

‘THE NECESSITY MUST BE CONVINCINGLY SHOWN TO EXIST’: STANDARDS FOR COMPULSORY TREATMENT FOR MENTAL DISORDER UNDER THE MENTAL HEALTH ACT 1983

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ABSTRACT

Current English law has few controls on the involuntary treatment of persons detained under the Mental Health Act 1983. In 2001, *R (Wilkinson) v. Broadmoor Special Hospital Authority* provided some hope that, in conjunction with the Human Rights Act and the European Convention on Human Rights (ECHR), meaningful substantive and procedural standards for compulsory psychiatric treatment might be developed, but that hope has not been fulfilled. Using *Wilkinson* and the ECHR jurisprudence as a starting point, this article considers when, if at all, compulsory psychiatric treatment might be justified. In particular, it considers the difference between the ‘appropriateness’ standard of the English legislation and the ECHR requirement of ‘therapeutic necessity’, the requirements for appropriate procedure and appropriate legislative clarity, how the courts should deal with disagreements among treating physicians, and the relevance of the capacity and best interests of the detained person.

Keywords: compulsory psychiatric treatment, compulsion, *Herczegfalvy*, *Wilkinson*, Mental Health Act 1983, best interests, mental capacity.

I. INTRODUCTION

The Mental Health Act 1983 as amended (most notably by the Mental Health Act 2007) contains few restrictions on the compulsory psychiatric treatment of detained patients. There are restrictions on psychosurgery and electroconvulsive therapy, and treatment continuing beyond three months requires a second opinion through a statutory scheme

that it is ‘appropriate’, but that is all: any other psychiatric treatment of detained patients may be given compulsorily, in the discretion of the responsible clinician.

A decade ago, a possibility was created that some significant exploration of the limits of this discretion might occur. *R (Wilkinson) v. Broadmoor Special Hospital Authority*¹ was on its face a procedural case about whether cross-examination of witnesses was permitted under a judicial review application, but it held the potential to open up a range of substantive questions about compulsory treatment to judicial scrutiny. Previous cases had for example tested the breadth of the phrase ‘treatment for mental disorder’ or sought confirmation that medical treatment should be given when individuals lacked or were of marginal capacity, but *Wilkinson* was about the administration of anti-psychotic medication in circumstances that were clearly within the legal parameters of the statute: this was unquestionably treatment for mental disorder of a person detained under the Mental Health Act 1983. The question was instead whether notwithstanding the domestic law the treatment should be enforced.

The primary ‘hook’ for this issue was the European Convention on Human Rights (ECHR), following the Human Rights Act 1998 taking effect the previous year. On the ECHR issues, the court held that neither *Wednesbury* nor even super-*Wednesbury* would be a sufficient standard of review.² A full-merits hearing was instead necessary, with cross-examination of witnesses available when appropriate. In reaching that result, the Court of Appeal opened up a very interesting substantive discussion as to the scope of permissible compulsory treatment, and made it clear that the courts had a role in ensuring that any compulsory treatment was indeed within that permissible scope. The stage seemed set for the development of a sophisticated jurisprudence on the scope of compulsory treatment under the Mental Health Act 1983.

That promise, sadly, was not fulfilled. It would seem that there have been a total of nine relevant decisions flowing from *Wilkinson* including both first instance and appellate judgments, relating to five applicants.³ All concerned the pre-2007 standard for compulsory treatment that had

¹ [2001] EWCA 1545, hereinafter *Wilkinson*.

² *Wilkinson* at para 36 (per Simon Brown L.J.); para 53 (per Brooke L.J.), para 83 (per Hale L.J.).

³ There is one case concerning PS, (*R (PS) v G* [2003] EWHC 2335 (*Admin*)), three concerning B (*R (B) v SS* [2005] EWHC 86 (*Admin*); *R (B) v SS* [2005] EWHC 1936 (*Admin*); *R (B) v SS* [2006] EWCA Civ 28), two concerning N (*R (N) v M* [2002] EWHC 1911 (*Admin*); *R (N) v M* [2002] EWCA Civ 1789), two concerning JB (*R (B) v Haddock* [2005] EWHC 921 and [2006] EWCA Civ 961) and one concerning Taylor (*R (Taylor) v Haydn-Smith* [2005] EWHC 1668 (*Admin*)).

continued beyond three months. All applicants have been unsuccessful, at all stages in their proceedings. Since 2006, the cases appear to have ground to a halt entirely. Little has been attained by way of clarifying the scope of permitted compulsion in psychiatric treatment.

The issues at the heart of *Wilkinson*, and in particular the question of when, if at all, compulsory psychiatric treatment is permissible, have not gone away. If anything, the legislative changes in 2007 weakened the test for compulsion, making the issues more pressing. While ECHR requirements will be pivotal to any debate in England regarding compulsory treatment, they are to be a floor and not a ceiling, and there is no reason that the discussion of standards of enforced treatment should be limited to ECHR analysis. Indeed, it will be argued below that the ECHR standards are themselves underdeveloped in this area, and the discussion advanced by this paper applies to a considerable degree to establishing meaningful ECHR standards, as well as to standards applicable in England and Wales. In addition to the ECHR standards, personnel enforcing treatment are exercising public law powers, and their actions must therefore be defensible according to general public law standards. The public law standard of review is super-*Wednesbury*,⁴ and thus somewhat less than for cases under the Human Rights Act, but there is a public law standard, nonetheless.

There are also ethical issues that come into play, and other international law, most significantly the new United Nations Convention on the Rights of Persons with Disabilities (CRPD).⁵ It is still too early to write with any certainty about how the CRPD will be interpreted, and a detailed analysis will not be offered by this paper. That said, the CRPD includes a right to medical treatment based on consent,⁶ and adopts a new approach that maximises capacity.⁷ All of this, along with the Convention's other guarantees, is to be provided in a framework that is free of discrimination:⁸ the expectation is that choices cannot be imposed on persons with disabilities when they are not imposed on persons without disabilities. It does seem clear that at the very least, much clearer justifications will be required for compulsory treatment in the coming years, if it is to be permitted at all, and it would be well to start a serious discussion of these issues now.

⁴ See *R (Brady) v Collins* (2000) 58 BMLR 173.

⁵ See United Nations General Assembly, A/61/611 (6 December 2006). The provisions concerning consent are contained in Art 25(d). Both the main CRPD and its first optional protocol, which allows for individual complaints to the CRPD Committee, took effect on 3 May 2008. The UK has signed and ratified both the CRPD and the option protocol.

⁶ Art 25(d).

⁷ Art 12.

⁸ Art 5.

II. COMPULSORY TREATMENT AS A HUMAN RIGHTS ISSUE

There seems to be a reluctance in the courts to acknowledge that compulsory treatment actually raises human rights concerns. In *R (JB) v Haddock*, for example, Auld L.J. held that ECHR safeguards should not be interpreted 'to cut across the grain of good medical practice'.⁹ This is perhaps based on an apparent sense in the wider world that psychiatric medication is unproblematic, with the reliable positive effects vastly and manifestly outweighing any negative effects. How else can one explain, for example, the statement by health minister Paul Boatang when the Richardson Committee was established that there is 'a responsibility on individual patients to comply with their programmes of care' and that '[n]on compliance can no longer be an option when appropriate care in appropriate settings is in place'.¹⁰ The image is one of no down-side to psychiatric medications.

Sadly, this is not a balanced reflection of the effects of the drugs. The benefits of psychiatric medication are not necessarily clear-cut, and the risks can be significant.¹¹ Indeed, more people now die from the adverse effects of anti-psychotic medication than are killed by people as a result of their mental disorder.¹² Adverse effects of antipsychotic drugs include obesity, diabetes, and dizziness. They also cause 'extrapyramidal symptoms', including parkinsonian symptoms (including tremors), dystonia (abnormal face and body movements), akathisia (restlessness), and tardive dyskinesia (rhythmic involuntary movements particularly of the tongue, lips, face, hands, and feet). These effects can be permanent. Even in the newer antipsychotics, these extrapyramidal symptoms occur in 35–55% of cases.¹³ Depression is normally treated with either tricyclic medication or selective serotonin re-uptake inhibitors (SSRIs). Tricyclic medication

⁹ *R (JD) v Haddock* [2006] EWCA Civ 961 para 33.

¹⁰ Department of Health, *Review of the Mental Health Act 1983* (Department of Health, 1999), 142 (Richardson Report).

¹¹ Unless otherwise indicated, medical information in this paragraph is drawn from Joint Formulary Committee [United Kingdom], *British National Formulary* (49th edn 2005) sections 4.2 and 4.3. The British National Formulary is available online free of charge at <<http://www.bnf.org>>.

¹² Deaths from anti-psychotic medication from 1997 to 2008 inclusive were 749: see written response by Jil Matheson, National Statistician, to Parliamentary Question 302898, HC Deb, 2 December 2009, column 825W. Homicides in the same period by people with mental illness at the time of the homicide were 658: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Annual Report (University of Manchester, 2011).

¹³ J Bobes and others, 'Frequency of Extrapyramidal Adverse Reactions in Schizophrenic Outpatients Treated with Risperidone, Olanzapine, Quetiapine or Haloperidol: Results of the EIRE Study' (2002) 22 *Clinical Drug Investigation* 609.

can cause heart problems, and deaths from heart attacks do sometimes occur. SSRIs can also cause nausea, gastro-intestinal problems and, less frequently, vascular problems. Medication may also interfere with the individual's lifestyle: much anti-psychotic medication has sedative properties, leaving an individual feeling drowsy or apathetic. These drugs also cause impotence or other sexual dysfunction in approximately 45% of individuals.¹⁴

This is not to deny the beneficial effects of these drugs in many (but not all) cases; it is instead to serve as a reminder that they can also be harmful. Consistent with this, the 2009 report of the United Nations Special Rapporteur for the Prevention of Torture notes the need for close scrutiny of any non-consensual administration of psychiatric medication.¹⁵ These are serious treatments, with serious human rights implications. That cannot be ignored in states that purport to take human rights seriously.

The reasons for treatment refusal are many and varied. Certainly, psychoses and similar manifestations of mental illness will be relevant in some cases, but there are other reasons for treatment refusal and non-adherence. Unsurprisingly, the presence of adverse effects is a significant factor: as extrapyramidal effects occur, refusals increase.¹⁶ Further, weight gain and sexual dysfunction are significant in service user attitudes to medication. In one study, obese people were more than twice as likely as people with normal body mass ratio to cease medication,¹⁷ and in another, 42% of men skipped medication because of sexual dysfunction.¹⁸ It would seem that relations between service user and prescribing physician are also relevant: poor communication between the two, and a lack of trust in

¹⁴ See M Olfson and others, 'Male Sexual Dysfunction and Quality of Life in Schizophrenia' (2005) 66 *J Clin Psychiatry* 331; K Rosenberg and others, 'A Survey of Sexual Side Effects among Severely Mentally Ill Patients Taking Psychotropic Medications: Impact on Compliance' (2003) 29 *J Sex Marital Ther* 289; T Apantaku-Olajide and others, 'Drug-induced Sexual Dysfunction and Mental Health Patients' Attitude to Psychotropic Medications' (2011) 26 *Sex Relation Ther* 145.

¹⁵ Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment (M Nowak), Interim Report, General Assembly A/63/175 (27 July 2008), para 63.

¹⁶ D Robertson and others, 'Predictors of Medication Discontinuation by Patients with First-episode Schizophrenia and Schizoaffective Disorder' (2002) 57 *Schizophr Res* 209; M Lambert and others, 'Impact of Present and Past Antipsychotic Side Effects on Attitude Toward Typical Antipsychotic Treatment and Adherence' (2004) 19 *Eur Psychiatry* 415.

¹⁷ P Weiden and others, 'Obesity as a Risk Factor for Antipsychotic Noncompliance' (2004) 66 *Schizophr Res* 51.

¹⁸ Rosenberg, n 16. See also Lambert, n 16.

the physician appear to predict treatment refusal.¹⁹ These factors all tie together in complex ways. Thus it would seem that psychiatrists are not good at identifying the adverse effects of relevance to service users when explaining proposed treatment,²⁰ and the use of compulsion can undercut the trust between psychiatrist and patient.²¹ Treatment refusals are thus a complex phenomenon, and the views of service users warrant appropriate respect. Courts have not necessarily acknowledged this, as in *R (B) v Haddock*, where Collins J. declined to hear the evidence of the patient, on the basis that ‘it did not seem to me that his evidence would conceivably assist me in reaching my decision’.²²

Further, it cannot be assumed that service users retrospectively approve of coercive measures to which they are subject (the ‘thank-you’ theory). Certainly, some do, and initial indications are that this may be particularly true when decisions are made on behalf of people lacking capacity. A study by Owen and colleagues of people lacking capacity admitted to London psychiatric facilities found 83% of those regaining capacity giving retrospective approval of the decisions made on their behalf.²³ The sample size for this study was only 35, but nonetheless the proportion of retrospective approvals is impressive. Other studies of retrospective views of coercion provide fewer grounds for optimism. In Priebe’s study of service user views a year after hospitalisation, only 40% of the 396 patients interviewed thought their involuntary admission justified.²⁴ This is broadly consistent with the smaller study by Gardiner and Lidz of retrospective approval of admissions in America, where roughly half of the sixty-five patients who did not think their detention justified when it occurred changed their view over time, but Gardner and Lidz note that even those who retrospectively viewed their detention as justified did not change in the way they felt about the admission: those that were angry at the time of admission were still angry. Even those who viewed their detentions as justified were

¹⁹ See discussion in A Mitchell and T Selmes, ‘Why Don’t Patients Take Their Medicine? Reasons and Solutions in Psychiatry’ (2007) 13 *Adv Psychiatr Treat* 336.

²⁰ J Day, P Kinderman and R Bentall, ‘A Comparison of Patients’ and Prescribers’ Beliefs about Neuroleptic Side-effects: Prevalence, Distress and Causation’ (1998) 97 *Acta Psychiatr Scand* 93.

²¹ R Kaltiala-Heino, P Laippala and R Salokangas, ‘Impact of Coercion on Treatment Outcome’ (1997) 20 *Int’l JL Psychiatry* 311.

²² [2005] EWHC 921 (Admin) para 14.

²³ G Owen and others, ‘Retrospective Views of Psychiatric In-patients Regaining Mental Capacity’ (2009) 195 *Br J Psychiatry* 403.

²⁴ S Priebe and others, ‘Patients’ Views and Readmissions 1 Year after Involuntary Hospitalisation’ (2009) 194 *Br Med J* 49. The authors consider that this may in fact be higher than the actual number, as roughly half of their original sample dropped out prior to the interview at the one year period.

still not grateful. Gardiner and Lidz view this as flowing from the feeling of injury consequent on the coercive elements of the detention, and the consequent loss of autonomy.²⁵ Consistent with this, Katsakou finds treatment satisfaction among those subject to enforced treatment lower than for those not coerced.²⁶ One thus cannot assume that patients are grateful for the treatment received; and when they are not, they can perceive the coerced treatment as remarkably violative – a reaction not necessarily noted or acknowledged by their professional carers²⁷ or the courts.

The standards of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) expressly preserve the decision-making rights over treatment of persons detained in psychiatric facilities:

Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.²⁸

This is consistent with jurisprudence in the United States, where such decision-making rights of persons detained in psychiatric facilities were held to be a constitutional principle in *Rogers v Okin* and *Rennie v Klein* thirty years ago.²⁹ Scotland, too, now allows compulsory psychiatric or other medical treatment only after a hearing before a

²⁵ See W Gardiner and others, 'Patients' Revisions of Their Beliefs about the Need for Hospitalization' (1999) 156 *Am J Psychiatry* 1385; and W Gardner and C Lidz, 'Gratitude and Coercion between Physicians and Patients' (2001) 31 *Psychiatr Ann* 125.

²⁶ C Katsakou and others, 'Treatment Satisfaction among Involuntary Patients' (2010) 61 *Psychiatr Serv* 286, 290. This study also finds that the relevant measure of coercion is the perceived coercion by the service user, not the formal legal mechanism, reminding us of the complex relationship between legal mechanisms and the experience of coercion.

²⁷ K Haglund and others, 'Forced Medication in Psychiatric Care: Patient Experiences and Nurse Perceptions' (2003) 10 *J Psychiatr Ment Health Nurs* 65.

²⁸ CPT Standards, CPT/Inf/E (2002) 1, Rev 2004, p. 57, para 41.

²⁹ *Rennie v Klein* 653 F 2d. 836 (USCA, 1981); *Rogers v Okin* 634 F 2d 650 (USSC, 1980); *Rogers v Okin* 738 F 2d 1 (USCA, 1984). A similar position has been adopted in Eire – see Mental Health Act (2001), discussed in detail by M Donnelly, 'Treatment for a Mental Disorder: the Mental Health Act 2001, Consent and the Role of Rights' (2005) *IJ* 220.

review tribunal, based on specific substantive and procedural safeguards.³⁰ None of these regimes entirely prohibit involuntary treatment; but all make it clear that compulsion is permitted only in strictly defined circumstances and only following appropriate procedural safeguards.

III. THE MENTAL HEALTH ACT PROVISIONS

The current law relating to treatment of detained patients is governed by part 4 of the Mental Health Act 1983. The general rule is contained in section 63:

The consent of a patient shall not be required for any medical treatment given to him for mental disorder from which he is suffering, not being a form of treatment to which section 57, 58, or 58A applies, if the treatment is given under the direction of the approved clinician in charge of the treatment.

The starting position of the legislation is therefore that the consent of patients is not required. While this applies only to ‘treatment... for mental disorder’, the courts have been expansive as to the meaning of this phrase, interpreting it in some circumstances to include enforced feeding,³¹ Caesarean section operations,³² and ‘milieu therapy’.³³

If treatment is for mental disorder, the legislation provides few safeguards. Psychosurgery may be performed only following the competent consent of the patient and the provision of a second opinion by a second opinion approved doctor (SOAD) – a psychiatrist appointed through the statutory scheme managed by the Care Quality Commission.³⁴

³⁰ Mental Health (Care and Treatment) Act 2003, asp 13, part 7.

³¹ See *R (Brady) v Collins* (2001) 58 BMLR 173 (QB); *B v Croydon DHA* (1994) 22 BMLR 13, affd [1995] 1 All ER 689 (CA).

³² See *Tameside and Glossop Acute Services Trust v CH* [1996] 1 FLR 762 (Fam).

³³ See *MD v Nottinghamshire Healthcare NHS Trust* [2010] UKUT 59 (AAC); *Reid v Sec State for Scotland* [1999] 1 All ER 481 (PC). ‘Milieu therapy’ occurs when the structured environment of the ward results in a reduction in the manifestations of an individual’s disorder. The Code of Practice draws the distinction between ‘nursing and specialist day-to-day care’, which can be treatment for mental disorder, and ‘simply detaining someone – even in a hospital’, which cannot; but in practice it is difficult to see clear distinctions between these: see Department of Health, *Code of Practice: Mental Health Act 1983* (London: The Stationery Office, 2008), para 6.17–18.

³⁴ See s 57(1)(a). By regulation, the ‘surgical implantation of hormones for the purpose of reducing male sex drive’ is subject to similar restrictions (see SI 2008/1184, reg 27), but this has no practical effect as it does not cover hormone analogues (the prevalent current treatment), nor the oral administration of these substances (the current preferred method of administration): see *R (X) v MHAC* (1988) 9 BMLR 77 at 85.

Restrictions also exist for electro-convulsive therapy, most significantly that it may be refused by a competent patient.³⁵

Otherwise, the only statutory restriction on compulsory treatment commences 3 months after medication is first given to the patient in his or her period of detention. From that time, treatment may occur if either the patient has capacity and consents to the treatment, or if a SOAD certifies that the patient either lacks capacity or is not consenting to treatment and that 'it is appropriate for the treatment to be given'.³⁶ This is a new standard, introduced by the Mental Health Act 2007. Previously, the SOAD had been required to certify that 'having regard to the likelihood of its alleviating or preventing a deterioration of [the patient's] condition the treatment should be given'. This is not merely a cosmetic change. In *Wilkinson*, the court held contrary to the then current guidance that SOADs were not merely to certify that proposed treatment was 'reasonable in light of the general consensus of appropriate treatment'; they were instead to reach their own independent judgment based on the section 58 criteria.³⁷ While the Code of Practice now requires the SOAD to reach an independent decision, the move to an 'appropriateness' test may well mean that it is now a decision as to the reasonableness of the treating physician's approach. This suggests a shift towards a *Bolam*-style threshold, rather than a test of what the SOAD would have done himself or herself. The 'appropriateness' language further mirrors the change to the previous treatability requirements for detention under section 3 of the Mental Health Act, and the changes in that context were broadly perceived as lowering the requirements for confinement of people for whom the old treatability test applied. The ramifications of that change will be discussed further below; but it is worth noting here that all the post-*Wilkinson* cases rely on the pre-2007 wording of section 58, and the standard appears to have fallen since that time.

Even for those patients within its remit, it is not obvious how much real protection the SOAD scheme offers. In 2008, while SOADs recommended some change to treatment plans in roughly one case in four, most of these were 'slight'. 'Significant' amendments were required in

³⁵ S 58A.

³⁶ S 58(3).

³⁷ *Wilkinson* para 32–33, 71; see also discussion in P Bowen, 'Detained Patients and the Right to Refuse Treatment' [2002] JMHL 59, 61. A similar point is made by the Court of Appeal in *R (B) v S* [2006] EWCA Civ 28; see also discussion in P Hope, 'Paternalism or Power? – Compulsory Treatment Under Section 58 of the Mental Health Act 1983' [2006] JMHL 90, 99.

only about 4% of cases.³⁸ There may be a variety of reasons for the relative rarity of these changes; but the high level of agreement is notable.

The SOAD system takes effect only after the first 3 months of detention – significantly longer than most detentions last. In the initial 3-month period, all psychiatric treatments except psychosurgery and ECT may be enforced at the discretion of the patient's responsible clinician. In 2009–10, 45,755 people were detained under the Mental Health Act 1983; SOAD opinions were given regarding these people in 8,781 cases – just under 20%.³⁹ For more than 80% of persons detained, therefore, compulsory treatment was at the sole discretion of their responsible clinician acting under the authority of section 63, with no formal safeguards or procedures required at any time. In its final report prior to its incorporation into the Care Quality Commission, the Mental Health Act Commission noted the deficiencies of this situation:

It seems quite possible that the absence of an external safeguard in relation to the imposition of medication without consent for such a period will, at some future point, be found incompatible with human rights obligations, given modern medical practice and pharmacopoeia.⁴⁰

Section 58 does provide some statutory language for the SOAD in determining whether treatment should be compelled, but both sections 58 and 63 are silent on the standard for compulsion to be applied by the responsible clinician. It is difficult to see that the standard for responsible clinicians can be lower than for the SOAD. Section 58 establishes an appropriateness test for the SOAD; could it really be defensible that a responsible clinician would impose inappropriate treatment? For SOADs and responsible clinicians alike, however, some courts in the post-*Wilkinson* jurisprudence have acknowledged that even the stronger, pre-2007s fifty-eight test is not sufficient, and have provided more expansive dicta as to how the compulsion decision is to be approached. These dicta flow in part from the courts' interpretation of the relevant portions of the ECHR, and will be discussed following an introduction to the relevant ECHR case law, and the courts' interpretation of it.

³⁸ Mental Health Act Commission, *Coercion and Consent: Monitoring the Mental Health Act 2007–9*, being the thirteenth biennial report of the Mental Health Act Commission (The Stationery Office, London 2009), figure 50.

³⁹ Care Quality Commission, *Monitoring the Use of the Mental Health Act in 2009–10* (CQC, 2010) at 19, 83.

⁴⁰ Mental Health Act Commission, see n 38, para 3.17. (13th biennial report of the Mental Health Act Commission.)

IV. THE ECHR

The introduction of the ECHR into domestic law through the Human Rights Act 1998 provides the legal structure of the *Wilkinson* and post-*Wilkinson* decisions. This is problematic, as the ECHR case law is in a variety of respects unconvincing.⁴¹

The key case is *Herczegfalvy v Austria*.⁴² While *Herczegfalvy* remains the fundamental Strasbourg case on psychiatric treatment, its interpretation is problematic, and raises as many questions as it answers. It was not primarily a treatment case at all: the considerable bulk of the decision is spent on finer points of the distinction between detention under Article 5(1)(a) (criminals) and Article 5(1)(e) (persons of unsound mind), a question on which it is now largely forgotten. Insofar as it involved treatment, it is not entirely clear what the treatment involved. Certainly, it included being handcuffed to a security bed for a period of more than 2 weeks, and it included sedation to allow treatment with perfusions, and a significant period of enforced feeding, all of which were performed with considerable force. It also seems to have included neuroleptic medication. The applicant had been found some years prior at least partially to lack capacity; but the facts are entirely unclear as to whether he lacked capacity for the specific decisions at issue at the times those decisions actually arose.

At issue was whether the treatment constituted a violation of Article 3 (freedom from torture and inhuman or degrading treatment) or Article 8 (right to privacy and family life). The Court disposed of the Article 3 issue as follows:

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 has been complied with. While it is 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 and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3 (art. 3), whose requirements permit of no derogation.

The established principles of medicine are admittedly in principle

⁴¹ For a detailed discussion of the ECHR jurisprudence, see P Bartlett, O Lewis and O Thorold, *Mental Disability and the European Convention on Human Rights*, (Martinus Nijhof, Leiden 2007).

⁴² Application No. 10533/83, judgment 24 September 1992. (A/242-B) (1993) 15 EHRR 437.

decisive in such cases; as a general rule, a measure 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.

No violation of Article 3 was found.

Because of the factual limitations of the case, it is difficult to know quite how to read this passage. It seems that it is not restricted to individuals lacking capacity,⁴³ but the paternalism implied in any broader reading does not chime well with the languages of therapeutic alliances and partnerships that have arisen since the judgment appeared, almost 20 years ago. What exactly is the scope of the phrase ‘therapeutic necessity’? What evidence is required, and what criteria must the court require to satisfy itself that the medical necessity has been ‘convincingly shown to exist’? The Strasbourg court is itself extremely hesitant about second-guessing domestic courts on matters of evidence – indeed, this is a key reason why *Wilkinson* was itself found inadmissible by the Strasbourg court and did not progress to a full hearing.⁴⁴ This is not, of course, an argument that domestic tribunals should not themselves develop suitably robust thresholds of evidence and procedure.

Even where the Court has not been prepared to say that a specific medical treatment per se violates Article 3, the manner in which the treatment is performed may constitute a violation.⁴⁵ Indeed, there is jurisprudence that any use of force not strictly necessary is sufficient to trigger Article 3 in detained populations.⁴⁶ Thus handcuffing a prisoner during chemotherapy,⁴⁷ shaving a prisoner’s hair,⁴⁸ and strip searches conducted in an unduly invasive manner⁴⁹ have all been held to be violations of Article 3 in circumstances where the facts did not warrant the behaviour. If we are to accept that people detained in psychiatric facilities must have at least the same rights as prisoners, then the manner of

⁴³ See *Nevmerzhitsky v. the Ukraine*, Application No. 54825/00, judgment of 12 October 2005.

⁴⁴ See application no. 14659/02, judgment 28 February 2006 (2006) 13 Eur JHL 186. The court also relied heavily on the integrity of the SOAD system, a procedure that does not apply for 80% of detained patients, as discussed above.

⁴⁵ See, eg, *Nevmerzhitsky v the Ukraine*, Application No. 54825/00, judgment of 12 October 2005.

⁴⁶ *Ribitsch v Austria*, Application No. 18896/91, judgment 21 November 1995 (1995) 21 EHRR 573, para 38.

⁴⁷ *Mouisel v France*, Application No. 67263/01, judgment 14 November 2002 (2004) 38 EHRR 34, para 48.

⁴⁸ *Yankov v Bulgaria*, Application No. 39084/97, judgment 11 December 2003 (2005) 40 EHRR 36, para 120.

⁴⁹ *Valasinas v Lithuania*, Application No. 44558/98, judgment 24 July 2001, 12 B.H.R.C. 2, para 117 and *Van der Ven v the Netherlands*, Application No. 50901/99, judgment 4 February 2003 (2004) 38 EHRR 46, para 62.

enforcement of treatment will be of particular relevance. All these cases are post-*Herzegfalvy*, and it is fair to wonder how the court would now approach the use of force in that case, in light of the subsequent jurisprudence.

The case may actually be stronger for persons detained in psychiatric facilities, based on the vulnerability of those people, noted by the court in the quotation from *Herzegfalvy* above. This was certainly the position in *Keenan v the United Kingdom*:

In particular, the assessment of whether the treatment or punishment concerned is incompatible with the standards of Article 3 has, in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment[.]⁵⁰

The fact that Article 3 may be violated by the manner in which the activity is done, even if the activity itself may themselves have been objectively appropriate, opens a wide variety of questions in a psychiatric context about doctor–patient interactions, choices of medications, and uses of force in implementing those choices, and in turn how these issues relate to the broader question of therapeutic necessity. By way of example, if a person with bipolar disorder is prepared to consent to anti-depressant A but not to antidepressant B, can he or she be forced to take B, assuming that there is little therapeutic reason to choose between the two? If B is indeed better than A, can its better efficacy be used to override the refusal, even if A would also be an appropriate (but not the medically optimal) treatment? The existing jurisprudence does not provide clear answers.

If the treatment of Article 3 in *Herzegfalvy* is problematic, the treatment of Article 8 is even more unsatisfactory. The court's reasoning is perfunctory:

86. The first two complaints relate to facts already complained of from the point of view of Article 3 (art. 3). Reference should therefore first be made to paragraph 83 above. In addition, the Court attaches decisive weight here to the lack of specific information capable of disproving the Government's opinion that the hospital authorities were entitled to regard the applicant's psychiatric illness as rendering him entirely incapable of taking decisions for himself. Consequently, no violation of Article 8 (art. 8) has been shown in this respect.

⁵⁰ Application No. 27229/95, judgment of 3 April 2001 (2001) 33 EHRR 38, para 111.

On one reading, this seems to say that people lacking capacity are unable to claim violations of Article 8. That position must be incorrect: rights to privacy and family life do not cease merely because an individual lacks capacity. At a deeper level, the statement does not deal with the different content and structures of Articles 3 and 8. Is it the intent of the Court to say that the thresholds for engagement of Article 8 are the same as those in Article 3, and that the therapeutic necessity test may be carried over as the test for a violation of Article 8? That approach is rightly criticised by Charles J. in *R (B) v SS*,⁵¹ but phrasing of paragraph 86 raises the question of whether this is actually what the court meant. In any event, even if (as seems likely) the criticism is correct, it raises the question of what is required by Article 8, if not Article 3 standards and approach? *Herczegfalvy* does not provide an answer.

Unlike Article 3, which admits of no derogation, Article 8 initially provides in paragraph (1) a right to private and family life, but allows in paragraph (2) interference with that right when ‘in accordance with the law’, and ‘necessary in a democratic society’ in the interests of, inter alia, the prevention of disorder or crime, the protection of health or morals, or the protection of the rights and freedoms of others.

Other ECHR jurisprudence would suggest that the threshold for engagement of Article 8(1) is low in the case of institutional medical treatment. *YF v Turkey*⁵² concerned a gynaecological examination of a woman in police custody. The Court held that even a minor medical intervention, if performed without consent, constituted an interference with Article 8 rights. It was not clear whether YF had in fact consented, but the court went on to hold that because of the control exercised over YF flowing from her detention, she could not have been expected to object to the examination. It therefore found an interference of her rights under Article 8 even if she had consented.⁵³ On this basis, it would seem that most treatment of detained people in psychiatric facilities – even treatment to which they consent – is likely to interfere with the rights in Article 8(1), and require justification under Article 8(2).

Article 8(2) requires that the interference in question is ‘necessary in a democratic society’ for one of the purposes listed in that sub-article. While ‘necessary’ does not mean indispensable, it does mean more than ordinary, reasonable, or desirable.⁵⁴ For the overarching policy of compulsory psychiatric treatment, this will presumably require that governments demonstrate a real need for treatment under compulsion. The fact that compulsory treatment exists in most jurisdictions in the

⁵¹ [2005] EWHC 1936 (Admin), para 78–80.

⁵² Application No. 24209/94, judgment of 22 July 2003, (2004) 39 EHRR 34.

⁵³ Paras 33–35.

⁵⁴ *Handyside v the United Kingdom* (A/24) (1976) 1 EHRR 737.

world will presumably be noted by a court considering this issue, but it is not analytically satisfying. Article 8(2) presumably requires governments to make a principled defense of their practice. This may be challenging. Compulsory treatment has long been a part of the mental health law landscape, and its justifications are largely unspoken. It is not obvious, for example, that it can be justified for public safety: ex hypothesi, the individual subject to compulsory treatment under the Mental Health Act 1983 is detained in a psychiatric facility, and the public is not therefore at risk. Arguments based on the protection of health are similarly problematic, in that they are based on the notion that compulsory treatment produces significantly better health outcomes than a lack of compulsion. In community settings, where the most developed empirical literature exists, evidence for this proposition is stubbornly elusive.⁵⁵ It would also seem that, in most cases, people who initially refuse treatment move on to take similar treatment without legal compulsion after a relatively short time.⁵⁶

We further know very little about the circumstances in which compulsory treatment is imposed. The experience of patients would suggest that at least some compulsion flows from administrative short-cuts or pressures on clinicians' time, and that better patient relations would reduce the need for compulsion. Mark Gray, a member of the Service User Review Panel of the Care Quality Commission, comments:

The doctor tells you what you should have and then prescribes it. There is no discussion or choice or any information leaflets given to you to help you understand it. The only option left open to the patient is to refuse the medication which results in an independent

⁵⁵ See S Kisely and others, 'Compulsory community and involuntary outpatient treatment for people with severe mental disorders' (Cochrane Library, 2005), available at <<http://www.thecochranelibrary.com>>; R Churchill and others, *International Experiences of Using Community Treatment Orders*, (Institute of Psychiatry, London 2007).

⁵⁶ It would seem that something in the range of 5–10% of patients refuse treatment initially. In the classic study by Hoge and others, more than half of the patients initially refusing treatment eventually agreed to treatment after a mean period of 7 days. Of the remainder, roughly half were permitted by their physicians to refuse medication, generally either because the refusal was viewed as not medically unreasonable or because the physician viewed it as in the longer term interest of the patient for the refusal to be complied with: see S Hoge and others, 'A Prospective, Multi-center Study of Patients' Refusals of Antipsychotic Medication' (1990) 47 Arch Gen Psychiatry 949. Similar results are found in Kasper and others' study, where 13% of patients initially refused treatment, but of this group, 68% ended their refusal within 2 days (the median length of refusal), and 90% within 4 days: J Kasper and others, 'Prospective Study of Patients' Refusal of Antipsychotic Medication Under a Physician Discretion Review Procedure' (1997) 154 Am J Psychiatry 483.

doctor visiting you, who then can give you the information you require and a helpful discussion.⁵⁷

It is difficult to see that compulsion would be justified if consent would follow from a full discussion of the drug and its effects.⁵⁸ It is not clear how frequently compulsion could be avoided by a different approach to patient care; but it does seem that if compulsion is to be justified, much clearer evidence should be required as to how it is used currently, and the circumstances in which it is actually necessary, rather than merely convenient.

Once Article 8(1) is engaged, the non-discrimination provisions of Article 14 should also come into play for any justification under Article 8(2). While disability is not one of the specifically enumerated grounds in Article 14, the list in that article is not closed, and the ECtHR has now held that it is included by implication.⁵⁹ If this approach is adopted regarding non-consensual treatment, it will be necessary for governments to explain why such measures are necessary for mental illnesses, but not for physical illnesses. It is not obvious that this will be easy, based on health outcomes.

The ECHR further requires that domestic legislation be formulated with a reasonable degree of specificity. The classic test, contained in *Sunday Times v the United Kingdom*, requires sufficient precision that the citizen may, with legal advice if necessary, reasonably foresee the consequences of his or her actions.⁶⁰ In the context of compulsory treatment, the issue is not merely that the citizen – the patient in the current context – can foresee the consequences of his or her actions; it is also that the person imposing the compulsion (the responsible clinician, here) is given sufficient guidance to ensure a reasonable degree of consistency between decision-makers. Absent such a standard, the imposition of treatment becomes a matter of luck as to who is the responsible clinician, and human rights become a lottery.

It is difficult to see that the Mental Health Act provisions meet this

⁵⁷ Care Quality Commission, *Monitoring the Use of the Mental Health Act in 2009/10* (Department of Health, 2010) 85. This may be a significant problem. In Haglud's study comparing service users' and nurses' experiences of involuntary treatment, all patients interviewed proposed alternatives to compulsion; no nurses did: K Haglud and others, 'Forced Medication in Psychiatric Care: Patient Experiences and Nurse Perceptions' (2003) 10 *J Psychiatr Mental Health Nurs* 65 at 70.

⁵⁸ Regarding service user understanding more generally as a determinant of drug compliance, see A Mitchell and T Selmes, 'Why Don't Patients Take Their Medicine? Reasons and Solutions in Psychiatry' (2007) 13 *Adv Psychiatr Treat* 336, especially at 339–40, 43.

⁵⁹ *Glor v Switzerland*, application no. 13444/04, judgment of 30 April 2009.

⁶⁰ *Sunday Times v the United Kingdom*, Application no. 6538/74, judgment 26 April 1979, (1979) 2 EHRR 245, para 49.

standard. No substantive guidance is provided to responsible clinicians as to how their discretion to impose treatment is to be exercised. Even the non-binding Code of Practice is largely silent on the issue. The Code does note that consent should be sought ‘wherever practicable’⁶¹ and that when consent is withdrawn ‘[t]he clinician in charge of the treatment must consider whether to proceed in the absence of consent, to provide alternative treatment instead or to give no further treatment’.⁶² It notes the possibility of infringements of Articles 3 and 8 of the ECHR, but claims that ‘[s]crupulous adherence to the requirements of the legislation and good clinical practice should ensure that there is no such incompatibility’.⁶³ It is difficult to see that this provides meaningful guidance. As there are no additional procedural safeguards for the first 3 months of detention, the Act provides no substantive criteria in this period. Even beyond this period, it is difficult to see that the ‘appropriateness’ test of section 58 provides anything resembling the level of certainty required by the *Sunday Times* test. Some guidance for SOADs is provided by the Code of Practice,⁶⁴ but there is no mechanism in place to determine whether it is being followed.

V. ISSUES FROM THE POST-WILKINSON JURISPRUDENCE

A. ‘Appropriate’ Treatment and ‘Therapeutically Necessary’ Treatment

As noted above, the provision of treatment which is not ‘therapeutically necessary’ to detained patients risks violation of Article 3. The post-*Wilkinson* jurisprudence is directed to the pre-2007 test for SOADs, that ‘having regard to the likelihood of its alleviating or preventing a deterioration of [the patient’s] condition, the treatment should be given’. Since the 2007 Act took effect in 2009, the test has instead become whether it is ‘appropriate that the treatment be given’.⁶⁵

There are a variety of difficulties with this standard. The first is that it would appear to set a standard well below therapeutic necessity. Many treatments may appropriately be prescribed which are not therapeutically necessary. Treatments which attack the symptoms of a disorder but not the underlying disease are an obvious example. It may be entirely appropriate that doctors prescribe medication that merely

⁶¹ Code of Practice, para 23.27.

⁶² Code of Practice, para 23.38.

⁶³ Code of Practice, para 23.41.

⁶⁴ Code of Practice, para 24.58; Care Quality Commission, ‘Guidance for SOADs: Consent to Treatment & the SOAD Role Under the Revised Mental Health Act’ (CQC, 2008) Appendix A.

⁶⁵ MHA s 58(3)(b), as amended by the MHA 2007.

makes us feel better (painkillers, for example); but patients refusing such medication will not necessarily get better any slower than those taking it. Such medication cannot be seen as therapeutically necessary, if what is meant by that is treating the underlying disorder or improving outcomes.

Therapeutic necessity also implies a severity to the disorder that is to be treated: treatment of minor or unthreatening conditions may certainly be appropriate; it is less obvious that it is therapeutically necessary to a degree that warrants compulsion, at least in the absence of incapacity. Consistent with this, some jurisdictions impose criteria related to the severity of the condition, before compulsory treatment may be given. Generally, these refer to the safety of the patient or others.⁶⁶

The Court of Appeal in *R(N) v (M)* went some way to defining a standard of medical necessity:

The answer to that question will depend on a number of factors, including (a) how certain is it that the patient does suffer from a treatable mental disorder; (b) how serious a disorder is it; (c) how serious a risk is presented to others; (d) how likely is it that, if the patient does suffer from such a disorder, the proposed treatment will alleviate the condition; (e) how much alleviation is there likely to be; (f) how likely is it that the treatment will have adverse consequences for the patient; and (g) how severe may they be.⁶⁷

This goes some way to establishing a framework, but it does little to determine a standard. The cases have not required formal evidence directed to these factors, and as noted, no patient has yet successfully challenged a decision to treat with compulsion, suggesting that the current requirements are not high.

No standard is in the Mental Health Act 1983 itself. The Act does provide that 'it is appropriate for treatment to be given to a patient if the treatment is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case'.⁶⁸ It is not obvious that this advances interpretation much, although it does seem to focus the evaluation on the individual patient, taking into account medical and non-medical factors. While a

⁶⁶ See, eg, Mental Health (Care and Treatment) (Scotland) Act, s 57(3)(c). Safety-based standards also exist in America; see *Hightower by Dahler v Olmstead*, 959 F. Supp. 1549 (N.D. Ga. 1996), *Fisk v Letterman*, 501 F. Supp. 2d 505 (S.D. N.Y. 2007). *Matter of Gertrude K.*, 177 Misc. 2d 25, 675 N.Y.S.2d 790 (Sup. Ct. 1998). These jurisdictions generally also require a lack of capacity or similar standard of impaired decision-making prior to involuntary treatment: see, eg, *Matter of Joseph O.*, 245 A.D.2d 856, 666 N.Y.S.2d 322 (3d Dep't 1997), and s 57(3)(d) of the Scots Act.

⁶⁷ [2002] EWHC 1911 (Admin) para 19.

multi-faceted analysis may be desirable in the context of deciding on treatment under compulsion, it is problematic to apply to the *Herczegfalvy* standard, which refers expressly to the 'principles of medical science' and 'therapeutic' necessity. The *Herczegfalvy* standard seems to reflect an internalist medical discourse, where the statutory approach is expressly wider than this. The expansion to a wider field of analysis is appealing, in its acknowledgement that appropriateness of compulsion involves the actual effect on the individual patient, not merely internalist medical health outcomes. This broader approach is visible in cases such as *Keenan*, noted above; but it is less obvious how it integrates with the more insular medicalism *Herczegfalvy*.

The broader range of factors further creates problems of its own. It appears to mean that enforced treatment of a person from one culture would constitute an ECHR violation where the same treatment in the same circumstances of a person from another culture would not. This is intuitively problematic, and potentially engages the non-discrimination provisions of Article 14. At the same time, there may well be cases where failure to take cultural difference into account may itself trigger an ECHR claim, including a claim under Article 14. The expectation that a history of sexual abuse will be discussed in detail with a male therapist may impact very differently on women from different cultural or religious backgrounds, for example. This in turn opens up a wide range of issues about what is required by different religions or cultures, and how far human rights law should take that into account – issues outside the scope of this paper, but issues that need to be thought through with care if compulsion is to be justified. It seems very unlikely that they were considered in the rather bald language of the *Herczegfalvy* decision.

The language of 'appropriateness' reflects the similar phrase 'appropriate medical treatment', which must be 'available' for detention beyond 28 days.⁶⁸ This test is discussed in some length in chapter 6 of the Code of Practice, and it may be that the similarity of language will mean that courts turn to this as an aid to interpreting the section 58 standard. This should be approached with considerable care, if at all. The Code notes that chapter 6 is about the test in the context of detention and supervised community treatment.⁷⁰ Detention and involuntary treatment are different decisions, with potentially quite different justifications. A key issue in detention may for example be public safety; but once the individual is detained, this objective is largely met. Justifications for compulsory treatment are different. As an ethical question, it

⁶⁸ S 64(3).

⁶⁹ S 3(2)(d) and 3(4).

⁷⁰ Code of Practice, para 6.1.

may be quite appropriate to require appropriate treatment to be available prior to detention; it is quite a different thing to say that because appropriate treatment is available, it should be administered by compulsion.

Chapter 6 of the Code requires that appropriate treatment 'must be treatment which is for the purpose of alleviating or preventing a worsening of the patient's mental disorder or its symptoms or manifestations'.⁷¹ This seems inoffensive, but not particularly enlightening in the context of compulsory treatment, beyond reinforcing the requirement in section 63 that the treatment must be for the mental disorder. More problematic are the Code's comments regarding the purposes of the treatment:

6.4 Purpose is not the same as likelihood. Medical treatment may be for the purpose of alleviating, or preventing a worsening of, a mental disorder even though it cannot be shown in advance that any particular effect is likely to be achieved.

* * *

6.6 Even if particular mental disorders are likely to persist or get worse despite treatment, there may well be a range of interventions which would represent appropriate medical treatment. It should never be assumed that any disorders, or any patients, are inherently or inevitably untreatable. Nor should it be assumed that likely difficulties in achieving long-term and sustainable change in a person's underlying disorder make medical treatment to help manage their condition and the behaviours arising from it either inappropriate or unnecessary.

On one level, these statements are perfectly sensible. The first is an acknowledgement that medicine can be an inexact science. Patients with physical ailments may well consent to treatments that have uncertain outcomes, and there may be no suggestion that they are treated inappropriately in those circumstances. The same uncertainties exist with psychiatric care. The second paragraph is an encouraging statement to the effect that clinicians should not give up on patients. This seems entirely laudable.

As standards for compulsory administration of treatment, however, these paragraphs are highly problematic. The Article 3 test flowing from the ECHR focuses to a marked degree on therapeutic necessity; that is not the same standard as therapeutic appropriateness. There is a difference between treatment a reasonable and competent patient

⁷¹ *Code of Practice* para 6.8.

might choose for himself or herself, and treatment which warrants compulsion. Other jurisdictions include requirements regarding the likelihood of success of treatment as part of their compulsion criteria,⁷² and this makes sense. Can it really be said that a treatment is a therapeutic necessity, when likelihood of a given result cannot be shown? In what sense can treatment that will not achieve long-term and sustainable change in a person's underlying disorder be understood as *therapeutically* necessary? The benefits that flow from the treatment must also, presumably, meet some sort of substantive threshold of degree of benefit to be 'necessary'. The Code quite rightly notes in paragraph 6.15 that stabilization of a condition that would otherwise worsen may sometimes be all that is realistic, and it is possible to imagine that treatments that will reliably achieve this end might sometimes meet a therapeutic necessity test; but the outcomes of treatment over non-treatment must presumably be real, significant, and manifest if treatment is to be considered 'necessary'. It is one thing to allow patients with capacity to choose to take treatment with significant risks and uncertain outcomes; it is quite another to compel them to do so.

An approach requiring reasonable certainty may be problematic in practice. Often, the predictability of the result will increase with a history of the use of the intervention in the patient's case: if drug A worked the last time, it may well work this time, if the individual's symptoms are similar. Two potential difficulties flow from this. The first is that it will be difficult to apply to people in their first episodes of mental ill health, when the track record has not been established. In practice, it seems that responses to serious mental illness involve a considerable amount of trial and error by clinicians in individual cases, trying to find the drug or drug combination that gets the best result with the fewest adverse effects. The results of this process can be mixed: sometimes, drug combinations are found which largely alleviate the disorder with minimal adverse effects; sometimes drug treatments have minimal beneficial effects, following considerable unpleasant adverse effects. In these circumstances, knowledge of probable outcomes in the specific case may be low, and the above standard would not allow compulsory treatment to be used to establish the therapeutic history that would reach the optimal treatment. While the practical difficulties this raises are acknowledged, it is not obvious that this warrants a departure from the standard: from a human rights perspective, it is difficult to see that people should be forcibly treated with mind-altering drugs that may have considerable adverse effects without a reasonable certainty about the positive results. Trial and

⁷² See, eg, Mental Health (Care and Treatment) (Scotland) Act, s 57(3)(b).

error does not belong in a human rights framework.

The second difficulty is that the reasons for the patient's rejection of the treatment may be increasingly significant when he or she has experience of the treatment. If one starts with a framework of non-discrimination, of course, the reasons for a competent patient's refusal of a treatment are not relevant: a competent patient is allowed in law to refuse treatment for any reason, good or bad, rational or irrational. That said, the ethical case for compulsion weakens when a patient objects to a treatment based on his or her actual experience of that treatment in the past. If, based on experience, the service user takes the view that the potential benefits do not warrant the adverse effects, that is a particularly powerful argument in opposition to compulsion: any other result makes a mockery of autonomy. The process of gaining the knowledge which might buttress a justification of compulsory treatment may therefore also enhance the respect that should be given to the patient's refusal of such treatment.

B. Medical Disagreement and the Role of the Court

It was argued above that reasonable certainty of diagnosis, therapeutically necessary treatment, and outcome should be required before involuntary treatment is contemplated. If such certainty is absent, it is difficult to see that a human rights infringement is 'balanced' by a corresponding benefit (if indeed such a balancing is the correct approach), since the benefit is speculative. The requirement that a therapeutic necessity must be 'convincingly shown to exist', as required by *Herczegfalvy*, suggests a medical consensus on the appropriate treatment in the patient's case, and disagreements between medical professionals are thus particularly problematic.

The response to disagreements between clinicians goes to the heart of the issue in *Wilkinson* itself, where the facts presupposed a real and legitimate clinical disagreement, and disagreements between clinicians feature in all the post-*Wilkinson* cases. The court in *Wilkinson* can be seen as adopting a classic judicial approach: evidence should be presented, including oral evidence if necessary; from this evidence, the court should reach the relevant findings of fact, and determine the questions at issue.

While this may be the classic role of a court, the courts themselves sometimes acknowledge that it is not necessarily a role that they perform particularly well, particularly on technical medical matters. It is thus fair to ask whether it is the right approach: if there is a real and bona fide disagreement between the clinicians as to diagnosis or appropriate treatment, should the court rather than deciding who is correct – a finding the court is not really equipped for – instead find

that a bona fide dispute exists and the level of certainty to justify compulsory treatment is therefore not met?

This approach was argued in *R (N) v M* in terms of what might be conceived as a reverse-*Bolam* test: if reasonable clinicians disagreed, the requisite standard of certainty would not be reached, and the treatment would not be convincingly shown to be medically necessary within the terms of *Herzcegfalvy*. The submission was rejected, both at first instance and on appeal,⁷³ essentially on the basis that there was no prior authority for the proposition, and on the basis that it was a test of negligence that should not be extended. Neither of these is particularly convincing, as they do not address the more significant point of how the court should deal with uncertainty or disagreement between clinicians about diagnosis and appropriate treatment.

On this issue, a *Bolam*-like approach seems to have much to recommend it. It must be the case that when faced with a disagreement, the court can reject opinions that are clearly inadequate. The approach allows the court to do so: opinions which are outside the range that a competent body of medical opinion would accept would be able to be ignored by the Court. In the event of a serious disagreement between professionals, all of whom are meeting the standard expected of competent clinicians, the Court would not have to make a decision as to who is 'right', a decision the Court is ill-equipped to make. That matter deserves a much more extensive discussion than that accorded in the *N* case.

C. *The Capacity of the Patient*

If non-discrimination on the basis of disability is a starting point for analysis, the capacity of the patient would seem to be of profound relevance. In England and Wales, non-psychiatric treatment is not imposed on patients who have capacity to consent to the treatment, even in cases where the refusal seems irrational or where the consequences of refusal are serious to the point of fatal. What can the justification be to enforce psychiatric treatment? We do, however, provide physical treatment without consent in the best interests of people who lack capacity.⁷⁴ The presence of a mental illness does not, of course, necessarily mean that the patient lacks capacity,⁷⁵ and a parallel approach could be adopted in mental health law.⁷⁶ If this approach were incorporated into English mental health law, persons with capacity could consent or refuse, and patients without capacity could be treated in their best interests, reflecting the position for non-detained psychiatric

⁷³ See [2002] EWHC 1911, para 113–116; [2002] EWCA Civ 1789, para 29.

⁷⁴ See Mental Capacity Act 2005.

⁷⁵ *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819, [1994] 1 WLR 290 (H.C.). Regarding the empirical literature surrounding psychiatric

patients and society as a whole for non-psychiatric treatments.

Such an approach is viewed sympathetically by Simon Brown LJ in *Wilkinson*.⁷⁷ The view of Hale L.J. was to the contrary:

I do not take the view that detained patients who have the capacity to decide for themselves can never be treated against their will. Our threshold of capacity is rightly a low one. It is better to keep it that way and allow some non-consensual treatment of those who have capacity than to set such a high threshold for capacity that many would never qualify.⁷⁸

Since *Wilkinson*, cases have viewed the presence of capacity as relevant but not determinative as to whether treatment should be enforced.⁷⁹

On examination, Hale's view is problematic. The standard of capacity in English common law and in the Mental Capacity Act 2005 is not really a low one. The classic array of tests of capacity to consent to medical treatment is contained in a paper by Roth, Meisel, and Lidz from 1977.⁸⁰ They list a range of possibilities, from being able to manifest a choice, up to actual understanding of the information provided. The English test, like many other modern legislative thresholds of capacity, is higher than any in their paper. It requires not merely an actual understanding of the information in question, but the ability to appreciate the consequences of the choice, and of the other choices open to the patient.⁸¹ This is not necessarily a criticism. It may well be appropriate that we insist that patients should have a reasonably

patients and capacity to consent to treatment, see P Appelbaum and T Grisso, 'The MacArthur Treatment Competency Study I: Mental Illness and Competence to Consent to Treatment' (1995) 19(2) *Law Hum Behav* 105; T Grisso and others, 'The MacArthur Treatment Competency Study II: Measure of Abilities Related to Competence to Consent to Treatment', (1995) 19(2) *Law Hum Behav* 127; T Grisso and P Appelbaum, 'The MacArthur Treatment Competency Study III: Abilities of Patients to Consent to Psychiatric and Medical Treatments' (1995) 19(2) *Law Hum Behav* 149.

⁷⁶ Such an approach is, indeed, adopted in some jurisdictions: see Ontario, Health Care Consent Act 1996, S.O. 1996, c. 2, sch. A. For a discussion of this legislation, see P Bartlett, 'English Mental Health Reform: Lessons from Ontario?' [2001] *JMHL* 27-43. Available online at <<http://eprints.nottingham.ac.uk/144/>>. Since *Rogers v Okin*, 478 F. Supp. 1342 (Mass. 1979), incapacity has also been pivotal to decisions regarding involuntary treatment in the USA. A similar standard of impaired decision-making is contained in the Scots legislation: see Mental Health (Care and Treatment) (Scotland) Act 2003, s 57(3)(d).

⁷⁷ *Wilkinson* at 30.

⁷⁸ *Wilkinson* at para 80. The third judge in *Wilkinson*, Brooke L.J., did not take a view on the relevance of capacity.

⁷⁹ See, eg, *R (PS) v G* [2003] *EWHC* 2335 (*Admin*) para 116; *R (B) v SS* [2005] *EWHC* 1936 (*Admin*) para 95.

⁸⁰ L Roth, A Meisel and C Lidz, 'Tests of Competency to Consent to Treatment', (1977) 134(3) *Am J Psychiatry* 279.

developed understanding of the nature and consequences of their treatment choices; but it is not a low standard. Indeed, it is somewhat difficult to see what higher threshold could be phrased in law, and still have the test one of capacity. Hale's position is further difficult to maintain when the actual case law is considered: the courts have seldom held that a patient has capacity, once that capacity is called into question.⁸² Hale's concern that using a threshold of capacity would force the standard of capacity upwards is not convincing: that pressure already exists and will continue to exist for physical illnesses. Insofar as the threshold is to be raised, therefore, it will be raised in any event. It is not obvious why applying the same standard to psychiatric treatments would affect this unduly.⁸³

While Hale's argument is problematic, her result should not necessarily be dismissed out of hand. Insofar as the tests of capacity are flexible, let alone manipulable,⁸⁴ results are unlikely to be consistent, valid, and reliable between decision-makers. This is in itself a reason to raise concerns about the use of capacity as a threshold, based on

⁸¹ Mental Capacity Act 2005, s 3(1)(c), 3(4). This largely reflects the common law test relating to capacity to consent to medical treatment existing at the time the statute was passed: see, eg, *Re MB (Medical Treatment)* [1997] 2 FLR 427; *Tameside & Glossop Acute Services Trust v CH* [1996] 1 FLR 762; *Re L (Patient: Non-Consensual Treatment)* [1997] 2 FLR 837.

⁸² See discussion in P Bartlett and R Sandland, *Mental Health Law: Policy and Practice* (3rd edn Oxford University Press, Oxford 2007) section 10.4. It would appear that this is not a uniquely English phenomenon. While interpretation of the Scots legislation is still in its early days, the Sheriff's Court has held that the requirement of impaired decision-making in the Scots act was met on the basis that a patient declined to speak or engage with staff regarding his treatment: see *M v Murray*, application B45/09, Sheriffdom of South Strathclyde, Dumfries and Galway, 17 April 2009, para 25. This does not suggest a robust approach to the Scots criterion.

⁸³ Section 58 of the Mental Health Act 1983 itself raises a problem of interpretation here that has to some degree vexed the courts. Treatment of a detained patient beyond three months may occur only if *either* the patient has capacity (as determined either by the responsible clinician or a SOAD) and consents to the treatment *or* the SOAD certifies that notwithstanding the competent refusal, the treatment should appropriately be given. The articulation of incapacity in s 58 requires that the patient 'is not capable of understanding the nature, purpose and likely effects of that treatment': s 58(3)(b). The absence of a requirement of appreciation in this test suggests that it is arguably lower than the common law threshold, and that contained in the Mental Capacity Act 2005. This view is supported by the case of *R (X) v Mental Health Act Commission* which further emphasises the patient's ability to understand, rather than his or her actual understanding: (1988) 9 BMLR 77 (DivCt), eg, at 85. This apparently lower threshold has been used in some of the post-*Wilkinson* jurisprudence to marginalise the role of capacity. In *R (B) v SS*, the first instance court held under the s 58 test, 'a patient might be regarded as having capacity even if he does not *actually* understand the nature, purpose and likely effects of the treatment': [2005] EWHC 86 (Admin) at para 76. This is not a convincing approach. If a

the *Sunday Times* threshold discussed above.

That said, if an individual is agreed to meet the current standard of capacity, he or she is therefore able to understand the information rel-

patient is able to understand the relevant aspects of the treatment and yet does not understand them, the question becomes why this is the case. Given that the patient has the relevant abilities, it is difficult to see that actual understanding would not be attainable, given additional effort and, perhaps, disclosure of relevant information to the patient. Thus a patient treated with medication covertly, as was the case in *RM v St Andrews* [2010] UKUT 119 (AAC), may have lacked actual understanding of the treatment; but this could presumably have been corrected if he were told he was being treated, and for what. This has obvious human rights advantages.

The absence of a requirement of ‘appreciation’ is however a real difference between the s 58 test and the approach used for medical treatment more broadly. It is difficult to see a logical reason to adopt a different standard for psychiatric and physical treatments. Not unreasonably, the Code of Practice does not attempt to set different capacity thresholds for treatment under s 58 and for other medical treatments, adopting the Mental Capacity Act approach as the baseline: see Code of Practice, paras 23.28 and 23.29. It is therefore open to question how far the lower test in s 58 is actually applied, and therefore to what degree the distinction between the tests is relevant in practice.

The drafting of the Mental Health Act provisions and the decision in the *X* case pre-date the careful analysis of incapacity law conducted by the Law Commission, a process that both resulted in the passage of the Mental Capacity Act 2005, and in the long run-up to that Act, affected the common law in the area: See Law Commission, *Mental Incapacity*, Law Com No. 231 (HMSO, 1995); Law Commission, *Mentally Incapacitated Adults and Decision-Making: An Overview*, Consultation paper 119 (HMSO, 1991); Law Commission, *Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction*, Consultation Paper 128 (HMSO, 1993); Law Commission, *Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research*, Consultation Paper 129 (HMSO, 1993); Law Commission, *Mentally Incapacitated Adults and Decision-Making: Public Law Protection*, Consultation Paper 128 (HMSO, 1993). There is no suggestion in the reasons of Simon Brown LJ in *Wilkinson* that he was considering anything other than the common law standard, and Hale LJ in that case refers to the common law standards specifically as influenced by the Law Commission reports as the basis of her reasoning: see *Wilkinson* at 66; see also *R (B) v SS* [2006] EWCA Civ 28, para 33. In that sense, the apparently lower standard of s 58 is a diversion: the comments of Hale LJ are meant to apply to the higher standard of common law, now also contained in the Mental Capacity Act. In any event, if a capacity threshold were adopted as relevant for decisions regarding compulsion base in part on an argument about non-discrimination, it would seem that the same threshold of capacity must be used for psychiatric and non-psychiatric treatment. Subject to the requirements of the CRPD, it is presumably the test applicable to consent more generally that should be considered.

⁸⁴ The degree to which capacity is insufficiently robust is a matter of dispute. The judicial decisions relating to incapacity do not inspire confidence in the robustness of the concept: see discussion in P Bartlett, ‘The Test of Compulsion in Mental Health Law: Capacity, Therapeutic Benefit and Dangerousness as Possible Criteria’ (2003) 11 Med L Rev 326. More recent empirical literature

evant to the treatment, to retain the information for a sufficient time to make a judgment on it, and to appreciate the consequences of the decision he or she is making, including the consequences of withholding consent to the treatment and the consequences of choosing other treatments, when available. This is a high standard indeed, and the decision made by a person with that standard of capacity warrants considerable deference. The non-discrimination point here is particularly relevant: why would we impose psychiatric treatment on a person making this standard of decision, when we do not do so for people making decisions related to physical health in these circumstances?

A rule that a capable person should be able to refuse psychiatric treatment may prove at least one piece of the best way forward. It is not entirely unproblematic, however. This is in part because of the malleability in the concept noted above. It is also because the effects of institutionalisation raise questions about the reality of choices made. This point was made in the *YF* case, where concern was raised that the applicant 'could not have been expected to resist submitting to such an examination in view of her vulnerability at the hands of the authorities who exercised complete control over her throughout her detention'.⁸⁵ This is in part a result of the perceived power of the authorities in the institution, but it is also likely to be a function of the nature of institutional life. While many detentions are now quite short, some are not. Wilkinson, for example, had been detained for 34 years.⁸⁶ One of the post-*Wilkinson* litigants had been detained for 10 years,⁸⁷ and another for 8 years.⁸⁸ At least since Goffman's work half a century ago,⁸⁹ it has been acknowledged that institutionalisation has effects on people, inducing specific forms of behaviour. Whether one now views this behaviour as compliance eroded into an individual by the system, or the generation of resistance reflected by challenges to the system in Foucauldian micro-theatres of power, we are a long way from the free and informed consent of liberal theory, and refusals of treatment must be understood accordingly. The unreality of voluntariness in the context of consent to psychiatric hospital admissions has long been noted;⁹⁰ it seems likely that there is a similar haziness surrounding consent to treatment while in psychiatric hospitals, with

suggests a consistency of capacity determination among doctors in a psychiatric setting, however: see R Cairns and others, 'Reliability of Mental Capacity Assessments in Psychiatric In-patients' (2005) 187 Br J Psychiatry 372.

⁸⁵ *YF v Turkey*, application No. 24209/94, judgment of 22 July 2003, (2004) 39 EHRR 34, para 35.

⁸⁶ *Wilkinson* at para 1.

⁸⁷ *R (B) v SS* [2005] EWHC 86, para 8.

⁸⁸ *R (PS) v G* [2003] EWHC 2335 (*Admin*), para 26.

⁸⁹ E Goffman, *Asylums* (1961).

capacity not really being questioned as long as the individual is taking his or her meds, in circumstances where the patient would not meet any meaningful test of capacity.

All these issues may well become more problematic as the CRPD is implemented. On some readings, the CRPD requires us to move beyond the competent/incompetent distinction, to a world where capacity is never entirely lost, and supported decision-making takes a new prominence.⁹¹ Such an abandonment of capacity as a concept would be a significant shift in the legal landscape, as a move towards an increased role for capacity has for a number of years been a part of the drive for more progressive and non-discriminatory mental health law.⁹² While this is not necessarily the only reading of Article 12, it is a sufficiently prominent interpretation that a number of signatories to the CRPD entered reservations to the Convention, protecting their right to allow for substitute decision-making,⁹³ and initial indications are that it is the reading of the UN Committee on the Rights of Persons with Disabilities.⁹⁴ Insofar as the result is a lowering or removal of the threshold of capacity, the temptation is to give additional credence to Hale's view, where maximum capacity was traded off to compulsion of the capable in some circumstances. This would not be consistent with the tenor of the CRPD, however, which is specifically designed to minimise compulsion of people with disabilities.

These comments serve as a reminder that capacity is not without its problems. And they do suggest that safeguards other than capacity may well be necessary prior to the provision of treatment without

⁹⁰ The groundbreaking paper on this point was J Gilboy and J Schmidt, "Voluntary" Hospitalization of the Mentally Ill' (1971) 66 Northwestern Law Rev 429. Since that time, there has been a considerable array of academic literature. The matter is further at the core of *HL v the United Kingdom*, application no. 45508/99, judgment of 5 October 2004 (2005) 40 EHRR 32.

⁹¹ See UN Committee on the Rights of Persons with Disabilities, Concluding Remarks on Tunisia, CRPD/C/tun/co/1, para 23; A Dhanda 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' (2007) 34 Syracuse J. Int'l L. & Com. 429, 456–60; Michael Bach and Lana Kerzner, 'A New Paradigm for Protecting Autonomy and the Right to Legal Capacity', report to the Law Commission of Ontario, 2010. Available at <<http://www.lco-cdo.org/en/disabilities-call-for-papers-bach-kerzner>>, accessed 16 August 2011.

⁹² See, eg, N Eastman and J Peay, *Law without Enforcement: Integrating Mental Health Law and Justice* (1999); J Dawson and G Szmukler, 'Fusion of Mental Health and Incapacity Legislation' (2006) 188 Br J Psychiatry 504–9.

⁹³ See, eg, Australia, Canada, and Egypt. The UK made no reservation on this basis. Copies of all reservations are available online at <<http://www.un.org/disabilities>> accessed 11 May 2011.

⁹⁴ See UN Committee on the Rights of Persons with Disabilities, Concluding Remarks on Tunisia, CRPD/C/tun/co/1, para 23.

consent.

D. Resistance to the Treatment

Some of the post-*Wilkinson* cases have held that the actual resistance of a patient to the proposed treatment is a relevant factor in deciding whether treatment should be enforced.⁹⁵ This must be correct. The threshold for degrading treatment under Article 3 of the ECHR is met when treatment is ‘such as to arouse in the victims feelings of fear, anguish and inferiority capable of humiliating and debasing them’.⁹⁶ There is nothing to suggest that people lacking capacity are somehow immune to feelings of fear, anguish, or humiliation. The existing English law does allow for the overriding of resistance to treatment where the intervention is in the best interests of a person lacking capacity, if the intervention is necessary to prevent harm and if the intrusiveness of the intervention is proportionate to the seriousness and likelihood of the harm.⁹⁷ There is no reason not to incorporate that approach into the analysis of compulsory treatment in the Mental Health Act, at least for people lacking capacity.

If that is the approach taken, many of the issues that arise in the context of a best interests test, discussed in the next section, will be relevant. In particular, some meaningful processes need to be developed to ensure that the tests do not become mere ‘tick boxes’, but do in fact represent real safeguards.

E. Best Interests and Therapeutic Necessity

A number of the post-*Wilkinson* cases adopted variants of a best interests model for compulsory treatment, either through provision of a gloss on the s 58 test as it was then phrased, or independent of that test. The High Court in *R (N) v M* applied the common law best interests test⁹⁸ – a flexible ‘balance sheet’ approach of risk–benefit analysis that allows for inclusion of medical and non-medical factors, used prior to the Mental Capacity Act 2005 for decision-making for people lacking capacity. Similarly, the Court of Appeal in *R (B) v SS* extended the statutory language to include a best interests test by implication:

⁹⁵ *R (PS) v G* [2003] EWHC 2335 (*Admin*), para 117, distinguishing *Wilkinson*. See also *R(B) v SS* [2006] EXCA Civ 28, para 62, discussed below.

⁹⁶ *Kudła v Poland* (Application No. 30210/96, judgment 26 October 2000), para 92. The suffering must go beyond that which is inevitable in the context of a legitimate form of treatment or punishment. While an intent to degrade or to treat in an inhuman fashion is relevant to the finding of a violation, it is not a requirement: *Peers v Greece* (Application No. 28524/95, judgment 19 April 2001, para 74; *Price v UK*, Application No. 33394/96, judgment 10 July 2001, para 30.

⁹⁷ See Mental Capacity Act 2005, s 6.

The express criteria in section 58(3)(b), namely ‘the likelihood of its alleviating or preventing a deterioration of his condition’ should not be equated with the test of whether treatment is in the best interests of the patient. That question will depend on wider considerations than the simple question of the efficacy of the treatment, such as whether an alternative and less invasive treatment will achieve the same result. The distress that will be caused to the patient if the treatment has to be imposed by force will also be a relevant consideration. English common law and medical ethics both require that medical treatment shall not be imposed without the consent of the patient unless the treatment is considered to be in the best interests of the patient. Thus, while the specified criteria are obviously critical to the decision of whether the treatment should be given, they are not the only considerations that are relevant to that question. The SOAD has to certify that the treatment should be given and we do not see how he can properly do that unless satisfied that the treatment is in the best interests of the patient.⁹⁹

Now that the criteria in section 58 have moved to an appropriateness standard, it is fair to ask to what degree the new standard mirrors a best interest standard, and insofar as the latter is relevant, how it should be determined.

For people without capacity, a coherent argument can be made for the centrality of a best interests test. As noted above, the threshold for treatment other than that provided under sections 63 and 58 is the best interests test provided in the Mental Capacity Act 2005, enhanced by the provisions of that act relating to restraint, if the patient resists the treatment. It is not obvious why psychiatric treatment should be subjected to a higher standard than other medical care. This might suggest that for people lacking capacity, the statutory best interests test represents a sensible way forward. This may be the case, but its employment to this end diverges from current practice in ways that warrant consideration.

The Mental Capacity Act test of best interests requires that the views of the person lacking capacity be considered, along with the values and beliefs he or she would have taken into account had he or she had capacity.¹⁰⁰ While not utterly determinative, the intent of the Act does seem to be that these factors are meant to hold considerable sway. This would be a departure from the approach of the Mental Health Act 1983, which would appear to adopt a more medically objective test. The difficulties of fitting non-medical factors into the

⁹⁸ [2002] EWHC 1911 (Admin) at para 88–106.

⁹⁹ [2006] EXCA Civ 28, para 62.

Herczegfalvy framework have been noted already; in the present context, the question is instead whether the more subjective approach of the Mental Capacity Act test is workable and appropriate. Certainly, it has its advantages. For a patient who would consent to medically appropriate, albeit suboptimal treatment, this test provides a framework to consider the strength and relevance of those views. In cases of manifest objective justification, however, the patient's preferences could be overridden.

While the Mental Capacity Act approach has its merits, it is problematic in that it provides a range of factors for consideration as part of the determination, yet no clear way in which to prioritise those factors. It is all very well to say that the patient's view should hold sway unless outweighed by objective factors, but how great a clinical or other advantage must there be before the views of the patient are overruled? It is difficult to see that this can be readily codified, but it raises the question of whether the best interest test in the Act is sufficiently clear that consistency of results can be reasonably assured. A test of compulsion must not become arbitrary, so the absence of a robust structure here is problematic.

The views of a list of carers are also to be considered in determining the individual's best interests. This too would represent a departure from the current law (although perhaps not current practice?)¹⁰¹ if applied in a mental health context, as in the 1983 Act has no role for carers or relatives in deciding whether treatment should be imposed. Once again, there are advantages to this. If the patient is to be discharged in the future, the views of the carers regarding treatment may well be pivotal to the treatment's ongoing success post-discharge. Involvement of the carers while the individual is still in hospital can engage them early on in the treatment process, and establish a relationship of trust between them and the clinical team. There are also problems that flow from this, however. Involvement of carers places the compulsion issue into a social network, where the tradition in human rights law is to look to the individual as autonomous: relying on carers to justify compulsion may merely shift the human rights issue from the doctor–patient relationship to the family–patient relationship. For the person on the receiving end of the compulsion, this is not necessarily an improvement.

Further, the question arises as to how to respond if the carers are

¹⁰⁰ Mental Capacity Act 2005, s 4.

¹⁰¹ In the event that the treatment becomes subject to an opinion by a SOAD, Collins J in *R (B) v Haddock* makes it clear that the SOAD 'should, if he thinks it desirable to do so', consult with the patient's nearest relative, family, carers, or advocate: [2005] EWHC 921 (Admin) para 8. This is reflected in the Code of Practice at para 24.55.

resistant to treatment that appears to be medically necessary. If mere consultation is required, then the refusal can be overridden; but if the carer is a holder of a lasting power of attorney (LPOA) for personal care which covers the treatment decision, the Mental Capacity Act approach would preclude the treatment from being given.¹⁰² One could, of course, not allow such binding decisions by attorneys in a mental health context, but that raises the discrimination question: what is different about psychiatric treatment that would justify a different regime from physical treatment, where such decisions are binding? Conceivably, such a refusal by the holder of an LPOA might be judicially reviewable, if it was clear that he or she was not applying the best interests test, although there has yet to be a case where this has been tested under the 2005 Act. Such an escape would not apply for advance decisions to refuse treatment under the Mental Capacity Act 2005,¹⁰³ which raise comparable complexities. To adopt a non-discriminatory approach, these ought to be as enforceable in a mental health context as they are in any other medical context. This is not necessarily impractical: Ontario's legislation allows the enforceability of both advance treatment refusals and the decisions of holders of lasting powers of attorney.¹⁰⁴ It would however be a significant departure from the current approach to mental health compulsion in England, as it would allow a patient in advance to determine the scope of treatment applied to him or her under compulsion, during a subsequent period of incapacity. That said, if the ethical case were accepted that a competent patient could refuse psychiatric treatment, it is not obvious why the ethical case for the enforceability of advance treatment refusals would not equally follow.

For people with capacity, best interests may perhaps be a *sine qua non* of compulsory treatment, but it cannot be sufficient. People with capacity are permitted to make decisions against their best interests in other areas of life; it is not obvious why decisions regarding psychiatric treatment are different. Not all decisions in an individual's best interest will be therapeutically necessary. They are different concepts and different standards. The argument here closely parallels the distinction between appropriate treatment and therapeutically necessary treatment.

Even if best interests are a *sine qua non* of compulsory treatment of people with capacity, it is not obvious that the Mental Capacity Act framework provides a helpful model of best interests, relying as it does to a considerable degree on ascertaining what the views of the patient would

¹⁰² Mental Capacity Act 2005, s 6(6).

¹⁰³ Mental Capacity Act 2005, s 24–26.

¹⁰⁴ See Ontario legislation discussed above. Regarding a controversial decision on this matter, see *Starson v Swayze* [2003] SCC 32, [2003] 1 S.C.R. 722.

be if he or she had capacity. When the patient in fact has capacity, this is not an issue. It is similarly not obvious what the people required to be consulted under the Mental Capacity Act would bring to the table when the person has capacity. If best interests are simply as perceived by the patient, the test will not assist, since a patient considering treatment to be in his or her overall best interests is likely to consent to it. The use of a best interests test must therefore involve the imposition of a different person's view of the patient's best interest onto the patient, raising obvious issues of social control. The ethical justification for such an imposition is at best problematic.

F. The Right to Process

The conflicting factors of the best interests test are but one example of a much larger problem. While certainly, considerable improvements can be made to the precision of the statute law regarding treatment in psychiatric hospitals, inevitably the law cannot cover all eventualities, and disagreements will arise. A practical and effective mechanism does need to be established to determine these disputes. This was the point of *Wilkinson* itself: where it is alleged that an individual's rights are being violated, there must be a forum to determine that issue, and it must be determined to a reasonable level of certainty. It flows further from Articles 6 and 8: the requirement that an intervention is to be prescribed by law means nothing if the application of the law cannot be challenged in individual cases, to ensure compliance. Leaving the matter to the sole discretion of clinicians is not in the end acceptable: they are likely to be too caught up in the situation to be perceived as objective, and if it is accepted that the test should be more than medical, it is not obvious that they are best placed to balance the overall range of factors for consideration.

It is not obvious that the appropriate body to engage in this enquiry needs to be the High Court, or the Court of Protection. It may well be that a suitably trained review tribunal would do at least as good a job. The point at the core of *Wilkinson* remains strong, however: human rights are at issue, and a meaningful process must be established.

VI. CONCLUSIONS

The compulsory treatment of detained psychiatric patients has long been left essentially to the discretion of the responsible clinician. Few if any legal standards have been applied in the vast bulk of instances, and no legal process is routinely available to patients wishing to challenge their treatment. *Wilkinson* provided a false dawn in this regard.

Hearings were few, and there have been none reported for 5 years. The ECHR jurisprudence in the area is undeveloped and unsatisfactory.

With the increasing attention of the last decades paid to human rights in a mental health context, and with the introduction of the CPRD in 2008, it is difficult to see that this is a sustainable situation. The time has come for a serious discussion of when, if at all, compulsory treatment should be imposed. Such a discussion will no doubt raise fears of patients 'rotting with their rights on', but this is not the experience in countries that have moved to enhance patient rights in this area: log jams can be broken.¹⁰⁵ It further cannot be concluded from the fact that we have always had compulsory psychiatric treatment that it is vital in the future, and it certainly does not follow that the current discretionary system is not open to challenge. An intelligent debate is required, taking into account empirical research into the positive and negative effects of compulsion and the doctrinal frameworks of mental health and human rights.

¹⁰⁵ In the leading empirical studies, no patient for whom the doctors availed themselves of procedures for compulsory treatment was eventually left entirely untreated: see S Hoge and others, 'A Prospective, Multi-center Study of Patients' Refusals of Antipsychotic Medication' (1990) 47 *Arch Gen Psychiatry* 949; J Kasper and others, 'Prospective Study of Patients' Refusal of Antipsychotic Medication Under a Physician Discretion Review Procedure' (1997) 154 *Am J Psychiatry* 483.