

Human Rights Act 1998 and mental health legislation: implications for the management of mentally ill patients

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In the management of mentally ill patients, there is a tension between protecting the rights of individual patients and safeguarding public safety. The Human Rights Act 1998 emphasises on the former while two recent white papers focus on the latter.

This article first examines the extent to which the Mental Health Act 1983 is consistent with the Human Rights Act. It argues that while the recent white papers exploit the gaps in the judgments given by the European courts, its compatibility with human rights is very doubtful. The practical implications of the Human Rights Act for doctors are discussed.

This paper briefly explains why doctors should know about the Human Rights Act 1998, examines the extent to which Mental Health Act 1983 is consistent with Human Rights Act, how the white paper apparently succeeds to resolve the two forces and the overall implications to doctors, particularly psychiatrists.

RELEVANCE OF HUMAN RIGHTS ACT 1998 TO DOCTORS MANAGING MENTALLY ILL PATIENTS

The UK played a major part in drafting the European Convention for the Protection of Human Rights and was one of the first countries to sign it in 1950. However, these rights have never been part of the UK legal system. The Human Rights Act 1998 incorporates most of the European Convention of Human Rights into UK law and brings several fundamental changes for mental health patients.¹ First, patients who allege that their human rights have been infringed may claim damages or other remedies more speedily via UK courts. Second, the courts must interpret the mental health acts, as far as is possible, in a way compatible with the Convention rights (Human Rights Act section 3). Third, and more importantly, it is unlawful for any public authorities (that is, including trusts, general practices, and health authorities) or any person carrying out functions of a public nature (that is, including hospital managers and psychiatrists) to act in a way incompatible with the Convention rights. Under section 8 of the Act, any victims of such unlawful acts of public authorities may bring proceedings against them. If the court finds that the acts were indeed unlawful, it may give orders or remedies (for example, injunctions) as it considers just and appropriate. The court may also award damages against the public authorities if this is necessary to afford just satisfaction to the victim, taking into account all the circumstances of the case.

Since the nature of mental illness often renders it necessary for psychiatrists to detain and treat patients against their will, Human Rights Act 1998 is inevitably more relevant to psychiatrists than doctors in any other specialties. Specific articles in the Human Rights Act especially relevant to the care for mental health patients are set out in box 1.

TO WHAT EXTENT DOES MENTAL HEALTH ACT 1983 FULFIL THE CONVENTION RIGHTS?

With minor exceptions, the Mental Health Act 1983⁴ fulfils the Convention rights. The most important European judgment on mental health

In drafting mental health laws, there are constant tensions in balancing the individual rights of the patients and protection of the public. On the one hand, well publicised homicides committed by patients with mental illness in recent years have placed considerable public and political pressure on the government to reform the Mental Health Act in favour of public protection. There has been considerable pressure to develop effective strategies to manage those suffering from untreatable personality disorders who are considered dangerous. On the other hand, the Human Rights Act 1998 came into force on 2 October 2000.¹ This Act emphasises on the rights of individual patients.

In spite of these two apparently irreconcilable forces, the Department of Health (2000) claimed that the proposals for radical changes in the white paper *Reforming the Mental Health Act*, parts 1 and 2, protect the rights of both the public and individuals.^{2,3} The background of this white paper, which amounts to the biggest shake up in mental health legislation in four decades since the 1950s, is as follows. The current 1983 Mental Health Act is largely based on a review of mental health legislation which took place in the 1950s.⁴ Since then the way services are provided has dramatically changed. For example, the majority of patients today are now treated in the community. However, under existing mental health laws, the only powers compulsorily to treat patients are if they are in hospital. As a result, severely ill patients have often been allowed to drift out of contact with mental health services. Occasionally, such patients commit homicides and suicides. The white paper proposals attempted to remedy these problems as part of the government's strategy to improve the way that services respond to people with mental illness and other mental disorders.

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Box 1: Articles in the Human Rights Act of particular relevance to mental health care**Article 3**

Prohibition of inhuman and degrading treatment.

Article 5

Right to liberty and security.

5(1) No one shall be deprived of his liberty save . . . (e) the lawful detention . . . of persons of unsound mind . . .

5(2) Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest . . .

5(4) Everyone who is deprived of his liberty . . . 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.

Article 8

Right to respect for private and family life.

law is *Winterwerp v Netherlands* (1979).³ It ruled that, except in an emergency, the detention of a person of unsound mind will be lawful only if:

- The person detained is reliably shown to be of unsound mind (that is, by objective medical experts).
- The relevant mental disorder is of a kind or degree warranting compulsory confinement, *and*
- There is a persistence of such a disorder to justify continuing detention.

Broadly speaking, the Mental Health Act 1983 requires two psychiatric recommendations for detention for more than 72 hours, and one psychiatric recommendation for up to 72 hours. Furthermore, there were clear regulations regarding the rights of patients to appeal to mental health review tribunals. Hence, the 1983 Act broadly fulfils these criteria.

Among cases heard by the European Commission, there was only one possible infringement of the 1983 Act with Convention rights. In *JT v UK* (1997), a patient who had been detained under section 3 of the 1983 Act had a difficult relationship with her mother, her nearest relative as rigidly defined in the 1983 Act.⁶ She was concerned that her confidential information would be divulged to her mother should she be compulsorily admitted again. She complained that as the 1983 Act did not allow her to change her nearest relative, it infringed on her human rights under article 8 (right to respect for private and family life). In 1998, the Commission unanimously concluded that there had been a violation of article 8, and the government achieved a friendly settlement in 1999. Besides compensation, the government agreed that the relevant legislation would be amended to provide the detainee with the power to make an application to court to have the “nearest relative” replaced where the patient reasonably objected to a certain person acting in that capacity. It was also to provide for the exclusion of certain persons from acting as “nearest relative”.

HOW DOES THE WHITE PAPER ATTEMPT TO FULFIL THE PUBLIC PROTECTION FUNCTION WHILE COMPLYING WITH THE CONVENTION RIGHTS?

Protecting the public

There are several features in the recent white paper which aim to fulfil public protection functions. First, the definition of mental disorders is greatly broadened to include “*any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning*”. It is no longer necessary to categorise the patient into any clinical types. It is clear that such a definition is sufficiently broad to include conditions ranging from the most serious psychiatric

Box 2: Criteria for care and treatment order under the proposed reformed Mental Health Act

1. The patient must be diagnosed as suffering from a mental disorder.
2. The mental disorder must be of such a nature or degree as to warrant specialist care and treatment.
3. A plan of care and treatment must be available to address the mental disorder:
 - If the order is primarily for the patient’s own interests, the plan must be expected to be of direct therapeutic benefit to the patient.
 - If the order is primarily to protect others from risks, the plan must be considered necessary directly to treat the underlying mental disorder and/or to manage behaviours arising from the disorder.

disorders (for example, schizophrenia) to personality disorders and intoxication by drink and drugs which might be regarded by some as “social problems”.

However, this broad definition of mental disorders does not appear to contradict directly with the Convention rights. Indeed, in *Winterwerp v Netherlands* (1979), the European Court gave no definitions of mental disorders and indeed noted that the definitions could change with time and advances in psychiatric management.⁵

Second, different treatability criteria for care and treatment order are applied for those primarily for the patient’s own interests and those to protect others from risks (see box 2). For orders primarily for the protection of others, the plan could be solely for managing behaviours arising from the disorders without any benefits to the detained patient. Surprisingly, this does not directly contravene Convention rights under judgments delivered by the European Commission or the European Court so far. Indeed, it was held in *Ashingdane v UK* (1985) that article 5(1e) does not require treatment to be given in any way (or at all) during detention.⁷ In *Ashingdane v UK* (1985),⁷ the mental state of a paranoid schizophrenia patient detained in secure accommodation had improved and psychiatrists agreed that he should be transferred to the local hospital. This was prevented by industrial action taken by the nursing trade union, which opposed admitting any offender patients into the local hospital. The European Court ruled that while article 5(1e) prohibits arbitrary detention and requires some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention, it is not in principle concerned with suitable treatment or conditions.

However, there is no doubt that the new criteria in the white paper will be tested in the European Court.

Thirdly, and most controversially, there are provisional proposals for managing dangerous people with severe personality disorders, who have not committed an offence and who do not benefit from treatment. This proposal makes use of the different criteria for treatment and care order applied to those primarily for the protection of others, as discussed above.

Finally, after the tragedy when Jonathan Zito was killed by a former patient,⁸ the government considered compulsory community treatment important. Under the white paper,² both formal assessment and treatment and care order may take place in the community. Many might think that patients who are not ill enough to be in hospital should not be assessed or treated compulsorily, and consider this proposal to infringe on patients’ rights. However, the European Commission ruled in *W v Sweden* (1988) that an order to accept psychiatric medication as an outpatient as a condition of discharge from hospital as “*not so severe that . . . could be characterised as a deprivation of liberty*”.⁹ Hence, this proposal on its own does not appear to contravene the Convention rights.

An attempt to comply with the Human Rights Act

There are other measures in the proposed reformed mental health act designed to ensure that the Human Rights Act is complied with. First, the rigid definition of nearest relative is removed. Instead, the patient may identify a “nominated person” in an advance agreement. This fulfilled the government’s agreement in its friendly settlement with the complainant in *JT v UK* (1997) as discussed above.⁶ Second, the new tribunals will have a legally qualified chair, and the time for which a patient has to wait for a tribunal hearing is carefully defined.

Is the proposed reformed Mental Health Act really compatible with the Human Rights Act?

It would seem that the proposed new Mental Health Act attempts to resolve the public pressure to protect the public and the impact of the Human Rights Act by exploiting the gaps in the judgments given by the European Commission and European Court so far. However, the combination of several factors—the very broad definition of mental disorder, the different criteria for treatment and care order applied to those for the protection of the public, and the introduction of care and treatment order in the community—means that the liberty of individuals may be curtailed to an extent far greater than cases which have previously come before the European Court so far. For example, people with personality disorders might be liable to be detained indefinitely if they are deemed to be “a risk to the public”, even though they have not been convicted of any offences and that they might not benefit from such detention. Clearly, this goes against the basic principles and spirit of article 5 that no one shall be deprived of his liberty. The civil liberties of patients with chronic mental illnesses might be restricted over a considerable period of time, even if their conditions are stable. In other words, their liberty will be restricted, although they are not really “of unsound mind” at the time. It is doubtful that after taking all factors into account, the European Court will still rule the Mental Health Act compatible with Convention rights.

PRACTICAL IMPLICATIONS OF THE HUMAN RIGHTS ACT FOR DOCTORS (PARTICULARLY PSYCHIATRISTS)

It is unlawful for public authorities (including NHS trusts and psychiatrists) to act in a way incompatible with the Convention rights (Human Rights Act section 6(1)). However, under section 6(2a), they have a defence if they could not have acted differently due to a primary legislation (for example, if the proposed reformed mental health act comes into force). Under these circumstances, the court could declare that the proposed reformed Mental Health Act incompatible with Convention rights.

Potential practical dilemmas relating to the white paper proposals

The power to impose compulsory treatment in the white paper proposal brings much greater responsibility for doctors. When these proposals come into force, doctors face several practical dilemmas. First, doctors may be called upon to manage patients with “social problems” such as intoxication due to illicit drugs or drink. On the one hand, the proposed legislation provides power to detain the patient in order to protect the public. Doctors who fail to use these powers could be held accountable for any adverse consequences to the public. On the other hand, compulsory detention of the patient for such problems might potentially infringe upon the patient’s human rights. Until a test case arises, it is impossible to be certain how the European Court of Justice will rule. In any event, doctors certainly face difficult moral dilemmas. Second, doctors (especially psychiatrists) may be called upon to compulsorily detain persons with personality disorders perceived to be dangerous, even when their conditions are considered untreatable. Again, if doctors fail to exercise such power, they

might be held accountable for any adverse consequences to the public. However, since the conditions are untreatable, they cannot fulfil their traditional roles as healers. Instead, they are required to act as public protector, a role they have not been trained to excel in. Third, doctors may be under pressure to compulsorily treat and monitor patients with mental health problems who are currently stable and in remission.

A common theme to these scenarios is the difficulty in balancing the rights of the individuals and the need to protect the public. In practice, as it is difficult to predict accurately the risks of individual patients to the public, the public is unlikely to be protected to a reasonable degree without compromising the rights of individuals. A sceptical view of the white paper proposal is that by exploiting the gaps in the judgments of the European Court of Justice so far, the government has shifted its responsibility for this extremely delicate balancing act to individual psychiatrists and other health professionals. The best that psychiatrists could do under the situation would be to recognise the dilemmas, make decisions in collaboration with other colleagues, and record in detail the reasons for the decisions made.

Other issues

It is perhaps more important for the psychiatrists to take extra care on aspects of their practice relating to patients’ human rights not directly addressed by the proposed reformed mental health act, such as:

(A) Ward environment for detained patients (possible contravention under article 3)

After the government approved a friendly settlement with a Broadmoor patient alleging inhuman and degrading treatment during a five week seclusion period in a poorly furnished, lit and ventilated and insanitary room with inadequate clothing and opportunities for exercise in *A v UK* (1980),¹⁰ seclusion procedures were reviewed in 1985. In *B v UK* (1984),¹¹ a special hospital patient complained of an atmosphere of violence, overcrowding, a lack of sanitary facilities, lack of fresh air and privacy. It was ruled that there was no single incident which was so grave to constitute inhuman and degrading treatment.

To avoid potential infringements with the Human Rights Act 1998,¹ psychiatrists should work together with managers and other health professionals to ensure acceptable ward environments, particularly for patients detained compulsorily.

(B) Forced treatment (for example, stomach washout for overdoses, forced feeding for anorexia nervosa)—possible contravention under article 3

In *Herczegfalvy v Austria* (1993), a patient was transferred to an Austrian psychiatric hospital after having collapsed during a hunger strike in prison.¹² He was forced fed, received neuroleptics against his will, isolated, and attached with handcuffs to a security bed. Initially the Commission considered the excessively prolonged violent manner he was treated constituted “inhuman and degrading treatment” and was against article 3, and even contributed to the worsening of the patient’s condition. However, while the European Court also agreed that mental health patients remain under the protection of article 3, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. In the case, the Court was convinced that the medical necessity existed and ruled that article 3 was not infringed. It appears that the crucial question was whether the treatment was justified by medical necessity.

Clearly, mental health patients who strenuously resist lifesaving medical procedures pose considerable challenges for psychiatrists. It is good practice under these circumstances to obtain second opinions from other experienced psychiatrists beyond the minimum requirements imposed by the mental

health legislation. Such objective views are often invaluable to ensure that the judgments made by the doctors actively involved are reasonable.

(C) Frequency of review of the condition of detained patient—to ensure that their continued detention is justified

A common theme of the mental health cases heard by the European Commission or Court is the delay for a patient's case to be heard by a mental health review tribunal (*Lines (Pauline) v UK*, 1997),¹³ especially for restricted patients under sections 37 and 41 (*Roux (Joseph) v UK*, 1996)¹⁴ and (*Johnson (Stanley) v UK*, 1997).¹⁵ In these cases, it was held that there had been an unacceptable delay for the court to review the patient's detention and therefore constituted violation of article 5(4). In *E v Norway* (1990), a psychiatric patient's application to a mental health court in Norway was heard just over a month later and the judgment was given in less than eight weeks after the initial application.¹⁶ Nevertheless, the European Court held that this was not speedy determination and infringed on article 5(4).

It is clearly important that conditions of patients compulsorily detained are reviewed regularly to ensure that continuing detention remains justified. Psychiatrists must ensure that they regularly review their patients' progress and document their assessments. It is also important to ensure that the mental health tribunals review the patients at intervals required by the current mental health legislation. In practice, however, the mental health tribunals often find it difficult to cope with their current workloads.

CONCLUSION

It is difficult to safeguard the safety of the public at the same time without compromising the human rights of the individuals. The proposed reformed Mental Health Act attempts to do so superficially and shifts the difficult balancing act to individual psychiatrists and health professionals. However, the proposals are likely to be challenged in the European Court when they come into force. These issues are highly relevant to psychiatrists' professional practice, and it is important for psychiatrists to gain both theoretical and practical knowledge of how to deal with situations which might infringe on patients' human rights.

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