

What can the Human Rights Act do for my mental health?

Paul Sieghart Memorial Lecture 2004¹

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There are at least three reasons why I should not be here! First, I am standing in for Amartya Sen and the very idea that I should be thought able to do so is preposterous. Second, and much to my regret, I never knew Paul Sieghart. Fortunately, though, I recently chanced upon a wonderful portrait of him by Paul Benney. This confirmed all that I had ever heard about him – a formidable intellect combined with originality and humanity as well as considerable good looks. Even if I should not be here, I am glad to be able to honour his commitment to human rights in some small way. Third, although I listen to lawyers' arguments about human rights almost every day, I sometimes wonder whether we can recognise a real human rights abuse 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 2002³ She found a lamentable ignorance of human rights values

¹ *This is the text of the Paul Sieghart Memorial Lecture delivered for the British Institute of Human Rights at King's College, London, on 7 July 2004. The footnotes have been updated (to January 2005) to take account of later developments*

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³ *Something for Everyone: The impact of the Human Rights Act and the need for a Human Rights Commission, 2002, British Institute of Human Rights*

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 part of the generally negative image of the Act portrayed in the 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, rather than as a vehicle for protecting and enhancing the core values of human dignity as well as human freedom. That is why I want to ask the question, 'what can the Human Rights Act do for my mental health?'

What are those core human rights values in the mental health field? Services for mentally distressed and disabled people are perpetually struggling to reconcile three overlapping but often competing goals: obtaining access to the treatment and care that people need, safeguarding their civil rights, and protecting the public. Basing myself on the 1991 United Nations' *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*,⁴ I would sum up those core human rights something like this:

- (1) People with mental disorders and disabilities should be enabled to receive the care and treatment they need.
- (2) That treatment and care should be available to all who need it, without discrimination on grounds such as sex, racial or ethnic origin, membership of a particular religious or social group, or the nature of their disability (including, I would add, their age).
- (3) Enabling should not entail enforcing: a person's right to choose – at least if she is capable of choice – what may be done to her body or her mind should only be taken away with due legal process.
- (4) That due legal process requires (i) principled grounds for intervention; (ii) a fair machinery for determining disputes; and (iii) appropriate and humane treatment and care in return.
- (5) Underlying and overriding all of these is respect for the equal dignity and humanity of all people, however great their disorder or disability.

These are grand aspirations which we cannot hope to meet all of the time. What can the Human Rights Act do to help us try? The difficulty is that the law generally is better at preventing people and authorities from doing things than it is at making them take the necessary let alone desirable action. The same is true of the Human Rights Act. The European Convention on Human Rights was originally aimed at some very different targets. As we all know, it emerged from the horrors of the Second World War, the holocaust and the advance of communism across Eastern Europe. Like the United States Constitution, its focus is on freedom: freedom from slavery and torture, from arbitrary imprisonment, from intrusions into private and family life, freedom of religion, of expression and of association, freedom to marry and found a family, and freedom from confiscation or interference with property rights. Unlike the Universal Declaration of Human Rights, the Beveridge Report which led to the post war welfare state, and some later human rights instruments,⁵ it did not address the other great freedoms: from want, from disease, from squalor, from ignorance, and from idleness. It is, if you like, the New Zealand Bill of Rights Act 1990, which says in section 11:

"Everyone has the right to refuse to undergo any medical treatment",

4 General Assembly Resolution 46/119 of 19 December 1991

5 Most prominently in the United Nations International Covenant on Economic, Social and Cultural Rights, 1966; also in the United Nations Convention on the Rights of the Child, 1989

rather than the Bill of Rights in the Constitution of the Republic of South Africa 1996, which not only says in section 12:

“Everyone has the right to bodily and psychological integrity, which includes the right... (b) to security in and control over their body... “

but adds in section 27:

“(1) Everyone has the right to have access to – (a) health care services..

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.”

This focus on freedom makes it easiest to use the European Convention to improve the procedural protection against compulsory detention and treatment. That is where most of the successful activity has been. This dates back to the first case of *X v United Kingdom* (1981) 4 EHRR 181, long before the Human Rights Act, but has continued since. An early declaration of incompatibility related to the requirement for patients to prove to a tribunal that they were not detainably ill rather than for the hospital to prove that they were.⁶ This led to the first remedial order under section 10 of the Act.⁷ But there are some big ideas in the Convention which it might be possible to put to more constructive use.

(1) People with mental disorders and disabilities should be enabled to receive the treatment and care they need

A delegate to last year’s International Congress on Law and Mental Health ruefully observed that the only people in the United States with a constitutional right to free health care are serving prisoners. Over here too, it may be easier to use the Convention to secure proper treatment for compulsory hospital patients than for others. The usual route to this is through Article 3, which prohibits the use of torture and inhuman or degrading treatment or punishment.

This is an unqualified right: 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, *Keenan v United Kingdom* (2001) 33 EHRR 38, paragraphs 108 and 109:

“108 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 upon all the circumstances of the case, such as the duration of the treatment, its physical and/or mental effects and, in some cases, the sex, age and state of health of the victim.

109 In considering whether a punishment or treatment is degrading within the meaning of Article 3, the court will also have regard to whether its object is to humiliate or debase the person concerned and whether as far as the consequences are concerned it adversely affected him or his personality in a manner incompatible with Article 3. This has also been described as involving treatment such as to arouse feelings of fear, anguish and inferiority capable of humiliating or debasing the victim and possibly breaking their physical or moral resistance or as driving the victim to act against his will or conscience.”

⁶ *R (H) v Mental Health Review Tribunal* [2001] EWCA Civ 415; [2002] QB1

⁷ *Mental Health Act 1983 (Remedial) Order 2001*, SI 2001 No 3712

The Strasbourg case law and literature tend to deal with prisoners and patients together. But in *R (Munjaz) v Mersey Care NHS Trust; R (S) v Airedale NHS Trust* [2003] EWCA Civ 1036; [2003] 3 WLR 1505 (paragraph 55) the Court of Appeal was keen to point out the difference. 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 are there to look after people, contain their symptoms and hopefully 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, ought not be acceptable in a hospital.

On the other hand, viewed from the point of view of the patient or even the outsider looking through the door, a great deal of what goes on in psychiatric hospitals has the potential to be 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 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, the Court of Appeal was able to use it in *R (Wilkinson) v RMO Broadmoor Hospital* [2001] EWCA 1545; [2002] 1 WLR 419 to hold that the court must be able to hear evidence and adjudicate upon disputes about a controversial treatment decision which may breach the patient’s Convention rights. 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 person? This obviously would not do with, say, living conditions, food, and general care. What difference should it make if the elderly people described in my earlier examples were or were not demented? In *Wilkinson* (at paragraph 79), therefore,

"...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."

Thus far I have been looking at the preventive or negative aspects of Article 3. But it also has the potential to develop a positive right to appropriate treatment: one which says, if you are going to take away the liberty of a vulnerable person, there are certain minimum standards of care with which you must provide him. The best statement is in *Keenan v United Kingdom* (2001) 33 EHRR 38:

"110 It is relevant in the context of the present application to recall also that *the authorities are under an obligation to protect the health of persons deprived of liberty*. The lack of appropriate medical treatment may amount to treatment contrary to Article 3. In particular, the assessment of whether the treatment or punishment is incompatible with the standard of Article 3 has, in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment.

112 ... there are circumstances where proof of the actual effect upon the person may not be a major factor. 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." (my emphasis, not theirs)

This is reminiscent of ideas being developed by Larry Gostin 20 years ago.⁸ It is reflected in the principle of ‘reciprocity’ developed by the much-lamented Richardson Report⁹ which preceded the Government’s current attempts to reform mental health law. There is even a glimmer in the draft Mental Health Bill, published for consultation in 2002. This required as a condition of compulsion that ‘appropriate medical treatment is available in the patient’s case’.¹⁰ That falls somewhat short of an enforceable obligation to provide that treatment, but might the courts be prepared to construct one either under Article 3 or under Article 8?

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: (i) it is in accordance with a national law which conforms to the Convention concept of legality (ie it must be sufficiently clear and predictable to enable the citizen to conform his conduct to it); (ii) it is for a legitimate aim (eg ‘the protection of health or morals’ or ‘the protection of the rights and freedoms of others;’ and (iii) there is a pressing social need to which it is a proportionate response.

As with Article 3, Article 8 has both a negative and a positive aspect. Primarily, it is there to prevent the state interfering arbitrarily in family and private life. But it may do so to protect, for example, the health and welfare of a child. If it does so, the Court of Appeal has said that there should be a corresponding obligation to use its best endeavours to supply an alternative family life which will better protect the child’s health and welfare.¹¹ This again is the notion of reciprocity where compulsory powers have been used.

So far, however, Article 8 has rarely featured in mental health law, except 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 her treatment 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 there are indications that 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 EHRM 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.

8 Gostin L, ‘The Ideology of Entitlement: the Application of Contemporary Legal Approaches to Psychiatry’ in Bean P, ed, *Mental Illness: Changes and Trends*, 1986, Wiley; see also ‘Human Rights of Persons with Mental Disabilities: the European Convention on Human Rights’ (2000) 23 (2) *Int J Law and Psych* 125

9 *Review of the Mental Health Act: Report of the Expert Committee (Chair: Professor Geneva Richardson)*, 1999

10 Cm 5538-I, 2002, Draft Mental Health Bill, clause 6(5). The same condition is repeated in the 2004 re-draft, currently under scrutiny by a Parliamentary Committee: Cm 6305-I, 2004, Draft Mental Health Bill, clause 9(6)

11 *Re W and B (Children)* [2001] EWCA Civ 757; [2001] 2FLR 582; reversed by the House of Lords under the name *Re S(Children; Care Order: Implementation of Care Plan)* [2002] AC 291, but not, I believe, on this point

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. Whether in due course Strasbourg would 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, I do not know.

But there are signs that Strasbourg is beginning to develop concepts of self-determination and autonomy out of Article 8. In *Pretty v United Kingdom* (2002) 35 EHRR 1, it upheld our law’s ban on assisting suicide but appears to have thought (at paragraph 61) that Article 8 was engaged:

“Though no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees.”

A great deal of what goes on in hospitals and care homes betrays a lack of proper respect for patients’ and residents’ privacy and autonomy. Many of the incidents noted in the BIHR research show this only too well. Promoting a positive attitude to their rights as human beings could be a much more effective way of attaining proper standards than the big sticks of criminal or civil liability or even the Care Standards Act.

But what about securing proper treatment and care for people outside hospitals and care homes? One might naively have thought that it would be a breach of the right to liberty, protected by Article 5, to detain someone in hospital for the sake of her mental health if she did not need to be there. But the English cases suggest that it will rarely be possible to complain even if the only reason for the continued detention in hospital (or in the particular type of hospital) is the lack of appropriate community or half way house facilities. If a patient still meets the criteria for detention, our law says she may be detained. It does not say where she should be detained. Nor does it oblige the authorities to find appropriate facilities for a patient whom the hospital or a mental health review tribunal deems ready to move on but not ready for immediate discharge into the community. Even if she could be discharged into the community with appropriate help and support, the law only obliges health and social services authorities to use their best endeavours to arrange this.¹² For some patients, the tribunal has power to order a conditional discharge, but if the community agencies do not make the arrangements necessary to meet the conditions, our courts have held that it is not contrary to Article 5 to continue to detain a person who is ‘of unsound mind’ within the meaning of the Convention.¹³ It would be otherwise if he were no longer ‘of unsound mind’ at all:¹⁴ but the Convention criteria set out by the Strasbourg court in *Winterwerp v The Netherlands* (1979) 2 EHRR 387 (paragraph 39) are not very demanding:

“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

12 *R (K) v Camden and Islington Health Authority* [2001] EWCA Civ 230; [2002] QB 198; *W v Doncaster MBC* [2004] EWCA Civ 378

[2002] EWCA Civ 246; [2003] 3 QB 320; *W v Doncaster MBC* [2004] EWCA Civ 378

13 *R (IH) v Home Secretary* [2003] UKHL 59 upholding

14 *Cf Winterwerp v Netherlands* (1979) 2 EHRR 387 and *Johnson v United Kingdom* (1999) 27 EHRR 296

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.”

There is as yet little hint of a positive obligation to provide what the patient needs to be able to live safely in the community. Yet we know that it is the failure to do this which so often keeps people in unsuitable surroundings long after they could have moved on. The other side of the coin is that people may be forced into unsuitable institutional care, against their will, because of a lack of adequate domiciliary services to keep them within their own homes. The BIHR report gives many examples of this: elderly people who are not incontinent being expected to use incontinence pads because there is no-one to help them to the lavatory.

It is in this area of access to proper treatment and care that the Convention has least to offer, but there are a few ideas on which to build.

(2) That treatment and care should be available to all who need it, without discrimination on grounds such as sex, racial or ethnic origin, membership of a particular religious or social group, or the nature of their disability (including, I would add, their age)

One of the complaints made in the BIHR research was that the level and standards of community provision for elderly people varied so much from place to place. Article 14 requires that

“The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.”

Some other Convention right must be in play, even if it has not actually been breached. So it might be possible to attack some inequalities of access on the basis that the right to respect for private life in Article 8 was engaged even if it had not been breached. Differences in treatment which serve a legitimate aim are allowed, as long as they are proportionate to that aim. But the Court has said that ‘very weighty reasons’ would be required to justify differences of treatment based solely on race or gender. In the UK, there is some evidence of inequality in access to mental health care based on gender, rather less of it based on ethnicity, but much more of it based on socio-economic status.¹⁵ The inequalities can cut either way: in the use of compulsion or in the offer of services of particular kinds. For example, drug therapy is available to all, but talking treatments are much less readily accessible. The whole picture is distorted by the use or prospect of compulsion, which deters people from seeking treatment, denies them the right to choose the treatment they want, and prioritises certain kinds of patient in the offer of services.

The use of compulsion also raises some more fundamental questions about discrimination between people with mental disorders and everyone else. Why should the criteria for treatment for mental disorder be different from the criteria for treatment for physical disorder? In other words, why should not this too depend upon consent or incapacity? And why should capacitated people be able to make advance directives about treatment for future physical disorder but not about treatment for future mental disorder? But is mental disorder or disability a ‘status’ for the purpose of Article 14? If it is, and Article 8 protects personal integrity and autonomy, when is it justifiable to distinguish between that group and others in the enjoyment of that right?

15 A Rogers and D Pilgrim, *Mental Health and Inequality*, 2003, Palgrave Macmillan

(3) Enabling should not entail enforcing: a person's right to choose – at least if she is capable of choice – what may be done to her body or her mind can only be taken away with due legal process

The Convention can protect against forcible interferences with liberty and self-determination. Indeed, some would say that it is rather too good at doing this, at the expense of affording access to desperately needed treatment and care. But there is still the so-called 'Bournewood gap':¹⁶ the common law allows necessary treatment and care, including admission to psychiatric hospital, to be given without consent and without legal formality to those who are incapable of making the decision for themselves and do not actively protest. The Mental Capacity Bill, now before Parliament, maintains the basic principle that the compliant person without capacity may be given care and treatment without formality, although it does set some limits and provide some safeguards. Is incapacity a rational and sufficient reason for drawing this distinction? *Bournewood* was argued last year before the European Court of Human Rights in Strasbourg but news of a result has not yet reached me.¹⁷

(4) That due legal process requires (i) principled grounds for intervention; (ii) a fair machinery for determining disputes; and (iii) appropriate and humane treatment and care in return

This is the area where the Convention ought to do best. Under Article 5(1)(e) only those who are genuinely 'of unsound mind' can be deprived of their liberty. Yet in *Winterwerp* (paragraph 37) the Strasbourg court deliberately declined to define that concept,

“ . . . 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.”

There was little hint there of the philosophical debates about the justifications for compulsion which have been worrying mental health lawyers for decades if not centuries. The Richardson Committee, like the Law Commission in its work on mentally incapable adults,¹⁸ saw much of the answer in a rigorous definition of incapacity, although they acknowledged the need to cater for some who posed a risk to others. If incapacity were the criterion, rather than the severity of symptoms or the prospect of harm to others, then some people might be given the help they need before their situation became too desperate.

The other problem is that the Convention provides protection against arbitrary deprivation of liberty in the narrow sense of detention. Restrictions are not covered, especially if they are for the person's own good. Thus a discharge from hospital on conditions which still restrict the patient's

16 *Re L, R v Bournewood Community and Mental Health NHS Trust, ex parte L* [1999] 1 AC 458

17 The Court gave judgement in the Case of *HL v United Kingdom*, App No 45509/99 on 5 October 2004. It found that, in contrast to the facts in *HM v Switzerland* [2002] MHLR 209, the applicant had been deprived of his liberty, that the lack of procedural safeguards meant that this was not lawful contrary

under article 5.1, and that there was no procedure meeting the requirements of article 5.4 available. Accordingly, the Mental Capacity Bill, currently before Parliament, does not permit patients without capacity to be deprived of their liberty under the codified doctrine of necessity; but it has not yet been decided what will take its place

18 Report on Mental Incapacity, 1995, Law Com No 231

liberty, by requiring her to live in another hospital or hostel, even under 24 hour surveillance and only allowed out under escort, may not amount to a 'deprivation of liberty' under Article 5.¹⁹ The difference is one of degree rather than kind, so Strasbourg has found that measures taken in the best interests of a patient or child are less likely to amount to a deprivation of liberty.²⁰ This means that the procedural protections of Article 5 may not apply if and when compulsory treatment in the community becomes possible.

The best procedural protection is that required under Article 5. Article 5(4) requires a speedy review of the lawfulness of detention: and this has to be a proper merits review which can lead to release. Article 6 requires a fair process in the determination of civil rights and liabilities: and even if the right to bodily self-determination is not fully protected under the Convention, it is undoubtedly a civil right in domestic law. But protection of civil rights has traditionally been individually initiated after the event: people can sue for monetary remedies if wrongly interfered with and occasionally obtain an injunction to prevent it in advance. The same now applies to past or threatened breaches of Convention rights. There is also a useful procedural component in Article 8, under which Strasbourg has developed the right to be involved in the decision-making processes before the authorities interfere with the right to respect for family life: there is no reason in principle why the same should not apply to interferences in private life.

We have already seen that the Convention may help to secure appropriate and humane conditions of treatment and care for people detained in institutions, although the Strasbourg institutions appear able to tolerate much that we would not.

(5) Underlying and overriding all of these is respect for the equal dignity and humanity of all people, however great their disorder or disability.

Human dignity as a distinct concept has recently begun to appear in constitutions and human rights instruments; an example is the Constitution of the Republic of South Africa 1996 (s 10):

“Everyone has inherent dignity and the right to have their dignity respected and promoted.”

The Strasbourg court emphasised in *Pretty v United Kingdom* (paragraph 65):

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

I would suggest that human dignity is all the more important for people whose freedom of action and choice is curtailed, whether by law or by circumstances such as disability. The Convention is a living instrument. The recent development of its ideas on gender reassignment, homosexuality and sentences of life imprisonment gives me hope that it can develop a more positive role in the field of mental health. We need to be able to use it to promote respect for the inherent dignity of all human beings but especially those who are most vulnerable to having that dignity ignored. In reality, the niceties and technicalities with which we have to be involved in the courts should be less important than the core values which underpin the whole Convention. If everyone in the mental health and community care services were imbued with and committed to those values, I am sure that it would do much more for my mental health, and that of everyone else, than any number of cases in the courts.

19 *R (Home Secretary) v Mental Health Review Tribunal, PH interested party* [2002] EWCA Civ 1868

20 *HM v Switzerland* [2002] MHLR 209 (admission of an elderly woman to a nursing home); applying *Nielsen v Denmark* (1988) 11 EHRR 175 (admission of a 12 year old boy to a psychiatric hospital)