

ECT and the Human Rights Act 1998

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In the current edition of the Mental Health Act Manual¹, Richard Jones condemns the practice of detaining mentally incapacitated patients for the purpose of giving treatment which could lawfully be administered under common law. Jones draws particular attention to the ‘sectioning’ of compliant patients who require electroconvulsive therapy (ECT).

‘There is a widespread practice of making applications to detain patients who require medical treatment for their mental disorder despite the fact that such patients are both mentally incapable and compliant, in that they are not exhibiting dissent to being in hospital at the time the application is made. In particular, it is felt that a compliant elderly mentally ill patient who needs to be given ECT as a treatment for depression must be detained under this Act before the treatment can be given, even though the effect of the depression has been to render the patient mentally incapable. As the provision of medical treatment to a mentally incapable patient, using force if necessary (*Re MB (Medical Treatment)* [1997] 2 F.L.R. 426 at 439) is authorised under the common law if the treatment is considered to be in the patient’s best interests ... the “sectioning” of the patient for the purpose of providing “authority” for medical treatment for his mental disorder to be given is unnecessary. Such action is also almost certainly unlawful because the “sectioning” of a compliant incapable patient would not be warranted for the purposes of section 2 (see s.2(2)(a)) and it would not be possible to satisfy the requirement in section 3 that the treatment “cannot be provided” unless the patient is detained under that section (see s.3(2)(c)). It would also not be possible for an approved social worker to claim under section 13(1) that it was “necessary and proper” for an application to be made as it is neither necessary nor legally proper to make an application in respect of a patient who is not attempting to leave the hospital and whose medical treatment is authorised under common law.’²

Jones’s analysis of the common law is surely correct. Nonetheless, the administration of ECT to mentally incapable patients under the common law principle of necessity causes disquiet, not least among psychiatrists and approved social workers, and thus the practice which Jones deprecates is still widespread. This disquiet does not arise simply from ignorance of the law. There is a perception that because ECT is somehow different from other common forms of treatment for

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1 *Mental Health Act Manual*, Richard Jones, Sweet and Maxwell (8th edition) (2002).

2 *Jones at p.299.*

mental disorder there should be safeguards when it is administered to mentally incapacitated patients³. Such safeguards exist where the patient is detained under the Mental Health Act because of the requirement of s. 58 that, in the absence of the patient's informed consent, the treatment may only be given if approved by a second opinion appointed doctor (SOAD). It is for this reason that some doctors and social workers choose to detain such patients. They believe that they are acting in the patient's best interests by invoking the statutory safeguards.

There can be no doubt that, despite evidence of its clinical effectiveness, ECT remains controversial. This has recently been highlighted by the National Institute for Clinical Excellence (NICE) in guidance on the use of ECT.⁴ The guidance contains the following description of ECT and its side-effects:

‘3.1 During ECT, an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalised seizure activity. The individual receiving treatment is placed under general anaesthetic and muscle relaxants are given to prevent body spasms. The ECT electrodes can be placed on both sides of the head (bilateral placement) or on one side of the head (unilateral placement). Unilateral placement is usually to the non-dominant side of the brain, with the aim of reducing cognitive side effects. The amount of current required to induce a seizure (the seizure threshold) can vary up to 40 fold between individuals.

3.2 Although ECT has been used since the 1930s, there is still no generally accepted theory that explains its mechanism of action. The most prevalent hypothesis is that it causes an alteration in the post-synaptic response to central nervous system neurotransmitters.

3.4 ECT administration affects the central nervous system and causes changes in cardiovascular dynamics, which dictates the need for special caution in those individuals who are at increased risk of a cardiovascular event. There are also other immediate potential complications, such as status epilepticus, laryngospasm and peripheral nerve palsy, which overall have an estimated incidence of 1 per 1300 to 1400 treatments. The mortality associated with ECT is reported not to be in excess of that associated with the administration of a general anaesthetic for minor surgery.

3.5 ECT may cause short- or long-term memory impairment for past events (retrograde amnesia) and current events (anterograde amnesia). As this type of cognitive impairment is a feature of many mental health problems it may sometimes be difficult to differentiate the effects of ECT from those associated with the condition itself. In addition there are differences between individuals in the extent of memory loss secondary to ECT and their perception of the loss. However, this should not detract from the fact that a number of individuals find their memory loss extremely damaging and for them this negates any benefit from ECT.’

As well as taking evidence from clinical experts, the Appraisal Committee took account of the experience of people who have received ECT. Of particular concern to many people are the side-effects associated with ECT.

3 *The Government's recognition of the need for safeguards in respect of ECT both for patients made subject to compulsory measures and for Part 5 'qualifying patients' is reflected in the Draft Mental Health Bill 2002 (Cm 5538-I) within clauses 118–120 and 131.*

4 *National Institute for Clinical Excellence, Guidance on the Use of Electroconvulsive Therapy, Technology Appraisal 59, April 2003.*

‘4.3.2 The evidence submitted to the Committee, both written and verbal, demonstrated that, on balance, current opinion is that ECT is an effective treatment for certain subgroups of individuals with mental disorders. However, opinion varies from those who consider that its adverse effects are tolerable to those who consider that it is associated with unacceptable side effects including brain damage, severe confusion and considerable cognitive impairment in both the short and longer terms. While some individuals considered ECT to be a beneficial and lifesaving treatment, others reported feelings of terror, shame and distress, and found it positively harmful and an abusive invasion of personal autonomy, especially when it was administered without their consent.

4.3.3 In consideration of these extremes of opinion, the Committee concluded that the wishes of the patient must be of paramount importance and that it is essential that all attempts should be made to obtain valid and informed consent, following recognised guidelines. The Committee felt strongly that consent should never be obtained by coercion – either explicit or implicit – through threat of compulsory treatment under the Mental Health Act, and mechanisms to monitor and prevent this from occurring should be developed and implemented, in consultation with appropriate professional and user organisations.’

While the guidance says nothing about additional safeguards for mentally incapacitated patients, it does contemplate ECT being administered to people who lack capacity to consent.

‘1.5 In all situations where informed discussion and consent is not possible advance directives should be taken fully into account and the individual’s advocate and/or carer should be consulted.’

That ECT is disliked by some people and is associated with adverse side-effects does not detract from Jones’s legal analysis: under common law, the treatment can lawfully be given to the mentally incapable patient without consent provided it satisfies the best interests test.⁵ However, NICE’s discussion of ECT brings to mind the words of Lord Steyn in the *Bournewood* case, drawing attention to the lack of safeguards under common law.

‘The common law principle of necessity is a useful concept, but it contains none of the safeguards of the 1983 Act. It places effective and unqualified control in the hands of the hospital psychiatrist and other health care professionals. It is, of course, true that such professionals owe a duty of care and that they will almost invariably act in what they consider to be the best interests of the patient. But neither habeas corpus nor judicial review are sufficient safeguards against misjudgments and professional lapses in the case of compliant incapacitated patients.’⁶

Recent case law on non-consensual psychiatric treatment of detained patients suggests that the power to administer ECT to incapacitated patients under common law may have to be qualified in the light of the Human Rights Act 1998. The cases of *Wilkinson*⁷ and *N*⁸ both concerned challenges by detained patients to the administration of antipsychotic medication which was being given

5 See the discussion in *Jones (ante)* pp. 298 to 306 on medical treatment of the mentally incapable. The essential requirements of the best interests test are first, that the treatment is carried out either to save the patient’s life or to ensure an improvement or prevent deterioration in the patient’s physical or mental health; and second, that the treatment is in accordance with a practice accepted at the time by a responsible body of medical opinion skilled in the particular form of treatment in question.

6 *R v Bournewood Community and Mental Health NHS Trust, ex p. L* [1998] 3 All E.R. 289, HL at p.308.

7 *R v the Responsible Medical Officer, Broadmoor Hospital, the Mental Health Act Commission Second Opinion Appointed Doctor and the Secretary of State for Health ex p. Wilkinson* [2001] EWCA Civ. 1545.

8 *R v Doctor M and others ex p. N* [2002] EWHC 1911 (Admin) and [2002] EWCA Civ 1789 (Court of Appeal).

without consent but in accordance with the procedure under s.58, having in each case been authorised by a SOAD. Both cases make clear that such treatment potentially engages Articles 3 and 8 of the European Convention on Human Rights. Compliance with the statutory procedure under s.58 is thus a necessary but not sufficient condition for lawfulness.

In his extensive judgment in *N*, Silber J approached the case in the following way. He first satisfied himself that the s.58 procedure had been followed. He then considered the patient's capacity and, having found that she lacked capacity according to the common law test, he decided that the proposed treatment could lawfully be given under the principle of necessity. Finally, he determined whether the treatment infringed the patient's rights under Articles 3 and 8 of the Convention. In relation to Article 3 he concluded (at paragraph 112 of his judgment) that:

‘where medical treatment is administered on a patient against his or her will, Article 3 will be contravened if (a) the proposed treatment on the patient reaches the minimum level of severity of ill-treatment, taking into account all the circumstances, including the positive and adverse mental and physical consequences of the treatment, the nature and context of the treatment, the manner and method of its execution, its duration and if relevant the sex, age and health of the patient and (b) the medical or therapeutic necessity for the treatment has not been convincingly shown to exist.’

In relation to Articles 8, he found (para. 120) that:

‘Individuals have the right not to be subject to compulsory physical intervention and treatment and Article 8 can be engaged even where the minimum level of severity required in Article 3 cases was not reached. Thus, a prima facie breach of Article 8 may occur when treatment is given to a patient without consent, unless it is justifiable under Article 8(2).’

One of the justifications allowed by Article 8(2) is the protection of health. The Judge found that because the treatment was likely to alleviate or prevent a deterioration of *N*'s psychotic condition it was justified under Article 8(2).

The Court of Appeal, which was concerned only with Article 3, upheld Silber J's judgment. Dyson LJ, who gave the judgment of the court, dealt with non-consensual treatment in the following way (at paragraphs 16/17 of his judgment):

‘An important question is what standard of proof is required before a court can properly be satisfied that it is appropriate to give permission for treatment where the patient does not consent to it. The judge was right to say that he had to be satisfied that the proposed treatment was both in the claimant's best interests and “medically necessary” as that phrase should be understood and applied for the purposes of Article 3 of the Convention. The best interests test goes wider than medical necessity: see *Re S (Sterilisation: Patient's Best Interests)* [2000] 2 FLR 389. The focus of the argument before us was on the requisite standard of proof for the purposes of Article 3. In *Herczegfalvy v Austria* (1992) EHR 437, 484, the ECtHR said:

“82. The court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention is being complied with. While it is for the medical authorities to decide, on the basis of the recognisable rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are responsible, such patients nevertheless remain under the protection of Article 3, the requirements of which permit no derogation. The established principles of medicine are

admittedly in principle decisive in such cases; as a general rule, a method which is a therapeutic necessity cannot be regarded as inhuman or degrading. The court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist.”

In the light of this decision, it is common ground that the standard of proof required is that the court should be satisfied that medical necessity has been “convincingly” shown.’

The situation of the compliant incapacitated patient to whom ECT is administered differs from that of the patients in *Wilkinson* and *N* in one important respect. They had both refused and were actively opposing the treatment. The treatment was therefore being given against the patient’s will. This is apparent from the extract from Silber J’s judgment above and also formed part of Hale LJ’s analysis in *Wilkinson* (at paragraph 79):

‘One can at least conclude 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. I would hesitate to say which was worse: the degradation of an incapacitated person shames us all even if that person is unable to appreciate it, but in fact most people are able to appreciate that they are being forced to do something against their will even if they are not able to make the decision that it should or should not be done. The [European Court of Human Rights] understood how vulnerable such patients can be and how much in need of the protection of the world outside the closed world of the psychiatric institution however well meaning.’

It follows that where treatment, which is capable of being inhuman or degrading, is given to a mentally incapacitated patient, Article 3 will be engaged if the treatment is not medically necessary. On this analysis it is surely irrelevant whether the patient is compliant or is actively resisting the treatment. The potential breach of human rights arises from the position of the patient who is confined in a psychiatric institution and, in Lord Steyn’s words, is subject to the ‘effective and unqualified control’ of health care professionals and is thus vulnerable to ‘misjudgments and professional lapses’.

Taking account of the views of those who have experienced ECT, there can be little doubt that ECT reaches Silber J’s minimum level of severity. That is to say it would be inhuman or degrading to administer ECT to a person who is not capable of consenting and for whom it is not medically necessary. It is irrelevant whether the patient is actively refusing the treatment. The test under Article 3 is whether medical necessity can be convincingly shown to exist.

It then becomes a matter of weighing the evidence. The simplest way to establish medical necessity convincingly is for the doctor in charge of the patient’s treatment to seek a second clinical opinion. The opinion of two (or more) doctors that ECT is medically necessary will be more persuasive than that of a single doctor. This would also effectively reproduce for informal incapacitated patients the safeguards enshrined in the statutory procedure under s.58.

If this analysis is correct, Article 3 of the Convention requires that medical necessity be convincingly demonstrated before ECT can lawfully be administered to a mentally incapable patient, whether or not the patient is resisting. If medical necessity is to be convincingly shown, the clinician in charge of the patient’s treatment will have to obtain a second opinion supporting the proposed treatment. In the case of an informal incapacitated patient such an opinion cannot be that of a SOAD appointed under s.58, but the requirements of Article 3 would be met by a second opinion from a suitably qualified clinician.

This is consistent with Jones’s analysis and would also allay the disquiet of mental health professionals when ECT is given under the common law principle of necessity to compliant incapacitated patients.