PART III

ADMISSION TO HOSPITAL AND GUARDIANSHIP

Chapter 9

THE DEFINITION OF MENTAL DISORDER

A. STATUTORY DEFINITIONS

9.01 Mental Disorder

The provisions of the Mental Health Act have effect with respect to the reception, care and treatment of mentally disordered people, the management of their property and other related matters (s. 1(1)). The foundation upon which the Act is based is the statutory definition of mental disorder and the four specific categories of mental disorder. The provisions of the Act should not be used in respect of persons unless they are suffering from mental disorder; and, particularly, a compulsorily detained patient (even if subject to a restriction order) must be discharged once he is no longer suffering from mental disorder.[1]

"Mental disorder" is a generic term defined in section 1(2) as "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind". "Mental illness" (undefined) and "psychopathic disorder" are included as one of the four specific forms of mental disorder (see below). "Arrested or incomplete development of mind" can be taken to include most any kind of mental handicap or mental retardation. The definition of mental disorder is intentionally wide, particularly the phrase "any other disorder or disability of mind". Potentially it could encompass persons with a broad range of behaviour, emotion and intelligence. However, section 1(3) specifies that a person cannot be classified as mentally disordered solely by reason of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs. This does not preclude a person

[1] See *Kynaston v. Secretary of State for Home Affairs* (1981) 73 Cr. App. R. 281, C.A. Commented upon [1982] J S.W.L. 104 (M. J. Gunn). See also *X. v. the United Kingdom*, European Court of Human Rights, Nov. 5, 1981. But a restricted patient who is not mentally disordered need not be given an **absolute** discharge. See para. **18.13.1** *post*.

displaying any of these characteristics from being classified as mentally disordered; but it does mean that there must be other independent evidence and symptomology to justify the classification.

In *R. v. Mental Health Review Tribunal ex parte Clatworthy*,[1] the court made the assumption that, by virtue of section 1 (3), where the only evidence of mental disorder was sexual offending, the patient could not properly be dealt with as suffering from psychopathic disorder. It is, however, not clear whether the court was correct in assuming that the **behaviour** of committing sexual offences should be equated with the **passive condition** of sexual deviancy. Parliament may have had in mind precluding mere homosexuality from being used as evidence of mental disorder, but not violent behaviour manifested by sexual offences.

In *R. v. Mental Health Commission, ex parte W*[2] the court said that, where a mental disorder was quite distinct from sexual deviancy and the proposed treatment was solely for the purpose of sexual deviancy the treatment was not for mental disorder. In practice, however, it is likely that the sexual problem will be inextricably linked with the mental disorder so that treatment for the one was treatment for the other. See para. **20.19.1** *post*.

A classification of mental disorder is sufficient for many purposes under the Act—for example, for compulsory admission for assessment (s. 2 or 4) or to come within the jurisdiction of the Court of Protection (s. 94(2)). However, before a person can be compulsorily admitted to hospital under any of the longer term provisions of the Act (*e.g.* an admission for treatment (s. 3) or an order made under Part III) he must be classified as suffering from one of the four specific forms of mental disorder under the Act—mental illness, severe mental impairment, mental impairment or psychopathic disorder (see below). It is important to appreciate that these four forms of disorder, taken together, do not comprise all of the conditions which could be classified as mental disorder; mental disorder, as has been explained, is an umbrella term considerably wider in its ambit.

It is conceptually useful to divide the four specific forms of mental disorder into major and minor disorders because different legal consequences may ensue depending upon the classification adopted. Mental illness and severe mental impairment should be viewed as major forms of mental disorder, with mental impairment and psychopathic disorder as minor forms. Before a patient suffering from a minor disorder can be compulsorily admitted to hospital for treatment (s. 3) or under a hospital order (s. 37), he must be shown to be "treatable"; the treatability test (see para. **11.06.1** *post*), however, does not apply to those suffering from a major form of mental disorder. Indeed there are certain

[1] [1983] 3 All E.R. 699. See para. **18–24** *post*.
[2] *The Times*, May 27, 1988. D.C.

orders (*e.g.* remand to hospital for treatment (s. 36) or removal to hospital of unsentenced prisoners (s. 48) under Part III of the Act) which can be made only in respect of those suffering from one of the major forms of mental disorder. There follows a brief examination of each of the four specific forms of mental disorder.

9.02 Mental Illness

Mental illness is the classification used for the majority of patients detained in hospital. Yet, it is the only specific form of mental disorder which is not defined in the Act. The Butler Committee[1] and the DHSS[2] canvassed opinion on a "closed" definition of mental illness; but these were thought to be overly restrictive and were not adopted in the Act.[3]

The Percy Commission considered it preferable to use general terms without trying to describe medical conditions in detail.[4] This "lay view" of mental illness was supported by Lawton L.J. in *W. v. L.*[5]: mental illness are "ordinary words of the English language". They have no particular medical or legal significance. "Ordinary words of the English language should be construed in the way that ordinary sensible people would construe them". In this case the lay person would have said: "Well, the fellow is obviously mentally ill". Lord Justice Lawton's view must be unacceptable; mental illness was envisaged as a serious form of mental disorder and it could not be dependent upon any common person's misinformed view of behaviour which is perhaps only eccentric, non-conforming or anti-social.[6] In the absence of any statutory definition of mental illness much will depend upon medical opinion, which should be well founded upon behavioural evidence and adequate clinical assessment.

9.03 Severe Mental Impairment and Mental Impairment

Severe mental impairment is defined in section 1(2) as "a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct. . . ." The term **mental impairment** is defined in section 1(2) in precisely the same way, except that it encompasses "significant", as opposed to "severe", impairment of intelligence and social functioning. The difference

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[1] *Report of the Committee on Mentally Abnormal Offenders* (1975) Cmnd. 6244, HMSO, London, paras. 1.13, 18.35, Appendix 10.

[2] DHSS (1976) *A Review of the Mental Health Act 1959*, Appendix II.

[3] See, *Review of the Mental Health Act 1959* (1978) Cmnd. 7320, HMSO, London, paras. 1.16–1.17. Note that the term "mental illness" is defined for the first time in U.K. legislation in Article 3 of the Mental Health (Northern Ireland) Order 1985.

[4] *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* 1954–57 (1957), Cmnd. 169, HMSO, London, para. 357.

[5] [1974] Q.B. 711, 719, C.A.

[6] See B. Hoggett (1983) The Mental Health Act 1983, *Public Law*, p. 172 at p. 179.

between "severe" and "significant" is by no means clear, reflecting only a difference in emphasis. Despite the difficulty in distinguishing between the two conditions there can be real consequences of adopting one rather than the other; mental impairment, for example, is a minor disorder requiring a showing of treatability prior to compulsory admission for treatment, while severe mental impairment is a major disorder which has no such requirement.

The Code of Practice provides the following guidance on construing the definitions of mental impairment and severe mental impairment:

Impairment or arrested development of mind. The features that determine the mental handicap must have been present at a young age and permanently prevented the usual maturation of intellectual and social development. It excludes persons whose handicap derives from accident, injury or illness occurring after the point usually accepted as complete development.

Severe or significant impairment of intelligence. The judgement as to the presence of impairment of intelligence must be made on the basis of reliable and careful multidisciplinary assessment.

Severe or significant impairment of social functioning. The degree and nature of social competence should be based upon reliable evidence and recent observation from a number of sources such as social workers, nurses and psychologists. Evidence should include the results of social functioning tests.

Abnormally aggressive behaviour. The person's behaviour must demonstrate that he is outside the normal range of aggressive behaviour. The person's behaviour should have caused actual damage or real distress occurring recently, persistently, or with excessive severity.

Irresponsible conduct. The person's behaviour shows a lack of responsibility, a disregard of consequences, and causes actual damage or real distress occurring recently, persistently or with excessive severity. (Code of Practice, para. 28.5).

9.03.1 *Comparison with 1959 Act*

The term "subnormality", which was used in the Mental Health Act 1959, has been completely replaced by "mental impairment" in the 1983 Act. The difference between the two terms is of interest. First, "susceptibility to treatment" was part of the definition of subnormality in the 1959 Act. This concept is not in the **definition** of mental impairment; instead an explicit "treatability" requirement has been placed in the **criteria** for making an application for admission for treatment (s. 3) or a hospital order (s. 37). Second, a person cannot be classified as suffering from mental impairment unless there is an association with abnormally aggressive or seriously irresponsible conduct.

9.03.2 *Mental handicap still included in 1983 Act*

The contemporary history relating to the introduction of the term "mental impairment" into the legislation is instructive (see further para. **1.11.2** *ante*). In the Consultative Document[1] the DHSS canvassed opinion about totally removing mental handicap from the scope of the Act following strong representations made by MENCAP and MIND.[2] A compromise was reached in the House of Lords after this case was strenuously argued in Second Reading, notably by Lord Renton.[3] The compromise finally adopted was to replace subnormality with mental impairment, which would have the effect of limiting the exercise of longer-term powers "to those very few [mentally handicapped] people for whom detention in hospital is essential so that treatment can be provided and for whom detention in prison should be avoided".[4]

"Mental handicap" remains within the scope of the Act, because the general definition of mental disorder includes those who are suffering from "arrested or incomplete development of mind". The effect of the new terminology is that mentally handicapped people can no longer be subject to the longer-term provisions for compulsory admission (*e.g.* section 3 or an order under Part III of the Act) unless their conduct is associated with abnormally aggressive or seriously irresponsible conduct (see para. **9.05** below). However, mentally handicapped people will continue to be included within the Mental Health Act and other legislation so long as the statutory provision refers to the broad "umbrella" term, "mental disorder" and not a specific form of mental disorder. Mentally handicapped people can be compulsorily admitted for up to 28 days' assessment (s. 2) or for up to 72 hours for emergency assessment (s. 4); and they may be subject to the jurisdiction of the Court of Protection (s. 94(2)). Further, general health and social services legislation often gives an entitlement to services to people suffering from "mental disorder" (see paras. **4.06–4.08** *ante*). The wide definition of mental disorder insofar as eligibility for services is concerned is highly desirable, and a mentally handicapped person would clearly be so eligible.

9.03.3 *Derivation of "mental impairment"*

The term mental impairment derives from the World Health Organisation, which differentiates between three distinct and independent classifications, each relating to a different plane of experience consequent upon disease: impairments, disabilities and handicaps. Impairments are defined as any loss or abnormality of psychological,

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[1] DHSS, (1976) *A Review of the Mental Health Act 1959*, Appendix III.

[2] See Gostin (1978) The Right of a Mentally Handicapped Person to a Home, Education and to Socialisation: A Case for Exclusion from the Mental Health Act 1959, *Apex: J. Inst. for Mental Sub.* Vol. 6, p. 28.

[3] Renton (1 Dec. 1981) *H. L. Debs.*, vol. 425, cols. 970–74.

[4] Lord Elton, Under Secretary of State (19 Jan. 1982) *H. L. Debs.*, vol. 426, col. 533.

physiological or anatomical structure or function (in principle impairments represent disturbances at organ level).[1] While it has no listing for "mental impairment", the World Health Organisation does include the classification of "intellectual impairment", which includes mental retardation.[2] The use of the term "impairment" rather than "handicap" has the disadvantage that it suggests a physiological or organic disfunction, with a lack of emphasis on social and environmental factors; it also suggests the presence of an effectively unremediable condition. Careful examination shows that the definition of mental impairment in the Act constitutes an amalgamation of the previous definitions in the 1959 Act of subnormality and psychopathic disorder. As the definition of mental impairment suggests a rather static or unchangeable condition which has a connection with undesirable conduct, the term brings with it the danger of prejudice, alienation and rejection.

9.03.4 *Communication and assessment of mental handicap or impairment*

Persons should never be diagnosed as mentally handicapped or classified as mentally impaired or severely mentally impaired in the absence of a formal psychological assessment demonstrating significant retardation in intelligence and development. It is important that person(s) who know the patient and can effectively communicate with him are present during the assessment. The assessment should be part of a complete appraisal by medical, psychological, social work and nursing professionals experienced in the field of mental handicap.

9.04 Psychopathic Disorder

Psychopathic disorder means "a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct" (s. 1(2)). This definition is in many respects unhelpful for it does not specify the nature of the disorder or disability of mind other than the fact that it must be persistent. The word "persistent" denotes that the disorder must be a long standing one and not based upon an isolated offence or aggressive or irresponsible behaviour on one occasion only. The statutory definition can be distinguished from mental impairment in that psychopathic disorder must "result in" rather than be "associated with" aggressive or seriously irresponsible conduct. This suggests that the causal relationship between the condition and the conduct must be stronger in the case of psychopathic disorder.

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[1] World Health Organisation (1980) *International Classification of Impairments, Disabilities and Handicaps*, 13–14, 23–43, WHO, Geneva. (The WHO definition, of course, has no medical significance).

[2] *Ibid.*, pp. 53–54.

9.04.1 *Commentary*

The definition of psychopathic disorder is tautological in that it implies the existence of a disorder originating from anti-social behaviour, while purporting to explain the behaviour by the presence of the disorder. The disorder appears to be based almost entirely upon conduct which is indistinguishable from that of a wide range of repetitive offenders.

The Mental Health Act 1983 is one of the few mental health statutes which continues to employ the term psychopathic disorder; the classification is not used in the legislation in Scotland or Northern Ireland. More importantly, psychopathic disorder is not part of the World Health Organisation's International Classification of Diseases. The WHO has referred to the compulsory admission of psychopathic patients as one of "the most serious problems in the British mental health system".[1]

The concept of psychopathic disorder has been criticised on a number of grounds. There is disagreement as to whether it is a meaningful clinical entity which serves as a valid description of some underlying physiological or psychological disorder; whether the disorder can be reliably diagnosed; and whether persons suffering from the disorder can benefit from psychiatric treatment.[2] One study reviewing the medical literature observed that "psychopathy is a label which may be attached to a person for a variety of reasons, and that subsequently a large number of signs may be drawn upon to substantiate the application of the label".[3] The Butler Committee also referred to the potentially wide range of behaviour which could be included within the classification; they suggested that the mental health services were usually unable to provide any effective treatment for psychopathic disorder and that a prison sentence would often be preferable to confinement in hospital.[4]

9.04.2 *Proposals for Reform*

Pressure for reform of the Act relating to psychopathic disorder has come from diverse perspectives. Some argue that the definition of psychopathic disorder has not changed over the last two hundred years,[5]

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[1] W. Curran & T. Harding (1978) *The Law and Mental Health: Harmonizing Objectives*, WHO, Geneva.

[2] For a more detailed examination see Gostin (1984) Towards the Development of Principles for Governing the Admission to Hospital and Detention of Mentally Abnormal Offenders, in *Mentally Abnormal Offenders*, M. Craft, ed., Bailliere Tindall, London.

[3] W. Davies & P. Feldman (1981) The Diagnosis of Psychopathy by Forensic Specialists, *Brit. J. Psychiat.* vol. 138, p. 329.

[4] *Report of the Committee on Mentally Abnormal Offenders* (1975) Cmnd. 6244, chap. 5.

[5] Pinel, P. (1801) *Traite, Medico-Philosophique Sur L'Alienation Mental.* Richard, Caille, et Ravier, Paris (absence of any appreciable alteration in the intellectual functions, perceptions, judgments, imagination, and memory, but the presence of blind impulses to violence and a pronounced disorder of emotional functions).

and that it should be removed from the Act.[1] "The capacity to classify it, understand its aetiology, predict its course or to treat its victims has advanced correspondingly little."[2] Much of the conceptual confusion arising from the Act is attributable to the vagaries in the term "psychopathic disorder." Should the mental health system be used to detain persons in secure conditions whose doctors may not regard as mentally disordered or treatable as occurred in *R. v. Mersey Mental Health Review Tribunal ex parte Dillon*?[3] (See para. **18.13.1** *post*). Should an offender with a highly questionable diagnosis of mental disorder ever be preventively detained for a period disproportionate to the gravity of his offence, where this is unlawful for a "normal" offender?

On the other side are those who believe that the Act gives insufficient weight to public safety. A "psychopathic" patient can be discharged even though he is still considered a risk to the public. The period of his detention in hospital in some cases may be less than what he would have served in prison.

Professionals on both sides of this argument can come to the concordant view that, if the intention is to protect the public safety and not to treat a person for mental disorder, the prison system is preferable to the mental health system. This can also be fairer to the patient whose liberty is restricted according to the gravity of a proven act, rather than on an unscientific medical prediction of harm. Indeed, it is now almost axiomatic that psychiatrists (or any other professional group) cannot accurately predict future dangerous behaviour.[4]

The DHSS and Home Office issued a Consultative Document, *Offenders Suffering from Psychopathic Disorder* (August 1986), in which it reviewed proposals for reform of the law. Unfortunately, it did not consider the one logical alternative of removing psychopathic disorder from the Act. Rather, it recommended an amendment to section 37 of the Act, relating to hospital orders.[5] The favoured option was the replacement of section 37 (in so far as it relates to psychopathic disorder) by a new provision which would enable the court to sentence the offender to imprisonment and to direct that he be admitted to hospital from court. He would be treated as though he had been given a transfer direction (see para. **16.03** post).

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[1] See Gostin, L. (1977) *A Human Condition*. Vol. 2, MIND, London.

[2] Taylor, P. J. (Dec. 1986) Psychopaths and Their Treatment, *Journal of the Royal Society of Medicine*, Vol. 79, pp. 693–696. As to treatment approaches, see Whiteley, J. S. (1986) Sociotherapy and Psychotherapy in the Treatment of Personality Disorder: Discussion Paper, *Journal of the Royal Society of Medicine*, Vol. 79, pp. 721–724.

[3] (1987) *The Times* April 13, 1987.

[4] Monahan, J. (1981) *Predicting Violent Behavior: An Assessment of Clinical Techniques*, Beverly Hills, California, Sage.

[5] Removing the power of tribunals to discharge restricted patients would not be consistent with the United Kingdom's obligations under the European Convention of Human Rights (see para. **15.11** post).

9.05 Abnormally Aggressive or Seriously Irresponsible Conduct

The three forms of mental disorder actually defined in the Act are remarkably similar in their scope in that they all refer to "abnormally aggressive or seriously irresponsible conduct" and can also include "impairment of intelligence". There is no guidance as to what conduct is "abnormally aggressive" or "seriously irresponsible". The Act suggests only that the classification of severe mental impairment, mental impairment or psychopathic disorder must be based upon evidence of conduct which significantly deviates from social norms. It may be argued that the nature or degree of the behaviour required is, in part, a value judgment; further "irresponsibility" and "aggression" fall short of dangerousness. The Act appears to refer to current or future behaviour; a classification need not necessarily be based upon recent past behaviour, although that is probably the most reliable guide to future conduct. The Act therefore requires some kind of psychiatric prediction, which is frought with difficulties.[1]

9.06 Classification and Reclassification

Responsibility for classifying the patient as suffering from one of the four specific forms of mental disorder rests initially with those making an application and medical recommendations for compulsory admission for treatment. There is nothing to prevent a doctor from listing two different classifications such as mental illness and psychopathic disorder. But the patient must be described in each recommendation as suffering from at least one form of disorder in common (s. 11(6)). Once in hospital, there are provisions for re-classification of the patient by the responsible medical officer (s. 16) or by a Mental Health Review Tribunal (s. 72(5)) (see further paras. **11.06.6** and **18.11** *post*).

B. PSYCHIATRIC DIAGNOSES

9.07 Mental Illness

It is important to appreciate that the four forms of mental disorder specified in the Act are legal, not medical, terms. "Mental illness", for example, is a legal classification while a psychiatric diagnosis may refer to schizophrenia or depression. The World Health Organisation has classified mental disorders into psychoses, neurotic disorders and

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[1] P. Bowden (1985) Psychiatry and Dangerousness: A Counter Renaissance in L. Gostin, ed., *Secure Provision: A Review of Special Services for Mentally Ill and Mentally Handicapped People in England and Wales*, Tavistock, London.

personality disorders.[1] Psychoses are the clinical forms of mental disorder which most closely correspond with the statutory concept of mental illness. They are disorders in which impairment of mental function has developed to a degree that interferes grossly with insight, ability to meet ordinary demands of life or to maintain adequate contact with reality. The major forms of psychoses are:

(*i*) **organic psychotic conditions** such as senile dementia, alcoholic or drug psychoses which are characterised by impairment of orientation, memory, comprehension, calculation, learning capacity and judgment;

(*ii*) **schizophrenia** is a group of psychoses in which there is a fundamental disturbance of personality, distortion of thinking, a sense of being controlled, delusions, disturbed perception and abnormal affect—however, clear consciousness and intellectual capacity are usually maintained;

(*iii*) **affective psychoses**, such as manic-depressive psychoses, are usually recurrent conditions in which there is a severe disturbance of mood (mostly depression and anxiety but also elation and excitement) which is accompanied by delusions or disorder of perception and behaviour.

9.08 Mental Handicap

Mental handicap is a term used by professionals and successive Governments in England and Wales to describe a state of arrested or incomplete development of mind (usually manifested at birth or in the early years of life) which is normally associated with functional limitations such as in self-care, language, learning and independent living. The equivalent term used in North America and also by the World Health Organisation is mental retardation with the sub-classifications of mild, moderate, severe and profound.[2]

C. "UNSOUNDNESS OF MIND" UNDER THE EUROPEAN CONVENTION OF HUMAN RIGHTS

9.09 Article 5(1)

Article 5(1) of the European Convention of Human Rights provides that: "Everyone has the right to liberty and security of person. No one shall be deprived of liberty save in the following cases and in

[1] World Health Organisation (1978) *Mental Disorders: Glossary and Guide to their Classification in Accordance with the Ninth Revision of the International Classification of Diseases*, WHO, Geneva.

[2] *Ibid.*, p. 56.

accordance with a procedure prescribed by law." Sub-paragraph (*e*) lays down the case of the "lawful detention of a person of unsound mind". Article 5(1)(*e*) is relevant to the domestic law only to the extent that it places discernable limitations on the kind of mental disorder that can justify confinement under international standards.

9.09.1 *"In accordance with a procedure prescribed by law"*

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. There is also a more general requirement under the Convention to respect a fair and proper procedure—*i.e.* "that any measure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary."[1] The European Court of Human Rights has maintained the jurisdiction to examine whether a national authority has complied with the terms of its own legislation but the scope of review exercised by the court is extremely limited.

The European Court of Human Rights found a violation of Article 5(1) in *Van der Leer v. the Netherlands*[2] The judge had failed to hear from the patient or her representative, and gave no reason for doing so. The European Court viewed this confinement as "arbitrary" and a violation of Article 5(1).

9.09.2 *"Lawful detention of a person of unsound mind"*

The Convention does not state what is to be understood by the words "persons of unsound mind" and, because of the fluidity of the term's usage, the Court has determined that 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."[3]

The "lawful detention" of persons of unsound mind under the Convention requires the observance of three minimal conditions: except in emergency cases, the individual must reliably be shown to be of unsound mind on the basis of objective medical expertise; the mental disorder must be of a kind or degree warranting compulsory confine-

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[1] *Winterwerp v. the Netherlands*, Judgment of the European Court of Human Rights, October 24, 1979, para. 37, 2 E.H.R.R. 387.
[2] Judgment given February 21, 1990, *The Times*, March 2, 1990.
[3] *Ibid.*

ment; and the validity of continued confinement depends upon the persistence of such a disorder.[1]

The expression "lawful detention of a person of unsound mind" refers to deprivation of, and not mere restrictions upon, liberty. The distinction is one of degree or intensity, and not one of nature or substance. There are important differences between the regime in a special hospital and a local hospital. Nonetheless, they are both forms of detention. Thus, a special hospital patient who was prevented from being transferred to a local hospital would have no right to argue that he was being unlawfully detained, as both regimes involve a form of detention.[2]

In principal, the "detention" of a person of unsound mind will only be "lawful" if effected in a hospital, clinic or other appropriate institution. However, subject to this requirement, Article 5(1)(*e*) is not concerned with the environment, suitable treatment or conditions of detention.[3] (See further para. **20.29** *post*).

9.09.3 *Right to receive reasons for deprivation of liberty*

Article 5(2) of the Convention provides that "Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest or of any charge against him." This provision extends beyond the realm of criminal law, to any detention under mental health law.[4]

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 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.

9.09.4 *The right to a hearing*

Article 5(4) of the European Convention on Human Rights provides 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."

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[1] *Ibid.*, para. 39; *Ashingdane v. the United Kingdom*, Judgment of the European Court of Human Rights, May 28, 1985, para. 37, 7 E.H.R.R. 528. See also L. Gostin (1982) Human Rights, Judicial Review and the Mentally Disordered Offender, *Crim. L. Rev.* 779.

[2] *Ashingdane v the United Kingdom*, *op. cit.*, para. 43.

[3] *Ibid.*, para. 44.

[4] *X. v. United Kingdom*, Judgment of the European Court of Human Rights given Nov. 5, 1981; *Van der Leer v. the Netherlands*, Judgement of the European Court of Human Rights given Feb. 21, 1990. See further para **15.16.3** *post*.

The European Court of Human Rights has held on several occasions that Article 5(4) applies to persons detained under mental health law.[1] Article 5(4) encompasses several elements. First, the hearing must be by a court. The court need not be of the classic kind, integrated in the judicial machinery of the country. Rather, it requires a judicial character which affords minimum procedural guarantees and fundamental fairness. It must be independent of the executive and of the parties to the case and have the power to make a binding decision (see further para **15.11** *post*). If the judicial body fails to ensure one of the fundamental procedural guarantees in the field of deprivation of liberty, such as giving the person a right to be heard, then Article 5(4) is violated.[2]

Second, since mental illness is subject to amelioration and cure, a person detained as of "unsound mind" must have the right to periodic review of the lawfulness of detention.

Third, the proceedings must be instituted "speedily." The European Court has not indicated what it regards as "speedily" in the mental health context, and any determination is likely to depend on the facts of the case. In *Van der Leer v. The Netherlands*[3] the European Court held that mental health proceedings that lasted five months were "excessive." Because of the other violations of her human rights, there were particularly "compelling reasons for avoiding any dilatoriness." In the absence of any grounds justifying the delay, the Court found a violation of Article 5(4). See further para **18.23.1**.

Finally, the review of lawfulness of the detention goes beyond conformity with domestic law. The judicial body must review the merits of the case to see if adequate medical, behavioural, and social evidence exists to justify the detention. See para. **15.11** *post*.

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[1] *Van der Leer v. the Netherlands*, Judgement given Feb. 21, 1990; *X. v. the United Kingdom* (1981) 4 E.H.R.R. 188; *Winterwerp v. the Netherlands* (1979) 2 E.H.R.R. 387.

[2] *Van der Leer v. the Netherlands*, *The Times*, March 2, 1990.

[3] *The Times*, March 2, 1990.