

Casenotes

Capacity, Treatment and Human Rights

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**R (on the application of PS) v. G (RMO) and W (SOAD) [2003] EWHC 2335 (Admin).
Administrative Court (10th October 2003) Mr. Justice Silber.**

This is the most recent in a series of cases regarding the scope of the Human Rights Act and compulsory treatment under the Mental Health Act 1983. In particular, this case concerns the right of a competent patient detained under section 37 of the Mental Health Act 1983 (MHA) to refuse anti-psychotic medication, and the scope of articles 3, 8 and 14 of the ECHR.

The Facts

The applicant, PS, was detained under section 37 of the MHA in 1995, following conviction of manslaughter on the grounds of diminished responsibility. It would appear that the homicide occurred during a psychotic episode. He was conditionally discharged in April 1998, and re-admitted in December 1999. He was again conditionally discharged in January 2002, but recalled the following month. Both the readmissions were occasioned by apparent psychotic episodes. All of these psychotic episodes abated without resort to medication. With the consent of PS, Quetiapine, an anti-psychotic medication, was administered from September to November 2002. In the view of the then RMO, G, this trial was a success, and faced with PS's competent refusal to consent to further administration of the drug, he pursued the processes for compulsory treatment under the MHA. W, a SOAD, provided the required second opinion, but before treatment could recommence, PS obtained an injunction precluding treatment until his rights under the Human Rights Act 1998 could be determined.

Behind this legal question lay a factual question of diagnosis. PS had been given a variety of diagnoses during his time in the psychiatric system. Schizophrenia was first suggested in 2001, but by the time of the court application, it had become the consensus view of the treating physicians. PS's expert, however, instead diagnosed schizophreniform disorder, a condition with substantially similar symptoms to schizophrenia, but where the duration of the symptoms was instead less than six months. It was argued for PS that if the psychotic episodes he experienced were viewed discretely, schizophreniform disorder was a credible diagnosis. If they were instead viewed as

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manifestations of an ongoing disorder, schizophrenia was more likely. The distinction in diagnosis was important, as the manifestations of schizophreniform disorder would be likely to abate of their own accord, while schizophrenia was appropriately treated with medication such as that proposed in this case.

The Decision

The Factual Question of Diagnosis

Following the procedure established in *R (Wilkinson) v. RMO Broadmoor and MHAC SOAD*¹, Silber J heard oral evidence on the question of diagnosis. In considering that evidence, he made it clear that he was guided by the decision in *R (N) v. Dr M*², that the role of the court remained essentially one of review [para 5, quoting *N* at para 39], and that the court should ‘pay a very particular regard to the views held by those specifically charged with a patient’s care’ [para 82, quoting *N* at para 39].

Consistent with this orientation, the factual question of the appropriate diagnosis was determined primarily by findings of credibility of the various witnesses. The treatment team and those doctors who testified in their support were found to be credible, while the views of the patient’s expert were given less weight. The only other factor considered by the Court in its determination of diagnosis was the most recent review tribunal decision, which had, consistent with the treatment team, held that PS would not improve without medication. The Court also accepted this view, and held that the appropriate diagnosis was schizophrenia.

Article 3: The Right to be Free from Inhuman or Degrading Treatment

The Court applied a two-pronged test to determine an article 3 violation:

‘[W]here medical treatment is administered on a patient against his or her will, Article 3 will only be contravened if:–

- the proposed treatment on the patient reaches the minimum level of severity of ill-treatment, taking into account all the circumstances, including the positive and adverse mental and physical consequences of the treatment, the nature and context of the treatment, the manner and method of its execution, its duration and if relevant, the sex, age and health of the patient (“the Minimum Level of Severity Sub-Issue”) and
- the medical or therapeutic necessity for the treatment has not been convincingly shown to exist (“the Convincing Medical or Therapeutic Evidence Sub-Issue”).’ [para 107]

The standard of proof to be met was the criminal standard of beyond reasonable doubt. [para 106]

The Court held that neither aspect of the test had been met. Regarding the first branch of the test, the Court noted that the medication proposed had already been used for a three-month trial period on PS, without any suggestion that the result met the minimum level of severity to engage Article 3. That medication had been given with PS’s consent, and the withdrawal of that consent was relevant to but not determinative of the determination of the severity issue. The primary adverse effects of the proposed medication, tiredness and weight gain, could be easily controlled. While adverse effects would be more extensive if the medication were administered by depot medication rather than by mouth, the indications were that if the non-voluntary administration

1 [2001] EWCA Civ 1545

2 [2002] EWCA Civ 1789

were authorised by the Court, PS would in fact consent to the oral administration.

PS also relied on the judgment of Simon Brown LJ in *Wilkinson*, which on his counsel's reading appeared sceptical of the consistency of overriding competent treatment refusals with article 3. Silber J instead held that those remarks were confined to their facts, rather than purporting to impose a uniform prohibition on mandatory psychiatric treatment of competent and refusing patients. He instead preferred the approach of Hale LJ (as she then was) in *Wilkinson* to the effect that precluding treatment without consent of persons with capacity would have the undesirable result of driving up the standard of capacity, and that the preferred approach was to maintain a lower standard of capacity but to allow occasional treatment of those with capacity. Hale LJ did not say what threshold would be required to treat a competent patient without consent, but did hold that a requirement that the treatment be necessary to protect the patient or others was more stringent than necessary.

On this basis, the treatment was not sufficiently invasive to meet the minimum level of severity to engage article 3.

Further, PS had failed to demonstrate that the proposed treatment failed to meet the convincing medical or therapeutic evidence threshold. The Court considered two approaches to this question, without expressing a preference between them. In one, the question of therapeutic threshold was considered as a single 'simple' question: had the proposed treatment been convincingly shown to be necessary? In the other, regard would be had to seven more specific questions:

- (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 would have adverse consequences to the patient;
- (g) how severe may these adverse consequences be? [para 121]

A disagreement in medical opinion as to the necessity of treatment was relevant, but not determinative of the question of best interests or medical necessity. Relying on Hale LJ's decision in *Wilkinson*, Silber J held that it was not necessary to show dangerousness to self or others in order to override the views of a competent and refusing patient, although such refusal was an important factor to be considered.

On the facts as the Court found them, it was clear that PS was suffering from schizophrenia, a treatable mental disorder. While this disorder would not put others at risk while PS was in the medium secure unit, if relapse occurred in the community 'the risk of injury might well be great but nobody can be sure about it'. [125] When under stress, he behaved 'bizarrely and unpredictably, thereby making him a potentially dangerous individual to himself and to others, particularly to those known to him'. [125] On the questions relating to alleviation, the Court held that Quetiapine was an appropriate treatment for schizophrenia. On the evidence of the treating physicians, there was a 'good chance' that the medication would prevent relapse or deterioration in PS's condition. [126] It would also contribute to the suppression of PS's residual persecutory

ideas, making him more accessible to therapy and thus potentially more insightful into his condition. As to adverse consequences, the treatment might be expected to cause weight loss and drowsiness, the latter reducing over time. If administered by injection, there would also be risks of sedation and neurological effects, but some of these could be controlled by additional medication, and in any event, PS would likely choose to take the medication orally rather than by injection, if the treatment were ordered by the Court.

Whether the matter were considered according to the seven sub-issues above, or as one single question, the proposed treatment met the therapeutic necessity threshold. PS's claim therefore failed on this issue as well.

Article 8: The Right to Private Life

As with article 3, there was a level of severity which treatment must attain to engage article 8. This level of severity was not as high as under article 3, and would often be reached when a competent patient was treated without consent. The Court assumed without deciding that this threshold had been met in this case.

Such intrusions would nonetheless be justified under article 8(2) if 'necessary in a democratic society ... for the protection of health' and 'in accordance with law'. Such interventions would be considered necessary, if they corresponded to a pressing social need, if they were proportionate to the legitimate aim pursued, and if the reasons presented by the national government were relevant and sufficient. In this case, the proposed medication would be likely to lead to the rehabilitation and release of PS, rather than his continued incarceration. It would improve his mental health, and protect against relapse. It was therefore necessary within the terms of article 8(2).

Silber J also held that the treatment was in accordance with law, as it complied with the test of best interests laid down in cases such as *Re F (Mental Patient: Sterilisation)*³, and *Re S (Adult Patient's Best Interests)*⁴. This was determined by a two stage process: was the proposed treatment consistent with a reasonably competent body of medical opinion; and was it the best option available? The proposed treatment in PS's case clearly met the first criterion. The second criterion was to be determined by consideration of the efficacy of the proposed treatment, the availability of alternative treatments, and the necessity of the treatment's administration. In this case, the treatment was likely to alleviate PS's condition, and there was further no less invasive form of treatment that could be given. The matter of necessity in this best interests context was to be considered according to the following factors: (a) the patient's resistance to treatment; (b) the degree to which the treatment would alleviate or prevent a deterioration of the patient's condition; (c) the risk the patient presents to himself; (d) the risk he presents to others; (e) the consequences if treatment were not given; and (f) any adverse effects of the treatment. In this case, if the treatment were authorised by the Court PS would likely consent to its administration other than by depot, and the treatment would alleviate his condition. He further presented a risk to himself and others if in the community, under stress, and untreated. If untreated, he would be unlikely to be discharged, and if discharged, would be unable to cope in the community. The adverse effects of the medication would be minimal. [145]

The proposed treatment met the test of proportionality: it had considerable benefits, with minimal adverse consequences.

The proposed treatment was therefore not in violation of article 8.

3 [1990] 2 AC 1

4 [2000] 2 FLR 389

The Article 14 Issue: Freedom from discriminatory application of Convention rights

The question of discrimination was considered according to the following four questions, drawn from *Wandsworth LBC v Michalak*⁵:

- (a) Do the facts fall within the ambit of one or more of the substantive Convention provisions?
- (b) If so, was there different treatment as respects that right between the complainant and other persons put forward for comparison (the 'chosen comparatives')?
- (c) Were the chosen comparatives in an analogous situation to the complainant's situation?
- (d) If so, did the difference in treatment have an objective and reasonable justification? Did it pursue a legitimate aim and did the differential treatment bear a reasonable relationship of proportionality to the aim sought to be achieved?

The comparative chosen by PS in this case was drawn from the case of *Re W*⁶, a case involving a prisoner with a mental disorder who was not within the scope of the Mental Health Act as his psychopathy was held to be non-treatable. It was held in that case that he could refuse treatment to wounds caused by self-harm, even though his decisions were considered irrational or indeed manipulative, as it was thought that he was using these refusals in an attempt to force his transfer to a hospital.

Silber J held that the comparative was not in an analogous situation to PS. Unlike PS, W was not treatable, and therefore outside the remit of the Mental Health Act. The fact that PS could be treated for his condition, but W could not be, justified a totally different approach to the issue of administering treatment. The requirements of (c) and (d) above were not met, therefore.

Conclusion

As a result, the proposed treatment of PS would not violate his Convention rights.

Discussion

The Findings of Fact

The approach of Silber J to the findings of fact in this case reflect tensions in prior case law both in the application of the Human Rights Act to compulsory treatment, and in medical law more generally.

The underlying position of Silber J is that while the court in this case had to determine for itself the disputed facts, 'it must not be overlooked that the court's role is essentially one of review' [5]. On this point, His Lordship relies on *R (N) v. Dr M*, which in turn purports to rely on *Wilkinson*.

In *Wilkinson*, the Court of Appeal was impressed by the argument that a claim regarding unjustified treatment could be brought by way of judicial review or battery. If the case were brought through standard civil law channels, a full assessment of the evidence would be necessary. The Court held that when rights under the Human Rights Act were at issue, the form of the action ought not be relevant to the level of judicial scrutiny of facts. [*Wilkinson* at 24, 51, 62] Where as here there is no prior judicial forum that considers the matter, Simon Brown J expressly found that the failure of the court to reach its own, independent view of disputed factual questions would constitute a breach of article 6 of the Convention [at 35].

5 [2003] 1 WLR 617

6 [2002] MHLR 411

R (N) does not exactly dissent from those views, but after reciting them it does add a paragraph stating that ‘*Wilkinson* should not be regarded as a charter for routine applications to the court for oral evidence in human rights cases generally’ and, in the passage cited by Silber J, that the court’s role is essentially one of review. [39] The two aspects of these comments are not the same, and it is not clear how they are meant to be read within the context of *Wilkinson*. Insofar as the point is that there will be many cases where relevant facts will not be disputed, and thus where resort to cross-examination will not be necessary, it is unobjectionable. Rights under the Human Rights Act regarding enforced treatment are further unusual in a mental health context, as (unlike, for example, psychiatric confinement) there is no tribunal review or other judicial process prior proceedings before the Administrative Court. Insofar as the point of the comments is that cross-examination on judicial review should not be viewed as *carte blanche* for a second kick at the factual cat after an oral hearing elsewhere, it is also reasonable enough. Insofar however as the comments suggest a different standard of scrutiny as regards disputed facts that have not been judicially determined elsewhere, it is difficult to see that they are consistent with *Wilkinson*.

This set of issues is relevant in *PS* because of the court’s approach to the finding of facts. Certainly, the Court allowed oral evidence based on the affidavits of the medical experts; indeed, almost half of the judgment is devoted to recitations of the factual evidence. The Court’s articulation of the findings of fact, however, resemble traditional judicial review, rather than the substantive assessment required by *Wilkinson*: they are based on findings of witness credibility, rather than engagement with the substantive content of the witnesses’ testimony. [81–95] A variety of criticisms might fairly be levelled at this approach.

The Court identifies deference to the views of the treating physicians as its starting point. [82, 84] In this, the Court is following the approach of R (N): ‘Courts are likely to pay very particular regard to the views held by those specifically charged with the patient’s care.’ [38] In human rights terms, this is at best a peculiar starting point. It suggests that the factual basis of whether a basic human right has been violated will be determined by privileging the views of the alleged violator of the right. This cannot be a general principle of human rights law: we would not similarly defer to the views of alleged torturers in determining an article 3 violation. Can treating physicians be meaningfully distinguished from other alleged violators of rights, such as would warrant the deference proposed by the courts? Certainly, we may reasonably hope and expect that physicians are motivated by benevolence, but good faith does not guarantee compliance with the Human Rights Act. Few if any treating physicians, one hopes, are intentionally dishonest in their court testimony. The same must however apply to other witnesses, and the patient’s expert witness in particular. If the integrity attaching to respected professionals is the justification for deference, it should equally apply to expert witnesses testifying on behalf of the patient.

The RMO may have the benefit of an ongoing role regarding the patient, and this is identified as relevant to the respect accorded to his or her testimony both in *PS* [84] and in R (N) [38]. It will not always be the case that such an ongoing relationship exists, however. Particularly when an individual is civilly admitted under Part II of the MHA, periods spent in hospital may be short, and patient-doctor relationships transient. There may also be implicit in the court’s reasoning a romanticisation of the relationship between patient and doctor. Gone are the days, if they ever existed, of low patient-doctor ratios and frequent and extensive patient-doctor consultations. Determination of credibility by judicial fact-finders should not be naïve on these points.

It is perhaps in any event unfortunate to base the deference to the views of treating physicians on the relationship between patient and doctor, since the fact that the matter has ended up in court suggests that this relationship has broken down. In this context, deference to the views of the treating physicians places the patient at a considerable disadvantage. To be realistic, his or her medical expert will generally be funded through the legal aid scheme, and will therefore have become acquainted with the patient's situation only recently. Indeed, the evidence of the patients' experts in both *PS* [88] and *R (N)* [38] was criticised on precisely that basis. It is however difficult to see that the patient can acquire expert evidence other than on this basis. Deference to the evidence of treating physicians makes it almost impossible for the patient to challenge the factual context presented by those physicians. The treating physicians are not necessarily emotionally detached professionals in these situations. These are human rights claims, in which the treating physicians are respondent parties. It is difficult to see that approaching factual assessments as a matter of judicial review, with deference to the initial fact-finder and evidential practices that marginalise the evidence offered on behalf of the patient offers a level playing field.

The focus of the Court on the credibility of the various witnesses means that the Court does not engage with the factual situation it is asked to decide. Credibility may be understood in various ways. Certainly, there was no suggestion by anyone in the case that the medical witnesses were acting dishonestly or in bad faith. There was further no suggestion that they had been remiss in their recording of facts in the patient record; indeed, *PS* relied on aspects of that record to make his case. In these senses, the treating physicians and those testifying on their behalf were agreed to be credible. Such credibility does not necessarily imply agreement with their conclusions, however.

PS made quite specific factual submissions. It was clear that *PS* had suffered from psychotic symptoms in 1995 and 2002. A further apparent episode in 1999 was more difficult to analyse. It occurred in December 1999. *PS*, who had become a fundamentalist Christian, believed that the end of the world would occur at the end of that month, and that there would be major disasters caused by computer failure at that time as well. Counsel for *PS* submitted that these were consistent with fears of many non-psychotic people as 1 January 2000 approached. He further submitted that the 1995 episode had been caused by an adverse reaction to Paroxetine, an anti-depressant medication that had been prescribed for *PS*. All the episodes in question resolved themselves without medication. In the submission of *PS*'s counsel, *PS* suffered from an episodic disorder that could be triggered by stress.

The recitation of the facts in the judgment discloses much in the clinical records compiled by the treating physicians to support this view. A few examples will give a flavour of the ambiguities. The treating physician, *B*, in whom the Court placed such high regard, acknowledged in a report to the MHRT in 1999 that the 1995 psychotic symptoms were consistent with an adverse effect of Paroxetine. [36] For considerable periods of *PS*'s incarceration, the medical record notes that there was no evidence of mental disorder. While the file notes evidence of 'unreliability' – specifically an allegation that he was not truthful with *B* regarding his relationship with a parishioner in his church – there is no evidence of psychosis identified in the factual summary of the case notes from 1995 to 1999. The concern at that time instead appears to have been a concern that *PS* had a 'fragile personality' which might in conditions of stress result in a relapse of a depressive disorder, and a lack of insight of *PS* into his condition. At Christmas, 1999, Dr Boyd, another of the doctors whose evidence was given considerable respect by the Court, diagnosed 'underlying schizophreniform illness', [41] the diagnosis later provided by *PS*'s expert and rejected by the Court. The diagnosis of

schizophrenia was not made until 2001, and then not by Dr Boyd, but by another consultant. Until speaking with that consultant at that time, she had been expecting to support PS's application for a conditional discharge. After speaking with the consultant, she favoured continued detention and treatment instead. The nature of that conversation, and the specific reasons for her change of view, are never made clear in the factual findings.

By the time of the court hearing, all of these doctors had moved to a diagnosis of schizophrenia. This case note obviously cannot assess credibility of the evidence: the writer was not present at the hearing. At the same time, given the changes and development in the views of the witnesses to whom the court accords credibility, determination of the factual issues by stating that those witnesses are credible is not convincing. They would presumably also have been credible when they held their previous views. Had PS ended up in his expert witness's hospital, would the court have found that expert's testimony more credible? The specific questions and issues raised by PS remain largely unanswered. Their answer lies in the court engaging with the facts as they appear in the medical record and the testimony, not in blanket findings of witness credibility.

The Article 3 Issue

Neither English nor Convention jurisprudence is in a settled state on the question of the rights of competent patients who refuse psychiatric treatment. The Convention was concluded in 1950, and came into effect three years later. There can be little doubt that that the rights of psychiatric patients were not at the forefront of the minds of its drafters. Indeed, the lumping together in article 5 of 'persons of unsound mind' with 'alcoholics', 'drug addicts' and 'vagrants' serves as a salient reminder how attitudes to persons with psychiatric conditions have changed in the last half century. It was more than a quarter of a century before the first case concerning mental disability reached the Strasbourg court. From the mid-1990s there has been a considerable increase in the Court's caseload relating to mental disorder, but its jurisprudence remains in its relative infancy.

The Strasbourg court has never squarely addressed the scope of the phrase 'inhuman or degrading treatment' regarding the enforced psychiatric treatment of competent patients who refuse that treatment. There is a brief decision of the European Commission of Human Rights, from the days in which that body vetted cases prior to a hearing of the full court, in which the question was raised and dismissed summarily: *Grare v France*⁷. In that case, the treatment resulted in nervous shakes, blurred vision and attention deficit, but in the view of the Commission nonetheless did not reach the standard of gravity which would trigger article 3. The persuasive effect of this case is somewhat limited: it is more than a decade old; it is not a decision of the Court; and there is no significant analysis. The views of the Strasbourg court are thus a matter of speculation, based on analogy from cases where the psychiatric patient lacked consent capacity (eg., *Herczegfalvy v Austria*⁸) or cases where allegedly inhuman or degrading treatment occurred outside a psychiatric context.

Silber J applies a number of these cases to arrive at his two-pronged test for an article 3 violation, that the allegedly offensive treatment must reach a minimum level of severity and that there must be no convincing medical necessity for the treatment. While the factors cited by His Lordship including medical necessity will no doubt be relevant to the determination of whether a treatment violates article 3, the placement of medical necessity as a separate branch to assess an article 3 violation is inconsistent with the Convention jurisprudence. As noted by Silber J, the severity test

7 (1993) 15 EHRR CD 100

8 (1992) 50 EHRR 437

already includes a variety of contextual factors, such as duration of the alleged violative action, its physical or mental effects, and the age, health and sex of the alleged victim. This is how it is determined whether acts are 'inhuman' or 'degrading': see, eg., *Keenan v UK*⁹. *Keenan* notes that the severity test is determined according to all the facts of a case, and there is no reason that medical circumstances cannot be considered as part of this package. The placement of medical necessity as a second hurdle is however inconsistent with Convention jurisprudence, as it suggests that there is a defence available to the state when actions meet a level of severity to engage article 3. This is not the case: the jurisprudence is clear that article 3 admits of no derogation: see, eg., *Aksoy v Turkey*¹⁰. Silber J himself considers such a unified approach briefly at paragraph 130, holding that applying such an approach would still not result in a finding of an article 3 violation in this case. That is the stronger line of reasoning.

The Court's view on medical necessity appears to flow from a comment in *Herczegfalvy*, the interpretation of which is relevant both to whether medical necessity is a separate branch in the determination of article 3 violations, and to the question of whether enforced psychiatric treatment of competent patients violates a unified threshold of severity test:

'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 recognisable rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are responsible, such patients nevertheless remain under the protection of Article 3, the requirements of which permit no derogation.'

The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a method which is a therapeutic necessity cannot be regarded as inhuman or degrading.' [*Herczegfalvy* at 82, quoted in *PS* at 98]

At paragraph 99, Silber J appears to raise the second paragraph of this quote to a general principle regarding psychiatric treatment and article 3, re-quoting the sentence but deleting the phrase 'in such cases'. Even if Silber J is right to raise this to a general principle about psychiatric treatment, it does not suggest the need to establish it as a second and separate hurdle to the severity test. It merely suggests, as discussed above, that medical circumstances form a part of the determination of severity.

More difficult is whether the sentence can be raised to a general principle, as Silber J would seem to suggest. The question turns on the interpretation of the phrase 'in such cases'. The first sentence in the first paragraph of the above quotation would appear to refer to people confined in psychiatric facilities generally. If that is the reference, the Court's view is plausible. The second sentence refers to 'those who are entirely incapable of deciding for themselves'. If that is what is meant by 'such cases', the reference is to individuals lacking capacity, and raising the second paragraph to a general principle so as to include patients with capacity begs precisely the question raised in the *PS* case.

Further guidance on the interpretation of the Convention article may perhaps be gained from the 2000 summary report of the Committee for the Prevention of Torture and Inhuman or Degrading

9 (2001) 30 EHRR 38

10 (1996) 23 EHRR 553 at para. 62

Treatment or Punishment (CPT), in a passage cited by Simon Brown LJ in *Wilkinson* but not referred to by Silber J in *PS*:

*‘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.’*¹¹

This passage stops just short of saying that the overriding of a competent refusal of consent can never be justified. It would however appear to require ‘clearly and strictly defined exceptional circumstances’ for such an override, suggesting a level of specificity not obviously contained in either the relevant sections of the Mental Health Act or in the facts and reasoning of the *PS* case.

At the same time, the administrative context of the above passage must be acknowledged. The CPT is given the authority under a the Council of Europe treaty to conduct site visits to prevent article 3 violations, but it is not the European Court of Human Rights. How far the Court will adopt the CPT’s approach on this question as yet remains a matter of conjecture. Certainly, the Court is hesitant to allow the imposition of force on those in institutions:

‘In any event, the Court reiterates that, in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3.’ [*Selmouni v France*¹²]

This approach is most obvious in cases involving alleged violence or punishment of those in institutions. It is less obvious how the Court would apply it in a case of treatment refusal. Indeed, a separate line of comments makes it clear that in order to violate article 3, the force must go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment. [*Kudla v Poland* (2000)¹³] That in turn raises the obvious and unanswered question of whether enforced psychiatric treatment of competent patients is ‘legitimate’.

English law is similarly uncertain in its reading of article 3 rights in a psychiatric context. *PS* is the first case squarely to raise the question in the context of a competent and refusing patient. As the judgment of Silber J suggests, the most important precedent is *Wilkinson*, and His Lordship’s reading of the decision of Hale LJ (as she then was) in that case is uncontroversial. Hale LJ’s concern in *Wilkinson* is that a finding that treatment cannot be enforced on a competent and refusing psychiatric patient would create pressure to raise the threshold of capacity in treatment matters generally. She therefore holds that while capacity may be becoming more relevant in psychiatric practice, it was *not* the case that treatment could only be imposed on a competent and refusing patient for the protection of others or for their own safety. This is, in essence, the decision of Silber LJ in *PS*: each case is to be determined on its facts, and in *PS* the facts did not give rise to a violation. The practical difficulty with this is that it tells us what the test is not (dangerousness), rather than what the test is. On the latter point, Hale LJ’s judgment is silent.

11 *Committee for the Prevention of Torture, (2000) Report, Strasbourg: Council of Europe para 41. See also Wilkinson at para 28.*

12 (1999) 29 EHRR 403, at para 99

13 *appl. 3021/96, para 92*

The reading by Silber J of Simon Brown LJ's decision in *Wilkinson* is more controversial. Simon Brown LJ held:

'If in truth this appellant has the capacity to refuse consent to the treatment proposed here, it is difficult to suppose that he should nevertheless be forcibly subjected to it. True, Dr Horne appears to regard it as his only hope of eventual return to the community. That said, however, its impact on the appellant's rights above all to autonomy and bodily inviolability is immense and its prospective benefits (not least given his extreme opposition) appear decidedly speculative.' [30]

Silber J reduces this to a case-sensitive comment, [116] differentiating the facts of *Wilkinson* from *PS* on the basis of more significant adverse effects of treatment, the differences in the potential benefits of treatment, and the differing levels of restraint which would be required to conduct the treatment. This is not entirely convincing. The passage from *Wilkinson* follows shortly after Simon Brown LJ cites the view of the CPT, quoted above, as providing 'some indication of modern thinking on this sensitive subject'. [29] This suggests a difference from *Hale LJ* which is not based simply on the facts of the case. Further, the factual distinction with *PS* is not necessarily as obvious as Silber LJ suggests. Certainly, the adverse effects in *Wilkinson* appear more significant, but other differences are not as obvious. Anti-psychotic drugs are powerful. The previous use of Quetiapine had, as intended, altered *PS*'s personality, religious beliefs and behaviour. These raise fundamental questions of autonomy, analogous to those in *Wilkinson*. The fact that without medication, odds were thought to be better than even that *PS* would relapse still suggests a better chance at recovery without medication than was the case for *Wilkinson*.

The approach of Silber J, in the end, is that capacity is a relevant but not determinative factor in deciding whether treatment reaches the level of severity to engage article 3. Based on his reasoning, if he were to adopt a univocal test as proposed above, he would in addition consider the seriousness of the disorder, the potential adverse effects of the drug, the likely degree of invasiveness of the administration of the drug, the degree and likelihood of beneficial results of the drug, and the likely results if the treatment were not performed. The difficulty with this approach is that capacity disappears into the mix: there is no indication as to how the various factors play off against each other, to provide meaningful guidance in subsequent cases as to whether an article 3 violation has occurred. We still have no articulated test of when article 3 will be violated when patients have capacity, relative to when they do not. Meaningful guidance from the courts on this point is necessary, if practitioners are not inadvertently to fall afoul of the Human Rights Act.

Article 8: The Right to Private Life

The Court's reasoning regarding article 8 is reasonably brief. For purposes of the judgment, it assumed without deciding that the treatment in question would be sufficiently severe to constitute an interference with private life, and focussed instead on justifications for such an interference. This required consideration of three issues: was the interference necessary in a democratic society for the protection of health; was the interference prescribed by law; and was the interference proportionate to the legitimate aim it sought to achieve?

Regarding the first of these, the Court held that the interference would be necessary if it corresponded to a 'pressing social need'. In this, the Court viewed that the balance to be struck was between the protection of the individual right to private life and the community right as

acknowledged in the justification of necessity for protection of health. [133] The Court's articulation of this balance seems convincing, but its application to the facts is more problematic, as it cites benefits to the individual in its justification of curtailing the individual's rights: rehabilitation rather than incarceration, the suppression of PS's persecutory ideas, the gaining of insight, and the protection against future relapse. Only the last of these is an obviously *social* benefit, and that only if the relapse were to occur while PS was in the community. The rest, and perhaps even the prevention of relapse, are primarily benefits to PS, which he presumably had chosen to discount in his competent treatment refusal. There may well be a pressing social need to treat such patients, but it is not articulated here.

It is not initially obvious why Silber J turns to the common law of medical best interests in his assessment of whether the treatment of PS was 'according to law'. PS was to be treated under the terms of the Mental Health Act, not the common law. The decision as to whether the treatment was according to law should have been made with reference to the statutory provisions and, after *Munjaz v Mersey Care NHS Trust*¹⁴, to the Code of Practice.

It is at best doubtful whether the substance of that law is sufficiently clear for the purposes of article 8(2). It is not sufficient that the actions in question are within the scope of a validly-enacted statute. To be 'according to law', the law must be sufficiently clear that citizens can foresee its consequences for him. When the law provides discretion on a public authority, it must indicate the scope of the discretion. [*Herczegfalvy* para 89] The Mental Health Act provides merely a process for overriding the refusal of competent patients to consent to treatment. Whether that process is sufficient may be doubtful; there is no mechanism short of judicial review to challenge the decision of the RMO and SOAD, for example. In any event, neither the Act nor the Code of Practice provide any substantive standards: see Mental Health Act, ss. 57, 58, 63; COP para. 15.25. The following comment from *Herczegfalvy*, relating to whether a system by which patient mail was censored, also an article 8 issue, was 'according to law', seem at least at first blush to be apposite:

'These vaguely worded provisions do not specify the scope or conditions of exercise of the discretionary power which was at the origin of the measures complained of. But such specifications appear all the more necessary in the field of detention in psychiatric institutions in that the persons concerned are frequently at the mercy of the medical authorities, so that their correspondence is their only contact with the outside world.' [91]

The complete absence of substantive criteria in the Mental Health Act and Code of Practice at the very least offer cause for pause.

It is, perhaps, for these reasons that Silber J turns to the common law and the doctrine of necessity and best interests. This is the first time a court has expressly adopted this approach in its reading of sections 63 and 58 of the Mental Health Act. While it is a doctrine that His Lordship views as satisfying the Convention tests, practitioners will find it a mixed blessing. As His Lordship notes, the best interests approach can have the effect of limiting medical discretion. It requires doctors not merely to offer a treatment drawn from the range of treatments within the realm of appropriate professional practice, but also to assess which of the possible treatments is best for the individual patient. This secondary assessment is to be based on a wide array of factors, some medical and some not. As a matter of process, the courts have been clear that such questions of best interests are justiciable: see eg In *Re TF (An Adult: Residence)*¹⁵. The approach on such applications is based

14 [2003] EWCA Civ 1036

15 [2000] 1 MHLR 120

on the civil burden of proof, rather than the deference shown to doctors in judicial review. The application of best interests to the Mental Health Act therefore provides a new and more lenient judicial forum for patients to challenge treatment decisions.

The difficulty with this approach in the current case is that it does not solve the specific problem of providing guidance as to when *competent* patients should be treated without their consent, the core of the article 8 right alleged to be violated in this case. The doctrine of medical necessity is developed in the context of patients who lack capacity. By applying it to PS's case, the Court is treating PS as if he lacked capacity. No guidance is provided as to whether or how the fact that PS has capacity effects determination of his best interests. For that reason, it is difficult to see that it provides the level of direction necessary to make the treatment of competent patients 'in accordance with the law'.

The Article 14 Issue

Article 14 is meant to ensure that Convention-related rights are provided equally to all citizens, without unjustified discrimination. While an article 14 application must refer to a situation within the ambit of another Convention right, it is not the case that the other situation must on its face infringe that other right. To use the Court's example, if a state provided a system of courts in excess of its article 6 obligations, it would still be in breach of article 14 if the courts were available to some litigants but not others, without appropriate justification: '*Belgian Linguistic*' Case (No. 2)¹⁶. To apply this logic to the PS case, Silber J held that whether treatment absent consent of the competent patient violated articles 3 and 8 was a question of fact, to be determined in individual cases. It seems uncontroversial from the case that this would be sufficient to bring that situation within the ambit of the Convention, for purposes of article 14.

Article 14 does not preclude all discrimination. It refers in particular to an illustrative list of categories such as sex, race, and language. Disability is not on the list, but has now been held to be a similar analogous ground: *R (Pretty) v DPP*¹⁷. The sting of an article 14 argument involves identifying groups of people according to a precluded distinction but treated differently. It is then for the party wishing to justify the different treatment to show justification, that is, that the different treatment pursued a legitimate aim and was proportionate in its pursuit of that aim.

Counsel for PS cited *Re W*¹⁸, arguing that people with mental disabilities who were not confined under the Act were an analogous group to PS, but were treated differently because they had the right to consent to treatment. *W* involved a prisoner with psychopathic disorder who refused treatment for self-inflicted wounds. His mental disorder was not treatable, however, and he was therefore detained as a regular prisoner, not under the Mental Health Act. There was therefore no power to override his refusal of consent, irrational or manipulative though it may have been, and his refusal of treatment was honoured.

The Court's response was, once again, brief, holding that *W* was not similarly situated to PS, since PS met the criterion of treatability. 'Indeed, the fact that PS can be treated for his condition while *W* cannot be treated justifies a totally different approach on the issue of administering treatment in PS's case from that adopted in *W*'s case.' [154] Further, any difference in treatment was justified.

16 (1968) 1 EHRR 252 at para. 9

18 [2002] MHLR 411

17 [2002] 1 All ER 1 (HL) at para 105

The question is not as simple as this finding of the Court suggests, since W's wounds were treatable, and indeed it was for that treatment that the advice of the Court was sought. Treatability per se is therefore not a convincing distinction. It is tempting to argue that the treatment of the physical injuries W caused to himself is treatment of a physical disorder. As such, there would be no distinction: PS, like W, had the right to refuse treatment other than treatment for mental disorder: *Re C (Adult: Refusal of Medical Treatment)*¹⁹. The efficacy of such a claim would presumably depend on whether W's self-injury was related to his mental disorder. If it was, and one can certainly imagine patients where such would be the case, then based on the logic in cases such as *B v Croydon HA*²⁰ the treatments for the wounds would constitute treatment for mental disorder. This would suggest a much closer parallel with the PS case than the Court acknowledges. Other comparison groups may also be of interest here. Competent voluntary patients, for example, may refuse treatment for mental disorder even if their condition is treatable.

If a group were acknowledged to be analogously situated, that would still leave the question of justification. Certainly, there may well be a serious argument to be had on this point, and its articulation is beyond the scope of this casenote. The justification would need to focus on the question of the role of confinement in the determination of treatment rights, since competent informal in-patients can refuse psychiatric medication. A justification based solely on the general benefits of providing people with treatment for mental disorder would not suffice, as it would not address the discriminatory aspect of the enforced treatment.

Conclusion

It will come as no surprise to those following mental health law that the PS case does not solve the issues relating to the enforced psychiatric treatment of persons offering competent treatment refusal. The debate remains in its infancy in England, offered little guidance from a Strasbourg court that similarly has not addressed the core issue. If PS is correct in its application of *Wilkinson*, we know that a capable refusal is relevant to possible violations of article 3 in particular, and we know that the standard for intervention over the patient's objection is something less than the protection of the patient or others from serious harm (dangerousness). If we know what the standard is not, we sadly do not know what the standard is. Rather, the refusal disappears into an indeterminate mix of other facts, offering little guidance to clinicians and little protection to patients.

My thanks to John Horne and Oliver Lewis for providing comments on a draft of this article. All errors, of course, remain my responsibility.

¹⁹ [1994] 1 WLR 290

²⁰ [1995] 1 All ER 683 (CA)