decisions. The Government's Proposals for Making Decisions on behalf of Mentally Incapacitated Adults*, October 1999.

¹¹ Department for Constitutional Affairs, Draft Mental Incapacity Bill, with Commentary and Explanatory Notes, June 2003, Cm 5859-I, Cm 5859-II.

¹² House of Lords, House of Commons, Joint Committee on the Draft Mental Incapacity Bill, *Draft Mental Incapacity Bill*, Session 2002-03, Vol 1, *Report together with formal minutes*, HL Paper 189-I, HV Paper 1083 - I (London, Stationery Office, November 2003).

¹³ Twenty-third Report of Session 2003-4, *Scrutiny of Bills: Final Progress Report*, HL Paper 210, HC 1282, Chapter 2.

¹⁴ Fourth Report of Session 2004-05, *Scrutiny: First Progress Report*, HL Paper 26, HC 224, Chapter 4.

December 2004, was seriously debated over several days in the House of Lords, and eventually passed by the skin of its teeth just before Parliament was dissolved in April this year. But there was a new problem, which Parliament had to park on a back burner to be tackled later but before the Act comes into force, hopefully in 2007. This is how to plug the so-called ‘Bournewood gap’.

Along with new procedures for deciding disputes and appointing proxy decision-makers, the Law Commission wanted to make it clear in statute that these need not be used in every case. We wanted to put the *Re F* principle on a statutory footing, with some limitations, so as to reassure carers while protecting the people for whom they were caring. We recommended that it would still be lawful for one person to take action for the care and welfare of another person if the actor reasonably believed (a) that the other person lacked the capacity to take the decision for himself and (b) that he was acting in the best interests of that other person. As the Commission said,

“It would be out of step with our aims of policy, and with the views of the vast majority of respondents to our overview paper, to have any general system of certifying people as ‘incapacitated’ and then identifying a substitute decision-maker for them, regardless of whether there was any real need for one.”¹⁵

This was consistent with the presumption of capacity, with the fact that a person may be capable of taking some decisions some of the time even if not of taking all decisions all of the time, and with the desire to intervene in the least restrictive manner possible. A blanket scheme subjecting anyone who might be incapable of

¹⁵ Law Com No 231, para 4.5.

making some decisions some of the time would be both impracticable and disproportionate. The Act adopts the same policy, although in different language, in section 5. Subsection (1) sets the scene:

“If a person (“D”) does an act in connection with the care and treatment of another person (“P”), the act is one to which this section applies if –

- (a) before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and
- (b) when doing the act, D reasonably believes –
 - (i) that P lacks capacity in relation to the matter, and
 - (ii) that it will be in P’s best interests for the act to be done.”

Subsection (2) then provides that D does not incur any liability for doing the act which he would not have incurred if D had had capacity to agree to it and had done so.

This preserves the *Re F* principle in conjunction with the basic principles set out in section 1:

- (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
- (3) A person is not to be treated as unable to make a decision unless all practicable steps have been taken to help him to do so without success.
- (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

- (5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

Section 2(1) defines a person who lacks capacity thus:

“For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.”

Subsection (2) provides that:

“It does not matter whether the impairment or disturbance is permanent or temporary.”

Section 3(1) defines inability to decide thus:

“For the purposes of section 2, a person is unable to make a decision for himself if he is unable –

- (a) to understand the information relevant to the decision,
- (b) to retain that information,
- (c) to use or weigh that information as part of the process of making the decision, or
- (d) to communicate his decision (whether by talking, using sign language or any other means).”

Other subsections provide (2) that he is not unable to understand if he can understand an explanation given in a way which is appropriate to his circumstances; (3) that the fact that he can only retain the information for a short time does not prevent his being able to make the decision; and (4) that the relevant information includes information about the foreseeable consequences of deciding one way or another or of failing to make any decision at all. Thus the concept of capacity is decision-specific, functional, and cognitively based. It does not depend upon status or diagnosis. The Act even spells out, in section 2(3), that a lack of capacity cannot be established simply because of a person's age or appearance, or a condition or aspect of his behaviour which might lead others to make unjustified assumptions about his capacity. Still less does it depend upon the quality of the decision actually made.

Section 4 deals with how people acting under the general authority, or under a lasting power of attorney, or under a court appointment as deputy, are to decide whether something is in a person's best interests. Its final form clearly reflects some of the Parliamentary concerns. But the essence requires the decision-maker first to try and work out what the person himself would have wanted. Under subsection (3) he must consider whether and if so when it is likely that the person will actually have the capacity to make the decision. Under subsection (4) he must encourage the person to participate as fully as possible in the decision. And under subsection (6) he must consider:

- (a) the person's past and present wishes and feelings . . .

(b) the beliefs and values that would be likely to influence his decisions if he had capacity, and

(c) the other factors that he would be likely to consider if he were able to do so.

Under subsection (7) he must, if practicable and appropriate, take account of the views of anyone named by the person as a consultee on such matters, any donee of a lasting power of attorney, any deputy appointed by the court, and anyone engaged in caring for him or interested in his welfare.

The Bournewood gap: Article 5

But there are limits to the general authority preserved by the Act. The Law Commission's Bill provided that it did not allow (a) the use or threat of force to secure the doing of anything to which the other person actively objected, or (b) the detention or confinement of that person, whether or not he objected, unless such steps were necessary to avert a substantial risk of serious harm to the person concerned. In other words, coercion and confinement were only to be allowed in very limited circumstances. The Commission thought at the time that this might well be a change in the law,

“taking into account that *Re F* established that a major abdominal operation with irreversible effects was lawful according to the principle of necessity, it is highly likely that in appropriate circumstances acts of confinement or coercion

could equally be found to be lawful if performed in the best interests of the person concerned.”¹⁶

The Commission’s prediction was correct. Three years later along came *R v Bournewood Community and Mental Health NHS Trust, ex parte L* [1999] AC 458; [1998] 3 All ER 289. Mr L was in his forties, autistic, profoundly mentally disabled, and unable to consent to medical treatment. He had lived in a hospital for many years, but three years earlier he had left the hospital to live with paid carers. On 22 July 1997, he became agitated at his day centre, a doctor and social worker were called, and he was sedated and taken to the Accident & Emergency Department of his local hospital. A psychiatrist assessed him as needing in-patient treatment but it was not thought necessary to ‘section’ him, as he appeared fully compliant and unresisting. So he was admitted informally. His carers were very suspicious of the hospital’s intentions and proceedings were started in Mr L’s name for (a) judicial review of the decision to detain him; (b) habeas corpus; and (c) damages for false imprisonment and assault. The trial judge refused these applications, but on 29 October 1997 the Court of Appeal allowed his appeal. They held that he had been detained and that his detention was unlawful. The Mental Health Act was a complete statutory code leaving no room for the operation of the common law doctrine of necessity. Section 131(1) applied only to people who consented, not to people who did not dissent. One ‘troubling feature’ of the appeal was that (p 474D)

“the [NHS] trust is not alone in misinterpreting the effect of the Act. Apparently, there could be many patients, especially those suffering from

¹⁶ Law Com No 231, para 4.31.

dementia, who are in the same position as L. This is no doubt partly a consequence of opinions expressed in the authoritative textbooks which support what has happened in this case: *Hoggett, Mental Health Law*, p 9 and *Jones, Mental Health Act Manual*, 5th ed. (1996), p 340.”

They awarded him £1 damages and granted leave to appeal to the House of Lords. The day that the Court of Appeal announced that it had decided to allow the appeal, Mr L was detained under the Mental Health Act. He was released to his carers five weeks later on 5 December and formally discharged a week after that.

The House of Lords heard the case six months later and Richard Jones and Brenda Hoggett (as I then was) were vindicated. The House was given a much fuller account of the legislative history which had led us to hold our opinions about the effect of section 131(1). It was also told that the Court of Appeal’s judgment would lead to vastly more people being detained under the Act – an additional 22,000 on any one day and an additional 48,000 admissions per year (the Government is still assuming this sort of scale, together with untold numbers in residential care homes). All their lordships held that section 131(1) applied both to capable consenting and to incapable non-dissenting patients. All their lordships held that it was the intention of the Act that informal patients be given such treatment and care as was in their best interests. Mr L’s removal to hospital, treatment and care in hospital were lawful under the common law doctrine of necessity confirmed in *Re F*. The majority (Lord Goff of Chieveley with whom Lord Lloyd of Berwick and Lord Hope of Craighead agreed) went further and held that Mr L had not actually been detained: he had stayed on an unlocked ward and made no attempt to leave. Lord Steyn and Lord Nolan considered

that he had been detained: he was sedated to get him to hospital and while he was there; he would have been sectioned if he had attempted to leave; his carers were at first prohibited from visiting in case he tried to leave with them; the hospital was not prepared to release him back into the care of his carers until it thought him ready. Lord Steyn described the suggestion that he was free to leave as ‘a fairy tale’. But the minority also held that the detention was justified. Lord Steyn regarded the lack of protection for someone in his position as ‘an indefensible gap in our mental health law’ (p 305e). This swiftly became known as ‘the Bournemouth gap’. Lord Steyn also pointed out that the doctrine of necessity might even on occasions justify the detention of non-compliant patients – and that certainly happened in some of the earlier cases on necessity which were not referred to in *Re F*. He was only mildly reassured by the departmental promise that they were looking into it.

Throughout all this period, the Government had been attempting to reform the Mental Health Act. Its efforts to do so have been very controversial, for two main reasons. First, they vastly expand the range of people potentially subject to compulsory powers; and secondly, they provide for compulsory treatment in the community as well as in hospital. Its 2002 draft Bill contained provisions designed to fill the Bournemouth gap as it was perceived by the majority to be: a lack of safeguards for the incapacitated but non-detained. Meanwhile, our Human Rights Act had come into force and the Government was fighting the Bournemouth case in the European Court of Human Rights. At issue, of course, was the right not to be deprived of one’s liberty, save in defined circumstances and by due process of law, guaranteed by Article 5 of the Convention.

The case of *HL v United Kingdom* (2005) 40 EHRR 32 was decided in October 2004. The Strasbourg court agreed with Lord Steyn that Mr L had been deprived of his liberty within the meaning of Article 5.1 of the ECHR. The health care professionals treating and managing him exercised complete and effective control over his care and movements from the moment he presented problems on 22 July 1997 until he was compulsorily detained on 29 October 1997. The reality was that he was not free to leave (para 91).

That deprivation was in breach of the Convention unless it fell within article 5.1(e) . . . 'the lawful detention . . . of persons of unsound mind'. The criteria required under article 5.1(e) were laid down in the case of *Winterwerp v Netherlands* (1979) 2 EHRR 387. These are not very demanding. The court (para 37) deliberately declined to define what is meant by being 'of unsound mind':

". . . because its meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitudes to mental illness change, in particular so that a greater understanding of the problems of mental patients is becoming more widespread."

I still do not know whether those factors were meant to increase or decrease the scope of the concept. But then the court laid down three requirements for lawful detention (para 39):

"The very nature of what has to be established before the competent national authority - that is a true mental disorder - calls for objective medical expertise.

Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder."

The court accepted that Mr L had been shown to be suffering from a mental disorder of a nature or degree warranting compulsory confinement for all the time that he had been in hospital (para 101). However, it decided that such detention had not been 'lawful'. It is not enough that the detention is lawful in domestic law, as this was: it has to meet the Convention standard of lawfulness. This requires the law to be sufficiently precise to allow the citizen to foresee the consequences which a given action may entail (para 114); and any detention has to comply with the essential objective of article 5.1, 'which is to prevent individuals being deprived of their liberty in an arbitrary fashion' (para 115). Whether or not a detention on the basis of common law necessity fulfilled the first requirement, the Court was clear that the second had not been satisfied (para 119). There were no procedural rules for the admission and detention of compliant incapacitated people, no grounds, no statement of purpose, no limits of time or treatment, and no requirement of continuing clinical assessment (para 120). The absence of safeguards failed to protect against arbitrary deprivation of liberty and was thus in breach of article 5.1 (para 124). The lack of a speedy review of the merits of his detention was also in breach of article 5.4.

So what was the Government to do? The provisions in the 2002 draft Mental Health Bill had been designed to meet the Bournemouth Gap as it was then perceived to be – that there were no real safeguards in the treatment of informal patients even though they were not unlawfully detained. They did not meet the new Bournemouth gap –

that many such patients are in fact unlawfully detained. But the reality is that the dividing line between deprivation of liberty – which is prohibited by article 5.1 – and restriction of liberty – which is not so prohibited – is one of ‘degree and intensity’ and not one of ‘nature or substance’¹⁷. This is well illustrated in the difference between the facts of Mr L’s case and those in *HM v Switzerland* (2004) 38 EHRR 296. There, putting an elderly women in a nursing home to ensure satisfactory medical care, living conditions and hygiene was held not to deprive her of liberty: it was not established that she was incapable of expressing a view; she had often said that she was willing to go there and within weeks she was willing to stay (they always are); the regime there was entirely different, an open institution allowing freedom of movement and encouraging links with the outside world (para 93). But we cannot be sure that the line would be drawn in the same place for all the incapacitated old people who are currently living in residential or nursing homes.

So in March this year, the Government issued its “*Bournemouth*” *Consultation* on the approach to be taken in response to the European Court’s judgment. Its preferred option is for something called “Protective Care”. This would be a new institution for people lacking capacity who need to be detained so that care and treatment can be provided in their own best interests. The Government seems to think that this is only a problem if a public authority is involved in arranging the placement. But I wonder whether this is right. Clearly under our Human Rights Act, like yours, people only have a direct right of action against public authorities which fail to comply with their Convention rights. But I would guess that the United Kingdom would be in breach of its obligations under the Convention if it failed to take steps to protect people from

¹⁷ *HL v UK*, para 89; referring to *Ashingdane v UK*, 1975, para 41; *Guzzardi v Italy*, 1980, para 92.

deprivations of liberty by other people contrary to Article 5. It cannot be right that private homes and institutions, or indeed private individuals, are allowed to deprive people of their liberty in circumstances where a public authority would be prohibited from doing so by Article 5.

The Consultation Paper is remarkably thin on the detail of new institution. The Government obviously wants something less elaborate than the Mental Health Act procedures, but says little about what they might be, other than suggesting that there might be a first tier review involving an independent professional together with family and friends. The new institution would be aimed at people who did not meet the criteria for detention under the Mental Health Act. Those who did so would continue to be detained under that Act. But it would not matter if they also met the criteria for the new institution, whatever those may be.

The other two options canvassed are to extend the scope of the Mental Health Act powers to cover the Bournemouth people who would not otherwise qualify, either by extending the grounds for compulsory admission to hospital or by extending the scope of the little used Mental Health Act guardianship. The former might be seen as disproportionate when the patient is not in need of specialist psychiatric care. The latter looks much more sympathetic, but conflicts with the policy of abolishing guardianship in the proposed new Mental Health Act. Consultation closed in June but the Government has not yet announced what it proposes to do.

I have dwelt at length on this problem because it seems to me to be much the most theoretically challenging of the human rights issues raised by the lack of capacity to

decide for oneself. But what does it mean to be deprived of liberty when one lacks the ability to choose what to do? Of course we want proper safeguards against the improper deprivation of liberty, or for that matter against improper treatment of an incapacitated person. But neither do we want to impose a rigid regime which may unjustifiably curtail what freedom they do have or hamper rather than enable their proper treatment.

Dignity and respect: Articles 3 and 8

It goes without saying that people who are unable to care for themselves should be properly treated by those who are responsible for them. There are offences of ill-treatment and wilful neglect under both the Mental Health Act, in section 127, and the Mental Capacity Act, in section 44. But that is clearly not enough to prevent the sort of thoughtlessness and disrespect shown in the two cases with which I began. Can human rights law do any better? Here we must first turn to Article 3 - no-one shall be subjected to torture or inhuman or degrading treatment or punishment – and also to Article 8 – the right to respect for private and family life, home and correspondence. Both require the state, not only to refrain from ill-treatment or interference itself, but also to take reasonable steps to prevent such ill-treatment or interference by others.

Article 3 is unqualified: there are no ifs and buts. If the conduct complained of comes within Article 3, it cannot be justified or excused. This has understandably led to a very high threshold test of severity, although it does have a strong subjective component in the effect on the individual concerned. See, for example, *Price v United Kingdom* (2002) 34 EHRR 53, paragraph 24:

"The Court recalls that ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum is relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim.

In considering whether treatment is 'degrading' within the meaning of Article 3, one of the factors which the Court will take into account is whether its object was to humiliate or debase the person concerned, although the absence of any such purpose cannot conclusively rule out a finding of violation of Article 3."

Ms Price was a four limb deficient thalidomide victim with kidney problems. She had been committed to prison for contempt of court for failing to answer a means questionnaire in proceedings to recover a judgment debt. She spent the first night in a police cell, which was cold and totally unsuited to her needs, before being moved to the hospital wing of a prison, where male officers had to help with basic hygiene. The Court held (paragraph 30):

"There is no evidence in this case of any positive intention to humiliate or debase the applicant. However, the Court considers that to detain a severely disabled person in conditions where she is dangerously cold, risks developing sores because her bed is too hard or unreachable, and is unable to go to the toilet or keep clean without the greatest of difficulty, constitutes degrading treatment contrary to Article 3."

The Strasbourg case law and literature tend to deal with prisoners and patients together. But there are important differences.¹⁸ For prisoners, the mere fact of detention is an end in itself, as prevention, deterrence and punishment. For patients, detention is not, or should not be, an end in itself. It is merely the means to an end, which is treatment and care. Hospitals and care homes are there to look after people, contain their symptoms and possibly make them better. They are not there simply to imprison and keep people off the streets. Standards that might be acceptable in a prison, therefore, might not be acceptable in a hospital and even more in a care home, where there is no element of preventing harm to other people.

Nevertheless, a great deal of what goes on in psychiatric hospitals and care homes is potentially inhuman or degrading. But the Strasbourg court has imported a concept of medical necessity into its assessment of what amounts to inhuman or degrading treatment. In *Herczegfalvy v Austria* (1992) 15 EHRR 437, the Court started well in paragraph 82:

"The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are responsible, such

¹⁸ See *R (Munjaz) v Mersey Care NHS Trust; R (S) v Airedale NHS Trust* [2003] EWCA Civ 1036; [2003] 3 WLR 1505, (paragraph 55).

patients nevertheless remain under the protection of Article 3, the requirements of which permit of no derogation."

But then it gave the game away:

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

Mr Herczegfalvy had been force-fed, forcibly given psychotropic drugs, and most worryingly kept for more than two weeks in handcuffs and tied to a security bed, but the Court decided (in paragraph 83) that

". . .the evidence before the Court is not sufficient to disprove the Government's arguments that, according to the psychiatric principles generally accepted at the time, medical necessity justified the treatment in issue."

Although this was in many ways a very conservative decision, we have been able to use it to impose a greater degree of surveillance over the treatment of detained patients in hospital than might otherwise be possible. In *R (Wilkinson) v RMO Broadmoor Hospital* [2001] EWCA 1545; [2002] 1 WLR 419. Simon Brown LJ put it this way (in paragraph 26):

"It seems to me that the court must inevitably now reach its own view both as to whether this claimant is indeed incapable of consenting (or refusing

consent) to the treatment programme planned for him by . . . his RMO and, depending upon the court's conclusion on that issue, as to whether the proposed forcible administration of such treatment would (a) threaten the claimant's life and so be impermissible under Article 2, (b) would be degrading and so impermissible under Article 3, and (c) would not be justifiable as both necessary and proportionate under Article 8(2) given the extent to which it would invade the claimant's right to privacy."

How far is this concept of medical necessity dependent on the patient's incapacity? It was argued in *Wilkinson* that to impose treatment forcibly upon a patient who had the capacity to refuse it was a breach of his Convention rights, either under Article 3 or Article 8 (of which more later). Under the English Mental Health Act, however, the criteria for detention do not depend on incapacity and most forms of medical treatment for her mental disorder may be imposed upon a detained patient against her will, albeit some only with a second opinion. What did the European court mean in *Herczegfalvy* by 'patients who are entirely incapable of deciding for themselves'? Was it referring to a legal or a mental disability? I see the logic of saying that treatment for mental disorder should be no different from treatment for physical disorder. If so, it can only be given with the consent of a capable patient or where it is necessary in the best interests of an incapable one.

But I also see dangers in using capacity as a criterion for defining what is degrading treatment. Why should it be acceptable to treat an incapacitated person in a way which would be degrading if done to a capacitated? This obviously would not do with, say, living conditions, food, and general care. What difference should it make

whether the elderly people described in my earlier examples were or were not demented? In *Wilkinson* (at paragraph 79), therefore, I said this:

". . . I would hesitate to say which was worse: the degradation of an incapacitated person shames us all even if that person is unable to appreciate it, but in fact most people are able to appreciate that they are being forced to do something against their will even if they are not able to make the decision that it should or should not be done."

Article 8 gives everyone the right to respect for their private and family life, their home and their correspondence. Unlike Article 3, it is a qualified right. Interference is permissible under Article 8.2 if: (a) it is in accordance with a national law which conforms to the Convention concept of legality; (b) it is for a legitimate aim (eg 'the protection of health or morals' or 'the protection of the rights and freedoms of others'; and (c) it is a proportionate response to a 'pressing social need'.

Article 8 has mainly featured in relation to patients' correspondence: Mr Herczegfalvy won his complaint about unjustified censoring of his mail while losing his complaint about how he was treated. I do see how dangerous it is if institutions are allowed to cut off an inmate's access to the outside world, but it is equally dangerous if there is nothing that anyone outside can do about what is going on in the institution. So far, the Strasbourg court has not found it necessary to consider complaints about treatment in prison or hospital under Article 8 separately from complaints under Article 3. But it may be prepared to do so. The concept of private life is a fluid and dynamic one. It includes physical and moral integrity. The Court has said, in *Bensaid v United*

Kingdom (2001) 33 EHRR 205 (at paragraph 46), that treatment which does not reach the severity of Article 3 treatment may nonetheless breach the right to respect for private life in Article 8 if there are sufficiently adverse effects on physical and moral integrity. It went on (at paragraph 47):

“Mental health must also be regarded as a crucial part of private life associated with the aspect of moral integrity. Article 8 protects a right to identity and personal development, and the right to establish and develop relationships with other human beings and the outside world. The preservation of mental stability is in that context an indispensable precondition to effective enjoyment of the right to respect for private life.”

The threshold for what constitutes 'interference' under Article 8 can be much lower than for 'inhuman or degrading treatment' under Article 3, because of the qualifications. The qualifications are a sensitive instrument for determining whether the interference was indeed justifiable and proportionate. And the concept of 'respect' is also a powerful one because it is capable of bringing with it positive as well as negative obligations. One of the earliest cases on positive obligations was *X and Y v The Netherlands* (1985) 8 EHRR 235. This required the state to provide mentally disabled young women with adequate protection against sexual abuse.

In due course, therefore, Strasbourg might be willing to develop these to require minimum standards of appropriate treatment and care for vulnerable people who are unable to secure these for themselves. But I would like to think that both the people

with whom I began would already have a remedy for such gross disrespect for their human dignity.