Guidance for clinicians and SOADs: the imposition of medical treatment in the absence of consent.

This guidance relates to England only

previously issued by the Mental Health Act Commission January 2004 and revised October 2008

The legal judgment *R (on the application of PS) v (1) Responsible Medical Officer Dr. G, (2) Second Opinion Appointed Doctor Dr. W* addressed responsibilities and requirements under the Mental Health Act Code of Practice and the Care Programme Approach when imposing medical treatment upon a detained patient refusing consent. This guidance presents the Commission's view on how the requirements as outlined in the judgement should be met by approved clinicians in charge of the treatments in question. It is updated to reflect the changes in the Mental Health Act 1983 which take effect on 3 November 2008.

Introduction

1. The judgment in *R (on the application of PS) v (1) Dr G and (2) Dr W*[1], handed down in September 2003 and (usually referred to as the *PS* case), is significant for both patients and mental health practitioners. It was the first judgment to rule upon a human rights based challenge to the imposition of treatment under Mental Health Act 1983 section 58(3)(b), on a patient judged to have made a capacitated refusal of consent[2]. It confirmed that the Mental Health Act's provisions allowing the compulsion of patients who have mental capacity and refuse consent is compatible with human rights principles under the European Convention on Human Rights (ECHR). In addition the judgment set out criteria for such imposition of treatment that should be applied by all mental health practitioners, especially approved clinicians in charge of treatment with medication and Second Opinion Appointed Doctors (SOADs). This guidance provides the Commission's view on how this judgment should be applied by approved clinicians and SOADs.

The legal judgment and its consequences

2. The *PS* case is one of those legal cases in which a detained patient used the

1 *R (on the application of PS) v (1) Dr G and (2) Dr W* [2003] EWHC 2335 (Admin)

2 From the 3 November 2008, when revisions of the Mental Health Act 1983 come into force, treatments falling under s.58A (i.e. ECT) may not be given in the face of capacitated refusal by a patient. This guidance therefore relates to treatment with medication (i.e. falling within s.58) or other treatments for mental disorder that would fall under s.63. It does not relate to the treatment of SCT patients, who may not be compelled to accept treatment in the face of capacitated refusal of consent.

Human Rights Act (HRA) to challenge medical treatment authorised by a SOAD under section 58 of the Mental Health Act 1983.[3] The proposed treatment was antipsychotic medication, to be administered orally unless the patient's resistance made it necessary to give the medication by injection. In this case both the patient's consultant and the SOAD were of the opinion that he had mental capacity to consent to (or to refuse) the treatment. The issue was therefore whether section 58 could be used to override a capacitated refusal of treatment. The patient accepted that the correct procedure had been followed under section 58 but argued that the administration of the treatment against his wishes would be unlawful as being in breach of his rights under Articles 3 and 8 of the ECHR.

3. The court found against the patient, accepting that although the imposition of treatment to a capable patient clearly had the potential to breach Articles 3 and 8 of the ECHR, it was possible to implement the powers of the MHAct in such a way as to be compliant with ECHR principles. Provided that the imposition of treatment was medically necessary, being in the patient's best interests, the imposition of treatment could be justified as a proportionate response for the protection of the patient's health. The principles to be derived from this judgment are set out in more detail in Figure 1 on page 3 of this guidance.

4. The effect of the judgment is that the patient's capable refusal, which was given prominence in earlier cases,[4] is not a bar to imposing treatment with medication under s.58 but merely one of the factors to be taken into account by the SOAD, as far as may be relevant, in deciding the questions of medical necessity and best interests. Although this decision concerned treatment authorised by a SOAD under s.58, the same principles must apply in deciding whether it is lawful to treat a patient without consent under s.63 MHA, which provides power to treat a patient without consent, regardless of the patient's capacity, and without obtaining a second opinion. The burden on the approved clinician in charge of the treatment in every such case is to satisfy the best interests test.[5]

5. In the Commission's view, this judgment reinforces and extends the existing requirements of good practice according outlined in the Mental Health Act Code of Practice and Care Programme Approach. In particular, where a treatment is proposed for either a capacitous patient who is refusing or a patient incapable of consent under section 63, the approved clinician in charge of that treatment must satisfy him or herself that the treatment is in the patient's best interests, applying the common law principles described in chapter 15 of the Code which in turn

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[3] see R (on the application of Wilkinson) v Broadmoor Special Hospital Authority & another [2002] 1 WLR 419 and R (on the application of N) v Dr M [2003] 1 WLR 562, both discussed in MHAC (2003) *Tenth Biennial Report: Placed Amongst Strangers.* London: Stationery Office, Chapter 3.32 *et seq*.

[4] see Simon Brown LJ's judgment in R (Wilkinson) v Broadmoor Special Hospital Authority and another.

[5] see Jones, Richard (2008) *Mental Health Act Manual*, 11th Edition. London: Sweet & Maxwell para 1-1662 for a discussion of the best interests test.

reflects the approach endorsed in the Mental Capacity Act 2005. The patient's own views and wishes, including past wishes if known, will be pertinent to consideration of best interests, thus reinforcing the requirement under the CPA to involve patients in care planning. We have set out our interpretation of the principles to be derived from the judgment in Figure 1.

Figure 1

Principles derived from the judgment in *R (on the application of PS)*

(i) A decision to impose treatment without consent potentially breaches Articles 3 and 8 and s. 58 must be read so as to ensure compliance with those Articles.

(ii) The SOAD's function essentially mirrors the best interests test, even in a case where the patient has capacity.

(iii) For Article 3 to be engaged, the acts complained of must reach a minimum level of severity. This will depend on the particular circumstances of the case, but in general it would have to involve actual bodily injury or intense physical or mental suffering. In deciding whether the minimum level of severity has been reached it is also necessary to take account of any positive effects of the treatment.

(iv) Only if the treatment complained of reaches the minimum level of severity is it relevant to consider the second issue under Article 3, which is whether the medical necessity for the treatment has been convincingly shown to exist. This can be broken down into a number of elements: how certain is it that the patient does suffer from a treatable mental disorder; how serious a disorder it is; how serious a risk is presented to others; how likely is it that, if the patient does suffer from such a disorder, the proposed treatment will alleviate the condition; how much alleviation is there likely to be; how likely is it that the treatment will have adverse consequences for the patient; and how severe are they likely to be?

(v) Even where the patient has capacity, the view of the doctors (approved clinician in charge of the treatment and SOAD) as to what is in his best interests can override the patient's objections to the treatment.

(vi) In relation to Article 8, non-consensual treatment will constitute an interference with Article 8 rights unless, under Article 8(2), it is "in accordance with law" and 'proportionate' (in other words, "necessary in a democratic society… for the protection of health").

(vii) The phrase "in accordance with law" refers not only to the requirements of s.58 but also imports the common law best interests test. This requires a consideration of whether there is a less invasive form of treatment that could be given instead and which would be likely to achieve the same results. It also requires consideration to be given to: the patient's resistance to treatment; the degree to which treatment is likely to alleviate or prevent a deterioration of his condition; the risk he presents to himself and to others; the consequences of the treatment not being given; and any possible adverse effects of the treatment. A relevant consideration in deciding whether the treatment is justified is whether it is likely to lead to the patient being rehabilitated rather than remaining subject to long-term hospitalisation.

Fig 1: Principles derived from the judgment in *R (on the application of PS)*[6]

[6] The Commission is grateful to Mr Robert Robinson, Mental Health Act Commissioner and solicitor, for this analysis of the judgment.

Practice requirements for Approved Clinicians in charge of treatments

6. The judgment in *PS* should reinforce existing good practice as outlined in the Mental Health Act Code of Practice and Care Programme Approach. The Care Quality Commission assumes that approved clinicians or SOADs considering the imposition of treatment in the face of a capable patient's refusal already apply the 'best interests' test, and only impose treatment if the patient's best interests are met by such intervention. However the *PS* judgment provides an indication of the legal expectations about how decisions to impose treatment are made. It is likely that future legal challenges to the imposition of treatment will focus on the process of decision-making.

7. The Commission advises approved clinicians (and SOADs where relevant) to use the following approach, drawing on guidance in the Code of Practice (chapters 23, 24), and the Care Programme Approach, to the care of all detained patients following admission:
   (i) The mental capacity of the patient in relation to decisions regarding specific treatment proposals must be assessed and recorded in the patient's notes. Capacity assessments i.e. the patient's consent to particular treatments, should be regularly reviewed;
   (ii) Patients must be provided with appropriate opportunity to receive and understand information on the nature, purpose, likely effects of and alternatives to proposed treatment. Explanation and information form essential elements in determining a patient's mental capacity to make a particular treatment decision. As outlined in the Code of Practice for the Mental Capacity Act 2005, efforts should be made to provide information appropriate to the particular patient and their efforts to comprehend facilitated, perhaps over a period of time, where capacity is border-line;
   (iii) Discussions with patients regarding proposed treatment and consent to such treatment should be well documented from admission onwards, even during the period ('3 month rule') where such treatment can be given without consent;
   (iv) All patients have a right (MHA s.132) to information on the powers under which they are held and the effects of those powers, including the legal and practical mechanisms under which treatments can be administered. Clinically appropriate and relevant information should be provided with reinforcement over time.
   (v) Patients' views must be taken into account when determining their 'best interests' if treatment is likely to be imposed on them. (see also *(vii)*, Fig 1 above for 'best interests' criteria).
   (vi) The Commission strongly advises Approved Clinicians in charge of treatment to ensure there is a clear record in patients' clinical notes of treatment

decisions and their justification. Patients will generally have access to the treatment decision and rationale behind it in their written care plan.

Questions or concerns about this guidance should be addressed to the Care Quality Commission, The Belgrave Centre , Stanley Place, Talbot Street, Nottingham ,NG1 5GG, Telephone: 0115 8736250
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