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Declaration of interest

None.

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Medical treatment under Part IV of the Mental Health Act 1983 and the Human Rights Act 1998: review of Article 3 and 8 case law

SUMMARY
Since the introduction of the Human Rights Act 1998, all courts and tribunals are obliged to interpret all laws and statute consistently and compatibly with the Human Rights Act. This includes the Mental Health Act 1983 (and the 2007 amendments) and mental health review tribunals. Mental health case law has evolved with regard to medical treatment under Part IV (Consent to Treatment) of the Mental Health Act being compliant with the Human Rights Act. Review and analysis of such case law can aide everyday clinical decision-making as well as improving knowledge of the Human Rights Act.

The Human Rights Act 1998 (Office of Public Sector Information, 1998) incorporates most of the European Convention on Human Rights into domestic law and sets out fundamental rights that all people are entitled to enjoy. Since the Human Rights Act came into force, all courts (including mental health review tribunals) must now ensure that domestic law is fully compliant with the Human Rights Act. This includes the Mental Health Act 1983 (Mental Health Act) (Jones, 2006).

The important judgment in *Herczegfalvy v. Austria* [1992] observed 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'. Human Rights Act jurisprudence has emerged with regard to individuals receiving treatment under the Mental Health Act. This article analyses important mental health law cases which have concentrated on treatment under the Mental Health Act and in particular relying on Articles 3 and 8 of the Human Rights Act.

Article 3

Article 3 is an absolute convention right and states that 'no one shall be subjected to torture or to inhuman or degrading treatment or punishment'.

In the psychiatric setting, this Article is likely to be relevant to complaints arising from treatment and conditions of detention. Treatment can be construed as inhuman if it causes intense physical or mental suffering in the victim; and degrading if the object is to humiliate and debase the person which could adversely affect their personality. It may be found as degrading if it involves treatment which arouses feelings of fear, anguish, inferiority and that shows lack of respect for or diminishes their dignity (*Pretty v. UK* [2002]).

To violate Article 3, case law has concluded that 'ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3'. Furthermore, the 'assessment of this minimum is, in the nature of things, relative; it depends on the circumstances of the case, such as the duration of the treatment, its physical or

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mental effects and, in some cases, the sex, age and state of health of the victim, etc' (*Ireland v. UK* [1978]).

The Article 3 benchmark case remains *Herczegfalvy*, which makes it clear that incapacitated patients are still protected by Article 3.

> 'While it is necessary 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 . . . such patients nevertheless remain under the protection of Article 3'.

This judgment also demonstrated a core principle in Article 3 cases when it concluded 'as a general rule, a measure which is a therapeutically necessity cannot be regarded as inhuman or degrading' and the Court must satisfy itself that such medical necessity has been 'convincingly shown' to exist.

Article 8

Article 8 is a qualified right and provides that:

(1) Everyone has the right to respect for his private and family life, his home and his correspondence.

(2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Court judgments will initially ascertain whether Article 8(1) is engaged, i.e. does the infringement in question pertain to private and family life, home and correspondence, and then, if it does, paragraph 2 which sets out the exceptions (to be interpreted 'narrowly' (*Funke v. France* [1993]) in which interference with the right may be permitted, will then be analysed. Under Article 8(2), before interference with the right is permitted, it must (a) be 'in accordance with the law'; (b) it must be 'necessary in a democratic society'; and (c) it must be in pursuit of one of the specified objectives. There will be a breach of this Article unless the State establishes that the criteria set out in 8(2) are met, i.e. interference must be justified by one of the exceptions and must be the minimum necessary to obtain the legitimate aims. The key principles of proportionality and margin of appreciation (Appendix 1) underpin the application of Article 8.

Review of case law relying on both Article 3 and 8 of the Human Rights Act

The following cases have alleged violation of both Articles 3 and 8 in relation to psychiatric treatment under the auspices of the Mental Health Act. The main outcomes and principles of the judgments are outlined and issues for clinical practice elucidated.

R (on the application of Wilkinson) v. (1) The RMO Broadmoor Hospital (2) The Mental Health Act Commission Second Opinion Appointed Doctor & Secretary of State for Health (interested party) [2001]

In this case, the Court found that treatment of a protesting patient under the Mental Health Act is a potential invasion of his rights under Articles 3 and 8. Furthermore, the Court must reach its own view on whether treatment was lawful and in doing so cross-examination of doctors in judicial review hearings must be permitted (e.g. where there was considerable dispute among the medical witnesses that could not be resolved from written statements alone).

The applicant was a 69-year-old patient who had been detained at Broadmoor Hospital for the best part of 34 years. He was classified as suffering from psychopathic disorder. He was convicted in 1967 of the rape of a young girl and made subject to hospital and restriction orders ss.37 and 41 of the Mental Health Act (initially under ss.60 and 65 of the Mental Health Act 1959). In 1999 his responsible medical officer (RMO) considered the applicant needed to be treated with antipsychotic medication to which the applicant was 'vigorously opposed' and he made it plain that he would physically resist it. The crux of the case centred upon whether such treatment fell within s.58 of the Mental Health Act – being the administration of medication more than 3 months after the patient was first medicated following detention. Because the applicant did not consent to the treatment, the treatment plan had to be certified as appropriate under s.58(3)(b) by a second opinion apppointed doctor (SOAD) which happened following a SOAD assessment. The applicant was forcibly injected with antipsychotic drugs and on each occasion fought as he had said he would and had to be physically restrained. Because further such treatments were imminent, the applicant consulted his solicitors whereupon he obtained permission to apply for judicial review of the treatment decisions already taken by the RMO and SOAD and for an injunction prohibiting any further such treatment until the hearing of the substantive challenge. His solicitors also obtained an independent psychiatric report expressing very different views from the RMO and SOAD on all the important medical issues in the case, notably:

1. the nature of the appellant's mental disorder;
2. whether or not he is incapacitated;
3. whether the proposed treatment would benefit the appellant's condition and be justified even with his consent;
4. whether such treatment is justified if it has to be given under restraint.

The judgment included observations on the possible applicability of various Articles of the Human Rights Act to issues of compulsory treatment under the Mental Health Act (multiple violations under the Human Rights Act can be claimed within one case). In particular, the judgment noted that given the case 'raised fundamental

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human rights questions', the role of the Courts should be to undertake a 'full merits review' of the appropriateness of the treatment, including cross-examination of the specialists involved. With regard to this it was noted that in making such decisions, courts would pay 'very particular attention' to the views of the RMO in charge of the patient's care and that 'courts will not be astute to overrule a treatment plan decided upon by the RMO and certified by a SOAD following consultation with two other persons'.

This case was also important for it reaffirmed the primary role of the SOAD: a SOAD must come to their own view as to whether the proposed treatment was in the best interests of the patient – 'while, of course, it is proper for the SOAD to pay regard to the views of the RMO who has, after all, the most intimate knowledge of the patient's case, that does not relieve him of the responsibility of forming his own independent judgment as to whether or not the treatment should be given . . .'.

Clear guidance was given with specific regard to Articles 3 and 8 in that '. . . the decision to impose treatment without consent upon a protesting patient is a potential invasion of his rights under Article 3 or Article 8' and that 'one can at least conclude from this . . . that forcible measures inflicted upon an incapacitated patient which are not a medical necessity may indeed be inhuman or degrading. The same must apply to forcible measures inflicted upon a capacitated patient'. Justice Hale further opined that she 'did not take the view that detained patients who have the capacity to decide for themselves can never be treated against their will'. The issue was whether under the Mental Health Act 'medical necessity', meaning substantial benefit for the patient, could be demonstrated.

R (JB) v. Haddock and others [2006]

This recent case further elucidated the issue of cross-examination of witnesses. In particular, it drew upon the approach in *Wilkinson* when it stated 'A Court had to conduct a full merits review as to whether the proposed treatment infringed the patient's human rights and, to that end, a patient was entitled to require the attendance of witnesses to give evidence and to be cross-examined. However, the Court in *Wilkinson* could not have intended or contemplated that every case would require the hearing and testing of oral medical evidence, especially where . . . none of the parties requested it'.

R (on the application of PS) v. (1) Responsible Medical Officer (Dr G) (2) Second Opinion Appointed Doctor (Dr W) [2003]

The High Court held that treatment of a capacitous patient against his will with antipsychotic drugs did not breach his rights under Articles 3 or 8 and did not even reach the minimum level of severity necessary to engage Article 3. The applicant was detained under s.37 Mental Health Act and subject to a restriction order under s.41 upon his conviction, on a plea of diminished responsibility, for the manslaughter of his mother and of his son.

On Article 3 it was held that there were two 'sub-issues' to be decided: first, whether the Article was engaged at all, and second, if so, whether the proposed treatment could be justified on medical grounds. It cited earlier jurisprudence such as *Herczegfalvy* that had assumed that Article 3 was engaged and focused on whether the medical necessity for the treatment could convincingly be shown to exist, on the basis that 'as a general rule, a method which is a therapeutic necessity cannot be regarded as inhuman or degrading'. In this case, however, the judge held that it was necessary first to determine whether the proposed treatment even reached the minimum level of severity necessary to engage Article 3, distinguishing *Herczegfalvy* on three grounds: that *Herczegfalvy* did not have capacity; that the treatment proposed in his case was infinitely more intrusive than that in the case of PS; and that the necessity for treatment in *Herczegfalvy's* case was not disputed since he was starving himself to death.

The judge concluded that the minimum level of severity required to engage Article 3 was not reached in this case, rejecting the argument that a 'capacitated refusal' of treatment was in itself sufficient to override other factors. Having come to the conclusion that Article 3 was not engaged, the judge did not need to decide whether or not the treatment had convincingly been shown to be a medical necessity. However, he chose to do so and concluded that this test, too, was met in PS's case. In particular, he held that although the patient's capacitated refusal was a very important factor, so too were the views of the doctors as to the patient's best interests.

On Article 8 the judge was prepared to assume (without deciding the issue) that PS's Article 8(1) rights would be breached by treatment against his will. The issue to be decided was therefore whether that treatment could be justified under Article 8(2): whether the treatment was in accordance with the law, in pursuit of a legitimate aim (the protection of health) and necessary in a democratic society. The test of 'necessity' was whether the proposed action corresponded to a pressing social need, was a proportionate measure and whether sufficient reasons for it had been given. The judge concluded that these tests had been met, considering not only the provisions in the Mental Health Act which permit compulsory treatment, but also the common-law doctrine of best interests. In light of this important case, the Mental Health Act Commission (2004) provided specific guidance for RMOs.

Grare v. France [1992]

This case also held that the imposition of antipsychotic drugs, resulting in unpleasant side-effects did not breach Articles 3 or 8. The minimum level of severity for Article 3 was not reached; and even if the medical treatment in question and the applicant's lack of choice of therapist breached Article 8(1), this could be justified under Article 8(2) because of the need to maintain public order and to protect the applicant's own health.

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R (B) v. Dr SS and others [2005]

This case involved a detained patient at Broadmoor Hospital and similarly sought to use Articles 3 and 8 to prevent treatment being given against his will and again relied heavily on the *Wilkinson* approach. The judge noted that for Article 3 to be relevant to compulsory treatment for mental disorder, it must first be established that the suffering caused by that treatment risks reaching a minimum threshold of severity. He made a further important comment in that a patient's capacity is only one factor to take into account and is not a 'super-relevant factor'. The judge similarly found no breach under Article 8.

R (on the application of B) v. Ashworth Hospital Authority [2005]

The judgment in this House of Lords case suggested patients detained under the Mental Health Act may be compulsorily treated for any mental disorder, not just the disorder from which they are formally classified as suffering when detained.

This case centred on the use of s.63 – treatment not requiring consent (for a review of s.63 and Human Rights Act implications see Curtice, 2002) – in a patient who was detained under s.37/41 Mental Health Act following a conviction for manslaughter. At the time of his offence he was floridly psychotic and on admission to Ashworth Hospital the diagnosis was paranoid psychosis, a mental illness, but the psychiatrist also noted features of personality disorder in a setting of limited intellectual ability. He returned to a medium secure unit between 1992 and 1994. When he was readmitted to Ashworth he was then considered to be demonstrating features of a hypomanic illness and recommenced oral and depot antipsychotic medication. His condition became more stable on antipsychotic medicine and in 1999 a mental health review tribunal recommended that he be transferred to less secure conditions.

During 2000, he was given personality tests on which he scored 'very high' for psychopathic disorder, but his classified form of disorder remained mental illness alone. He was later transferred to a ward where the therapeutic milieu was particularly designed to address the traits of personality disorder. This was different in a number of respects from the regime of wards designed to treat mental illnesses. The precise extent of those differences is not agreed, but some aspects of the new regime were less agreeable to the patient than the regime which he had previously enjoyed. The patient also saw the further therapeutic work which might be expected of him there as placing new obstacles in the way of his transfer to a less secure hospital.

The judgment commented on the common problem in some patients of comorbidity when it stated that '. . . psychiatry is not an exact science. Diagnosis is not easy or clear cut. As this and many other cases show, a number of different diagnoses may be reached by the same or different clinicians over the years' and that 'It is not easy to disentangle which features of the patient's presentation stem from a disease of the mind and which stem from his underlying personality traits. The psychiatrist's aim should be to treat the whole patient'.

The judgment concluded 'that the words of section 63 mean what they say. They authorise a patient to be treated for any mental disorder from which he is suffering, irrespective of whether this falls within the form of disorder from which he is classified as suffering in the application, order or direction justifying his detention'.

On Articles 3 and 8, the judgment held that, following the case of *Herczegfalvy*, treatment which is a 'medical necessity' will not breach the right to freedom from inhuman treatment and the respect of private life protected by these Articles. It further concluded that if there were a risk that treatment given compulsorily to a detained patient were not a 'medical necessity', restricting treatment to the classified disorder would not be a protection. It advised that 'much better protection is given by the specific safeguards in s.57 and s.58; by the ordinary law of negligence, which protects the patient against medical treatment which is not considered appropriate by a respectable body of medical opinion; and by the Human Rights Act which gives the patient remedies against treatment which does not comply with his Convention rights'.

Clinical implications

These cases demonstrate the important interaction between the Mental Health Act and Human Rights Act that should now be considered in all mental health cases. Such principles will continue to have to be considered and implemented under the Mental Health Act 2007 Amendments (Office of Public Sector Information, 2007). These cases also illustrate important Human Rights Act concepts that underpin everyday clinical decision-making processes in the treatment of patients (Appendices 1 and 2).

In particular, they demonstrate how the current Mental Health Act is compliant with the Human Rights Act especially for issues of treatment of the incapacitated patient. Such Human Rights Act principles, of course, should equally be applied to informal patients. The importance of assessing the capacity to consent to treatment has been further enhanced with the advent of new statute embodied in the Mental Capacity Act 2005 (Office of Public Sector Information, 2005). Again, the Human Rights Act will need to be considered in Mental Capacity Act 2005 cases.

Declaration of interest

None.

Appendix 1

Article 8 – principles for clinical practice

- Main aim of Article 8 – to protect the individual against arbitrary interference by the public authorities but in doing so to strike a fair balance between the interests of the individual and the interest of the community as a whole.
- Article 8 engagement – the Court will first assess whether paragraph 1 applies and if it does Article 8 will

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be engaged and then the paragraph 2 components will be analysed to assess if the Article has been violated.

- Article 8(2) violations – there will be a violation unless the three criteria are met: the interference must be (a) in accordance with the law, (b) necessary in a democratic society and (c) in pursuit of one of the specified objectives. The onus is on the State to establish these are met otherwise there will be a breach.
- In accordance with the law – this is a three-pronged notion: (a) there must be a specific legal rule or regime which authorises the interference; (b) the citizen must have adequate access to the law in question; and (c) the law must be formulated with sufficient precision to enable the citizen to foresee the circumstances in which the law would or might be applied.
- Necessary in a democratic society – this is a two-pronged notion and implies: (a) that an interference corresponds to a pressing social need; and (b) that it is proportionate to the legitimate aim pursued.
- Article 8 specified objectives – these are national security, public safety, economic well-being of the country, prevention of disorder or crime, protection of health or morals and the protection of the rights and freedoms of others. These exceptions will be interpreted narrowly.
- Margin of appreciation – domestic states have different accepted clinical practices and standards; hence the margin of appreciation is accepted as being very wide to reflect this. Therefore, clinical decisions that are proportional, therapeutically necessary and in keeping with accepted clinical practice are very unlikely to be outside this margin.
- Proportionality – clinical intervention needs to balance the severity of the effect of the intervention with the severity of the presenting clinical problem, i.e. be a proportionate response to a clinical scenario.
- Proportionality 'test' – (a) what is the 'interest' that is relied upon (i.e. private and family life, home and correspondence); (b) does the interest correspond to a pressing social need; (c) is the interference proportionate to the interest; and (d) are the reasons given by the authorities relevant and sufficient?
- Private life – this concept covers the right to develop one's own personality and to create relationships with others. It contains both positive and negative aspects.
- Positive obligations – the State has an obligation to provide for an effective respect for private life.
- Negative obligations – the State should refrain from interference with a private life.

Appendix 2

Article 3 – principles for clinical practice

- Torture – the wilful (criminal) infliction of severe physical or mental pain as a punishment or a forcible means of persuasion.
- Degrading treatment – assess whether the object is to humiliate and debase the person which could adversely affect his/her personality. It may be degrading if it involves treatment which arouses feelings of fear, anguish, inferiority and which shows lack of respect for or diminishes his/her dignity.
- Inhuman treatment – treatment could be construed as inhuman if it causes intense physical or mental suffering in the victim.
- Threshold of severity to engage Article 3 – ill treatment must attain a minimum level of severity; assessment of this minimum is relative. All circumstances of the case need to be considered.
- Level of suffering – inhuman or degrading treatment must go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment.
- Capacity – patients with and without capacity remain under the protection of Article 3. Current jurisprudence suggests capacity is not crucial when making decisions which may engage Article 3 as long as medical necessity is convincingly demonstrated.
- Therapeutic necessity – a treatment or intervention that is convincingly shown to be a therapeutic or medical necessity in general will not be regarded as inhuman or degrading.
- Medical care – authorities are obliged to provide adequate and requisite medical care. A delay in providing care may engage and breach Article 3. Good documentation in medical notes is vital both clinically and legally.

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