

Is this a revolution? The impact of the Human Rights Act on Mental Health Law

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In 'Almost a Revolution: Mental Health Law and the Limits of Change', Prof. Paul Applebaum, writing in 1994, describes a period of tumultuous change in the United States during the late 1960s in civil rights and mental health law and which lasted nearly three decades¹. At the end of that period, he concluded, there had been little real and substantial change to mental health law in the United States. This article looks at some of the changes to mental health law that have already been wrought in England & Wales by the Human Rights Act 1998 and briefly considers its potential for creating real and substantial change in the longer term.

Current legislation governing the detention and treatment of those with mental disorder – the Mental Health Act 1983 – is widely recognized as being out of date, based as it is largely upon its predecessor, the Mental Health Act 1959. New legislation is proposed, much of which is highly controversial, demonstrating that while there may be a perception by significant elements in society that change is required, there is by no means unanimity as to the direction in which that change should take. Perhaps less controversially, but no less necessary, Incapacity legislation is also likely soon to be introduced, after many years of urging from the Law Commission, the Courts and interested groups.

On 2 October 2000 the Human Rights Act 1998 (HRA) came into force. The United Kingdom has been a signatory to the European Convention on Human Rights 1950 (the Convention) since its inception – indeed, was the first to ratify the Convention, on 8 March, 1950 – and the Convention has led to significant changes prior to its incorporation through the HRA. Most notable, perhaps, is the seminal case of *X v United Kingdom*² which established that, in order to comply with Article 5(4), a Mental Health Review Tribunal must have power to order a patient's release from hospital, even one who has committed serious criminal offences. This led to a change in the law introduced

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1 Applebaum P, 'Almost a Revolution: Mental Health Law and the Limits of change', (Oxford University Press) (1994)

2 (1981) EHRR 181

by the Mental Health (Amendment) Act 1982 whereby the Tribunal's power of recommendation to the Home Secretary became a power to discharge in the face of objections from that minister.

But that case is also an illustration of the shortcomings of the Convention prior to its incorporation through the HRA, as it was *only* through the introduction of primary legislation that the law could be changed so as to comply with the Convention. The impact of the Convention on domestic law was limited by the constitutional principle of the sovereignty of Parliament. As a matter of international law the executive may bind the state to abide by the terms of international treaties, but the legislature alone can give effect to those terms in domestic law by passing legislation, which it has now done, by introducing the HRA. Accordingly, in the absence of such enacting legislation, individuals could not enforce their Convention rights directly through domestic courts, which were obliged to uphold primary legislation, and could find it unlawful or invalid, notwithstanding any conflict with the United Kingdom's Convention obligations³. Accordingly, although the Courts applied the presumption that Parliament has enacted legislation so as to comply with the United Kingdom's Convention obligations⁴, that presumption had to yield to express statutory wording, even if that violated Convention rights.

The HRA, however, has introduced three fundamental changes to the law. First, it confers upon individuals the right to enforce Convention rights directly through the domestic courts. Section 6 provides 'It is unlawful for a public authority to act in a way which is incompatible with a Convention right'. An aggrieved individual is no longer confined to invoking an analogous common law right (where one existed) or to taking his case to Strasbourg: by section 7 he may directly rely upon the Convention rights contained in the Schedule to the HRA, whether by bringing proceedings against a public authority or by raising it in other proceedings to which he is a party, most notably by way of a defence to civil or criminal proceedings. Second, by section 3 the HRA imposes a strong interpretative obligation upon the Courts to 'read and give effect to' Convention rights in a way which is compatible with the Convention rights. By contrast with the position prior to October 2000, Courts must construe legislation in a Convention compatible manner even where there is no ambiguity; indeed, provided it does not lead to an absurd result. Third, and last, while the principle of Parliamentary sovereignty is preserved in that Courts cannot strike down incompatible legislation, by section 4 HRA they can make a 'declaration of incompatibility' in respect of a provision that cannot be 'read and given effect to' under section 3 in a way that complies with the Convention. While the HRA has its limitations, which are becoming more apparent as time goes by, we do now have a 'a body of theory that can be applied to extend or alter the law in the desired direction', if not as far as some would like.

In Scottish cases, the Scotland Act 1999 goes further, enabling Courts (including the Privy Council, as the highest Court of Appeal) to strike down legislation of the Scottish Parliament when it is incompatible with Convention rights.

We are now more than three years on from the coming into force of the HRA. Mental Health has proved to be one of the most fruitful areas of challenge under the Act. At the time of writing there have been 10 declarations of incompatibility, three of which have related to the MHA, and one of which has led to the only remedial legislation yet to be introduced under section 10 of the Act.⁵

3 *see, e.g., R v Home Secretary, ex p Brind* [1991] A.C. 696, *per Lord Bridge* at 747

4 *see, e.g., Lonrho Plc* [1990] 2 AC 154, *per Lord Bridge* at 208

5 *The Mental Health Act 1983 (Remedial) Order 2001*

The following provisions have been declared incompatible: the reverse burden of proof under section 72/ 73 (see *R (H) v Mental Health Review Tribunal*⁶); sections 26 and 29 MHA (nearest relative provisions) (*R (M) v Health Secretary*⁷); and section 74 MHA (absence of any power in the Tribunal to release a transferred post-tariff discretionary lifer: *R (D) v Home Secretary*⁸). Others are likely to follow.

But declarations of incompatibility are only a very small part of the process of change. There has been a great deal of activity in the Courts, particularly in applications for judicial review, some of which has led to enhanced protection for those with mental disorders, and much which has not. I am going to focus on five areas in this paper:

- Detention and discharge
- Compulsory treatment
- Seclusion
- Other conditions of detention
- Protection of confidential information.

Detention & discharge

The clearest developments have been in relation to Article 5, with some significant enhancements to the existing procedural safeguards provided by the Mental Health Review Tribunal.

The reverse burden of proof has been declared incompatible with Article 5 and reversed by remedial legislation (*R (H) v Mental Health Review Tribunal*⁹), subsequently affirmed by the ECHR in *Hutchison Reid v United Kingdom* 20 February 2003.

Undue delay by the Home Office in granting leave of absence to a patient who has been conditionally discharged by a Tribunal, but deferred, may violate Article 5 (*R (RA) v Home Secretary*¹⁰).

A series of cases brought in relation to delay in the arrangement of MHRT's have led to findings of violations of the 'speediness' requirement of Article 5(4), although the level of damages paid out has been fairly low (*KB and others v MHRT*¹¹).

The Court of Appeal has affirmed the power of the Tribunal to discharge a patient from high secure accommodation via 'stages', by ordering their discharge on condition of residence either in another hospital or in hostel accommodation with suitable levels of security, provided those conditions do not amount to a 'deprivation of liberty': see *R (SSHD) v MHRT, PH interested party*¹². The Home Secretary argued that the Tribunal's decision amounted to an order for transfer, rather than discharge, which it had no power to make. Not so, said the Court of Appeal; the fact that the conditions were imposed so as to *increase* the patient's freedom, by allowing his release from a high secure hospital, was a key factor in their finding that the order would not result in PH continuing to be 'detained' and was, therefore, lawful.

6 [2002] QB 1

7 [2003] EWHC 1094 Admin

8 [2003] 1 WLR 1315

9 [2002] QB 1

10 [2002] EWHC 1618 (Admin)

11 [2003] EWHC 193 (Admin)

12 [2002] EWCA Civ 1868

However, a number of challenges in relation to the procedural protections of Article 5 have failed. The dual role of the medical member as both witness and judge, although clarified (*ex p. Hannaway*), has nevertheless been found not to be incompatible with Article 5 (*R (S) v MHRT*¹³).

The vexed question remains of who is bound by the decision of a Mental Health Review Tribunal. A series of cases has now considered two linked questions: first, are doctors and social workers bound by a Tribunal's decision to discharge so that they cannot lawfully detain a patient if they disagree with the Tribunal's decision¹⁴; and, second, are other statutory agencies (in particular section 117 Health & Social Service Authorities) bound by a decision to discharge so that they act unlawfully if they fail to provide the services necessary to implement a patient's discharge¹⁵. The House of Lords has now confirmed that the answers to each, in turn, are (a) yes, if there has been a relevant change in circumstances¹⁶; and (b) no, there is no positive duty under the Convention to provide accommodation or treatment that will enable a detained patient to be discharged into the community¹⁷.

The Tribunal remains powerless to order a restricted patient to be *transferred* from one hospital to another, either as a necessary precursor to discharge¹⁸ or to ensure the patient is close to his family¹⁹.

Both the Privy Council in the Scottish case of *Anderson, Doherty & Reid v Scottish Ministers*²⁰, and the ECHR in *Hutchison Reid v UK*²¹, have confirmed that it is not a violation of Article 5 to detain a mentally disordered individual on the grounds of dangerousness, even if they are considered to be 'untreatable'. A person may be detained under Article 5(1)(e) where they suffer from a qualifying mental disorder even if there is no treatment available for that disorder:

'Such confinement may be necessary not only where a person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons (Hutchison Reid v United Kingdom, ibid, §51; Witold Litwa v. Poland, (2000) 33 EHRR 53, § 60).

It is likely, then, that the proposals in the Mental Health Bill 2002 for removing the 'treatability' requirement for psychopathic patients will survive the HRA.

Although a case preceding the coming into force of the HRA, the *Bournewood* case nevertheless represents a failure by the Courts through the existing law to safeguard vulnerable mentally disabled patients. In *R (L) v Bournewood Community Mental Health NHS Trust*²², the House of Lords overturned the Court of Appeal in finding that so-called 'Bournewood patients', i.e. who lack capacity but do not object to their detention or treatment, do not need to be formally detained under the MHA, notwithstanding that they are therefore left with inadequate legal protections. In May 2003 the ECHR conducted a final hearing of the case brought on behalf of Mr. L under Article 5, and judgment is awaited.

13 [2002] EWHC 2522

14 see *Von Brandenburg* [2002] QB 235 and *R (H) v Ashworth* [2002] EWCA Civ 923

15 *R (K) v Camden & Islington HA* [2002] QB 198 and *R (H) v Home Secretary* [2003] 3 QB 320

16 *Von Brandenburg* [2003] 3 WLR 1265

17 *R (H) v Home Secretary* [2003] 3 WLR 1278

18 *R (SSHD) v MHRT, (MW & FO intervening)* [2001] ACD 62

19 *R (H) v MHRT* [2002] EWHC 1128 (Admin)

20 [2002] 3 WLR 1460

21 *Application 50272/99*, *Times Law Reports* 26th February 2003

22 [1999] AC 458

Treatment

As to compulsory treatment, there have been a number of significant cases. In *R (Wilkinson) v Broadmoor*²³ the Court of Appeal accepted that a combination of Articles 2, 3, 6 & 8 entitled a patient to a determination by a court of the lawfulness of compulsory treatment *in advance* of the treatment being given. Moreover, because domestic law created no statutory right to such a hearing, the Administrative Court on judicial review was required to reach its own views on the *merits*, where the treating doctor was required to prove to a high standard that the treatment was medically necessary. In doing so, it would be necessary for the Court to hear live evidence with cross-examination.

Wilkinson was followed by the case of *R (Wooder) v Dr. Feggetter*²⁴, in which the Court of Appeal ruled that, given the fundamental rights engaged by a decision to compulsorily treat an individual (notably Articles 3 & 8), a SOAD is required to give reasons for his decision for endorsing an RMO's treatment plan under section 58.

A subsequent decision of the CA, *N v DR M*, has watered down the impact of those judgments, particularly *Wilkinson*, by expressing the view that it will rarely, if ever, be necessary to hear live evidence on a challenge to a treatment decision, and that such a right cannot be derived from Article 6 ECHR. However, the Court did emphasise the high standard of proof required to demonstrate medical necessity.

Most recently the Court of Appeal in *R (B) v Ashworth HA*²⁵, in a perhaps surprising decision, held that a patient may only be compulsorily treated under the MHA Part IV in respect of the mental disorder from which he is classified as suffering. Although not explicitly reasoned as a human rights decision, the case imposes some limitations upon the circumstances in which treatment may be imposed without consent (although it is not clear, in practice, how significant those limitations will prove to be, given that the Court of Appeal confirmed that where necessary the common law could be invoked to provide treatment for disorders that the patient was not classified as suffering from). Nevertheless, it is likely that in respect of many patients, particularly those in Special Hospitals, there will be an increase in applications to reclassify brought by the hospital before Tribunals. The House of Lords has recently given leave to Ashworth HA to appeal this judgement.

I have only mentioned those aspects of the case law that have lead to an increase in *procedural* protection against arbitrary or mistaken treatment. Of potentially greater significance is the proposition, advanced in *Wilkinson*, and accepted (in part) by one of the judges (Simon Brown LJ), that a detained patient who retains *capacity* to refuse treatment should remain entitled to refuse treatment even if he is detained under the MHA, as the right of autonomy of self-determination is one protected by Articles 3, or 8, or 6. This right of autonomy or self-determination has since been explicitly recognized as a component of Article 8 by the ECHR in *Pretty v UK*²⁶, albeit in a slightly different context, and is likely to form the basis of future challenges to compulsory treatment and detention of patients who, despite the existence of a mental disorder, retain the capacity to make decisions about their future and who would rather suffer the effects of their illness than the effects of their treatment.

23 [2002] 1 WLR 419

24 [2002] 3 WLR 591

25 [2003] EWCA Civ 547

26 [2002] 2 FLR 45

It is difficult to predict which way the Courts will go on this issue. A recent decision of the Scottish Court of Session, *Petition of WM for Judicial Review*, Court of Session, 11 July 2002, rejected the argument; on the other hand, in *Starson v Swayze*²⁷, the Ontario Court of Appeal affirmed the right of the competent individual to refuse treatment, which was upheld on appeal to the Canadian Supreme Court. In the United States the Supreme Court has never directly addressed the issue, but relevant decisions of the federal courts (including the Supreme Court) have tended to adopt a conservative, treatment-driven approach, although state courts have been more proactive in protecting the rights of the competent to refuse treatment²⁸. The issue is squarely raised in an application brought by Mr. Wilkinson to the European Court of Human Rights, *Wilkinson v United Kingdom*, but the case has yet to reach the admissibility stage.

The failure to provide suitable treatment to those suffering from mental disorder is also capable of giving rise to violations of Convention rights. Complex issues are raised by the transfer between prison and hospital of convicted prisoners who are suffering from mental illness. A recent challenge was brought by a transferred life sentence prisoner, detained under sections 47 & 49, to his return to prison under section 50 on the grounds that he remained so mentally ill that to return him to prison would constitute inhuman and degrading treatment, contrary to Article 3²⁹. He also claimed that he remained of 'unsound mind' within the meaning of Article 5(1)(e) and thus his detention anywhere other than in a 'hospital, clinic or other appropriate institution' was unlawful. The prisoner was diagnosed as suffering from paranoid schizophrenia which was controlled by medication. However, on two previous occasions his condition had relapsed while in prison and an independent psychiatrist gave evidence that it was almost inevitable that his condition would deteriorate once again if returned to prison. The Administrative Court, while accepting in principle that the detention of a mentally ill individual in prison might violate both Articles 3 and 5, rejected the challenge on the basis that the Secretary of State was entitled to rely upon the patient's doctor's opinion that suitable treatment was available for the patient in prison. The Court's role was limited to one of review of that decision; it was not required to determine for itself whether, on the facts, the patient would receive appropriate treatment while in prison.

Seclusion

As to the use of *seclusion*, in two cases decided in 2002 the Administrative Court reached rather disappointing conclusions as to the effect of the Convention rights on the practice of seclusion, finding that to seclude the patient in circumstances where the Code of Practice was not complied with did not give rise to a breach of either Articles 3, 5 or 8 (*R (Col. Munjaz) v Ashworth HA*³⁰; *S v Airedale NHS Trust*³¹). The Court of Appeal considered the cases in a conjoined appeal on 16th July 2003 and overturned the two earlier High Court rulings³². The appeal court held that seclusion that did not comply with the Code of Practice was in breach of Articles 3 & 8. The Convention requirement of 'legality' was only met through adherence to the Code of Practice. The Court went on to say that the Code should not be departed with as a matter of policy and should be observed

27 (2001) 201 DLR (4th) 123

28 Applebaum P, 'Almost a Revolution: Mental Health Law and the Limits of Change', 1994, pp. 131-132)

29 *R (R) v. Shetty and Home Secretary* [2003] EWHC 3022 (Admin); see also *R (Morley) v Nottinghamshire Healthcare NHS Trust* (2003) 1 All ER 784

30 [2002] EWHC 1521 Admin

31 (2003) Lloyd's Rep Med 21

32 *R (on the application of Munjaz) v Mersey Care NHS Trust*; *R (on the application of S) v Airedale NHS Trust* [2003] EWCA Civ 1036

by all hospitals unless they have good reason for departing from it in relation to an individual patient or groups of patients with well-defined characteristics. The House of Lords has recently granted Mersey Care NHS Trust leave to appeal.

Other conditions of detention

As to other *conditions of detention*, there has yet to be a successful challenge under either Articles 3 or 8 to the conditions of detention in any of the detaining hospitals. Challenges have failed to the policy of a Special hospital not to issue condoms (*R (RH) v A Hospital Authority*, 30 October 2001), a refusal to permit a patient to dress as a woman (*E v Ashworth*³³), the introduction of random telephone monitoring in special hospitals (*R (N) v Ashworth*³⁴), and the restriction on visits by children to patients in special hospitals (*R (L) v Secretary of State for Health*³⁵). However, this is an area that is likely to see an increase in challenges as litigators become more sophisticated in the means employed to mount such challenges, so as to adduce greater evidence as to the prevailing standards in other hospitals and in other countries, and as judges become more comfortable with making decisions of a kind that previously fell outside their remit altogether.

Confidential information

The Admin Court has recently affirmed the ECHR decision in *JT v UK*³⁶ to the effect that the disclosure of confidential medical information to the nearest relative, in circumstances where the patient objects, violates Article 8 (*R(M) v Health Secretary*³⁷). A declaration of incompatibility has now been made in relation to sections 26 and 29.

Where next?

The law is in a state of flux, and it is difficult to predict where it will end. However, it is likely that more is yet to be said by the Courts (both here and in Strasbourg) on the following issues:

- Powers and procedures of the Mental Health Review Tribunal. I expect challenges to the standard of proof in Tribunal proceedings: the current civil standard may be too low; the use of hearsay evidence will be more tightly regulated; the qualifications of those giving evidence in support of a patient's continuing detention will be more anxiously scrutinized.
- Whether Article 5 and/ or 8 requires the tribunal to have power to transfer patients to lower security, or grant leave of absence, as a necessary precursor to discharge.
- Whether decisions of the Tribunal to discharge are binding on subsequent clinicians (including those in the community) in the absence of compelling reasons.
- Whether positive obligations may be derived from Article 5(1) upon public authorities to provide both in-patient and after-care treatment which will enable patients to be discharged.
- Bournewood: whether compliant incapacitated adults are to be given greater safeguards against arbitrary and mistaken detention or treatment.
- Whether the right of autonomy entitles a competent patient to refuse treatment other than in circumstances where he is a threat to others.

33 [2001] EWHC 1089 Admin

34 [2001] HRLR 46

35 (2000) 58 BMLR 101

36 [2000] 1 FLR 909

37 [2003] EWHC 1094 Admin

Conclusion

In conclusion, however, I consider it unlikely that the HRA will lead to a 'revolution' in mental health law, for three reasons. First, the constitutional doctrine of the separation of powers obliges the judiciary to allow a certain discretionary area of judgment to our elected representatives and those upon whom Parliament confers statutory powers. That principle remains largely unaffected by the HRA, particularly in cases involving the allocation of scarce public resources, although the width of that discretion has undoubtedly narrowed. Second, the search for solutions that comply with Convention rights involves a balancing exercise between individual rights and the interests of the wider community (see *Sheffield and Horsham v UK*³⁸):

'In determining whether or not a positive obligation exists, regard must be had to the fair balance that has to be struck between the general interests of the community and the interests of the individual, the search for which balance is inherent in the whole of the Convention'.

Any shifts in that balance are likely to be incremental rather than seismic. Third, the HRA cannot always provide an effective remedy where domestic law fails to meet up to the standards of the Convention. Where the failure is a result of an incompatible provision of primary legislation, the Courts' power under section 4 HRA is limited to making a declaration of incompatibility which does not bind the Government to take steps to remedy the incompatibility. Moreover, where the lack of adequate protection stems from a gap in the law the Court is powerless to intervene: a declaration of incompatibility may only be made in respect of a specific provision of primary legislation³⁹ and no challenge may be brought to a failure of the Executive to introduce or lay before Parliament a proposal for legislation or to make any primary legislation: HRA 1998, section 6(6). The sovereignty of Parliament to legislate is unaffected.

Although the Human Rights Act has proved to be an effective means of highlighting the potential for human rights violations involved in the detention and treatment of the mentally disordered, substantial reform is likely to occur only by democratic means through Parliament. We must continue to wait for a new Mental Health Act and a new Incapacity Act.

38 (1998) 27 EHRR 163, at 191, para 52

39 *Re. S (Minors) (Care Order: Implementation of Care Plan)* [2002] 2 AC 291, §§85–86 per Lord Nicholls