

## **Paternalism or Power? – Compulsory treatment under section 58 of the Mental Health Act 1983**

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R (on the application of B) v S and others

Court of Appeal; Lord Phillips CJ, Thorpe LJ and Rix LJ; 26 January 2006

[2006] EWCA Civ 28

### **Introduction**

This case was the latest in a series of challenges brought under the *Human Rights Act 1998* against compulsory treatment under Part IV of the *Mental Health Act 1983*. The Court of Appeal again confirmed the statutory authority to impose treatment for mental disorder, even where the patient has capacity, although it has left a number of issues still unresolved.

### **The Facts**

The patient, B, had been detained at Broadmoor Hospital under sections 37 and 41 of the *Mental Health Act 1983* (MHA) following his conviction for rape in 1995. He had been diagnosed by his Responsible Medical Officer (RMO), Dr SS, as suffering from bi-polar affective disorder and, from the time of his arrival at the hospital in April 1995, had been treated with anti-psychotic medication. Initially this was Depixol administered by depot injection, but from August 1997 this had been changed to Risperidone which B took orally and voluntarily. In May 1999 B began a medication-free trial period, although medication was resumed in February 2000 when his condition deteriorated.

In July 2003 a further medication-free period was begun but in July 2004, again following a perceived deterioration in B's condition, the RMO decided that medication should be resumed. B however, who was deemed to have the mental capacity to consent to or refuse treatment, now refused to undergo the proposed treatment. On 15th July 2004 the RMO sought a second opinion and obtained the required certificate to allow the imposition of treatment under s.58 MHA. On 19th July B obtained an interim injunction preventing treatment and initiated proceedings against the RMO and the Second Opinion Appointed Doctor (SOAD) for their decision to medicate him compulsorily, and against the Secretary of State, claiming that the imposition of treatment under s.58 MHA, in the face of his capacitated refusal, would infringe his rights under the *European Convention on Human Rights* (ECHR).

By the time of the hearing, the SOAD's certificate had almost expired, the RMO had anyway decided that he no longer wished to proceed with treatment and a further injunction had been granted. Despite this, B argued that his claim against the Secretary of State should be determined. In a judgment delivered in January 2005, Silber J refused B's application, holding that the claim was

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academic, but nevertheless addressed all the substantive issues on the claim at some length and held that s.58 MHA was not incompatible with the ECHR.

Subsequently, in May 2005, the RMO decided that the circumstances had changed and that compulsory treatment was warranted. Having obtained the necessary second opinion certificate, he applied in June to the Administrative Court to discharge the injunction preventing treatment. In response, B commenced new judicial review proceedings to challenge the legality of treatment. The case was heard before Charles J who, in his lengthy judgment of September 2005, dismissed B's application, declaring that the proposed compulsory treatment would be lawful, and duly discharged the injunction.

The Court of Appeal was thus effectively required to deal with an appeal against the judgments of both Silber J and Charles J.

### **The Law**

The *Mental Health Act 1959* had clearly prescribed the conditions under which patients could formally be detained for observation or treatment but, surprisingly, did not include specific provisions for compulsory treatment; this was regarded as implicit in the Act. Enactment of the MHA however, removed any uncertainties and, under Part IV (ss.56–64) brought the compulsory treatment of detained patients firmly within the statutory framework.

Section 63 MHA provides:

*“The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being treatment falling within section 57 or 58 above, if the treatment is given by or under the direction of the responsible medical officer.”*

The special safeguards of ss.57 and 58, which can be overridden when treatment is required urgently (s.62), apply to two categories of treatment: (a) the most serious treatments which require the patient's capacitated consent *and* a second opinion (s.57), and (b) other serious treatments which require the patient's capacitated consent *or* a second opinion (s.58). Where a second opinion is required, this is provided by an independent second opinion appointed doctor (SOAD) appointed for this purpose by the Mental Health Act Commission (MHAC). Treatments under s.58 include the administration of medication for mental disorder after three months from its first administration, as in B's case. Before issuing a certificate authorising treatment, the SOAD must, under s.58(3)(b), be satisfied that the treatment should be given to the patient 'having regard to the likelihood of its alleviating or preventing a deterioration of his condition'.

The provisions of s.58 might thus have seemed to provide unequivocal authority to treat even capacitated patients without their consent. The enactment of the *Human Rights Act 1998* (HRA) however, with its requirement (s.3(1)) that 'so far as it is possible to do so' statutory provisions be exercised in a manner compatible with rights under the ECHR, offered a route for challenge in the courts. A series of challenges to s.58 treatment, and therefore effectively to any compulsory treatment under Part IV, then resulted. The first of these was *R (Wilkinson) v RMO Broadmoor and MHAC SOAD*<sup>2</sup> in which the Court of Appeal held that where a decision to administer medical treatment to a patient without his consent under s.58(3)(b) was challenged by way of judicial review,

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<sup>2</sup> *R (on the application of Wilkinson) v Responsible Medical Officer Broadmoor Hospital, the Mental Health Act Commission Second Opinion Appointed Doctor and the Secretary of State for Health* [2001] EWCA Civ 1545

the court was entitled to reach its own view on the facts as to whether the treatment infringed the patient's rights, through oral evidence and cross-examination if necessary. The Court also held, obiter, that notwithstanding the statutory authority of Part IV MHA, when treatment was imposed without consent upon a protesting patient, with or without capacity, this would be a potential invasion of his Convention rights under Articles 3 or 8. Using the guidance of the European Court (ECtHR) in *Herczegfalvy v Austria*<sup>3</sup> though, a breach of these rights would be avoided if the 'therapeutic necessity' or 'medical necessity' for the treatment had been 'convincingly shown to exist'<sup>4</sup>.

The compatibility of the treatment provisions of Part IV with Articles 3 or 8 was then examined more directly by the courts, firstly in *R (N) v Dr M*<sup>5</sup> and subsequently in *R (PS) v Dr G (RMO) and Dr W (SOAD)*<sup>6 7</sup>.

In *PS*, Silber J<sup>8</sup> ruled that the forcible administration of medication was lawful under s.58 MHA, notwithstanding the patient's capacity and refusal to consent. He confirmed however, that administration of medication to a patient against his or her will would have the potential to contravene Articles 3 and 8, but only in the following defined circumstances.

Article 3 would be engaged if the proposed treatment reached the minimum level of severity and the medical necessity had not been convincingly shown to exist. Reaching the minimum level of severity would normally involve intense physical or mental suffering<sup>9</sup> and this would need to be proved 'beyond reasonable doubt'. To determine convincing medical necessity, the judge endorsed the checklist of factors to be considered which had been set out by the Court of Appeal in *N v Dr M* [para 19].

Compulsory treatment imposed on a non-consenting patient could often result in a prima facie breach of Article 8, but this could be justified under Article 8(2). Such justification would have to be based on the proposed treatment being 'necessary in a democratic society... for the protection of health' and 'in accordance with the law'. Silber J held that this latter phrase meant compliance with the common law test of best interests, in that the treatment must be in accordance with 'responsible and competent professional opinion' and that the best available option for treatment had been chosen<sup>10</sup>. This in turn meant that the proposed treatment was likely to alleviate or prevent deterioration in the patient's condition<sup>11</sup>, that a less invasive treatment which would be likely to achieve the same beneficial result for the patient was not available, and that it was necessary for the treatment to be given to the patient with regard to (a) his resistance to treatment, (b) the degree to which treatment is likely to alleviate or prevent deterioration of his condition, (c)

3 *Herczegfalvy v Austria* (A/242B) (1993) 15 EHRR 437 at 484-485

4 In *Herczegfalvy* the ECtHR appeared to use the terms 'medical necessity' and 'therapeutic necessity' interchangeably

5 *R (on the application of N) v Dr M and others* [2002] EWCA Civ 1789

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

7 For a comprehensive review and analysis of this judgment, see Bartlett, P. 'Capacity, Treatment and

Human Rights', *Journal of Mental Health Law*, February 2004 pp 52-65

8 Silber J had given the first instance judgment in *R (N) v Dr M* and built on this in the *PS* case.

9 *Pretty v United Kingdom* (2002) 35 EHRR 1 at [52]

10 This two stage approach to the best interests test had been laid down by Butler-Sloss P in *Re S (Adult Patient: Sterilisation)* [2001] Fam 15 at 27-28

11 This element follows the wording of the statutory test under s.58(3)(b)

the risk he presents to himself, (d) the risk he presents to others, (e) the consequences of the treatment not being given and (f) any possible adverse effects of the treatment<sup>12</sup>.

This then was the clear legal framework regarding the imposition of treatment under Part IV MHA at the time B's first challenge came to the Administrative Court.

## **The Decisions**

### **(a) Administrative Court (1)**<sup>13</sup>

The first challenge brought by B, against the Secretary of State, was effectively a challenge to the judgment in *PS*, discussed above. His counsel, Paul Bowen<sup>14</sup>, argued that medical necessity alone was insufficient justification for imposing treatment under s.58 on a competent patient who was refusing treatment. Instead he asserted that:

(i) s.58(3)(b), when construed with the benefit of s.3 HRA, authorised compulsory treatment of a capacitated patient against his will only where it was convincingly shown that such treatment was both medically necessary ('the medical necessity requirement') and necessary to prevent serious harm either to the public or to the patient's health ('the threshold requirement'); or

(ii) if s.58(3)(b) could not be construed in this way, a declaration of incompatibility under s.4 HRA should be considered.

Mr Bowen argued that his interpretation was supported by Articles 3, 8 and 14, and international consensus.

Although Silber J refused B's application, deeming it academic, he commented in some detail, albeit obiter, on all the substantive points in the claim, essentially by following and developing his own reasoning in *PS*.

On Article 3 he held that this would not automatically be breached *merely* because the patient had capacity to consent but did not do so; the 'minimum level of severity' would still need to be demonstrated on the facts. He also held that the ruling in *Herczegfalvy*, that treatment which has been convincingly shown to be medically necessary cannot infringe Article 3, applied equally to capacitated patients. His conclusions on Article 3 were reinforced by his assertion that the threshold of capacity for mental patients is not only low, but actually lower than for non-patients, thus increasing the case for overriding the refusal of treatment by detained patients assessed as having capacity. For this assertion he drew support from several sources, including the dicta of Hale LJ in *Wilkinson*<sup>15</sup>, and the precise wording of s.58 MHA which suggested that the patient need only be '*capable* of understanding the nature, purpose and likely effects of the treatment', rather than *actually* understanding these things.

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12 Silber J had developed this approach to the determination of the single best option for treatment in his first instance judgment in *R (N) v Dr M* and thus imported it directly into *PS*.

13 *R (on the application of B) v Dr SS (1), Dr AC (2), Secretary of State for the Department of Health (3)* [2005] EWHC 86 (Admin)

14 Mr Bowen had also represented the claimant in *Wilkinson* and appears to have refined and developed the arguments used there, particularly in relation to

international consensus.

15 See *Wilkinson*, *op.cit.* at [80] per Hale LJ: "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."

On Article 8 he held, as in PS, that any breach of Article 8(1) could be justified under Article 8(2), but now made it clear that ‘in accordance with the law’ meant consideration of both the common law requirements of the ‘best interests test’, and the statutory requirements of s.58 MHA.

Having rejected the Article 14 challenges on the basis that the chosen comparators were not in an analogous situation to B, Silber J finally rejected Mr Bowen’s extensive representations on the growing international consensus. Amongst other reasons, he held that none of the material was binding on English courts nor, since none of it had been incorporated into English law, did it allow a first instance judge to depart from established principles.

He concluded that in any event, the proposed imposition of treatment on B would not have infringed his Convention rights, irrespective of his capacity.

### **(b) Administrative Court (2)**<sup>16</sup>

In the second hearing in the Administrative Court, following the RMO’s decision that he now wished, with the support of the SOAD, to pursue treatment under s.58(3)(b), the challenge was made on different grounds; those issues which had been argued and had failed before Silber J were reserved for appeal.

Before Charles J it was contended by B’s counsel, again Mr Bowen, that for the purposes of Articles 3 and/or 8, the required threshold of ‘convincing medical necessity’ for the proposed treatment had not been reached because (i) B had capacity to refuse treatment, and (ii) the evidence did not convincingly establish that he was suffering from bi-polar affective disorder that was relapsing.

The application was dismissed, with Charles J finding that the claimant lacked capacity and that the proposed treatment had been convincingly shown as a medical necessity. In setting out the legal framework for his decision, while substantially following the dicta of Silber J and earlier cases, Charles J added some additional, and in some cases contradictory, insights of his own.

In assessing B’s capacity, he systematically applied the conventional three-stage test of *Re C*<sup>17</sup>. He found that B was able to comprehend and retain information concerning his proposed treatment. However, B’s refusal to believe that he was or might be mentally ill meant that he could not effectively weigh in the balance the relevant information about the treatment in reaching a decision as to whether to accept or refuse it.

In respect of allegations of Article 3 breaches, the Court confirmed the authority of the *Herczegfalvy* approach, and also that the proposed treatment would not amount to a breach merely because a patient had capacity. Indeed B’s refusal of treatment and the effects of its compulsion were regarded as more significant than the issue of whether he had capacity. Further it was confirmed that in judicial review of potential Article 3 breaches, the court must determine for itself whether medical necessity had been ‘convincingly shown’. In attempting to clarify the meaning of this phrase, which had been recognised as a high standard of proof in *N v Dr M*<sup>18</sup> [18] but left undefined, Charles J reasoned that it must lie somewhere between the English criminal and

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<sup>16</sup> *R (on the application of B) v S and others* [2005] EWHC 1936 (Admin)      <sup>18</sup> See footnote 5 above

<sup>17</sup> *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819

civil standards. In B's case, the Court held it unlikely that the compulsory administration of anti-psychotic medication would result in a sufficient degree of severity to engage Article 3. In any event, there were sound and compelling reasons to believe that the proposed treatment would achieve many or all of its intended purposes, including alleviation of B's symptoms and the improvement of his chances of rehabilitation, and thus its therapeutic or medical necessity had been convincingly shown.

When considering justification for potential breaches of Article 8(1), the Court confirmed, as already decided in *PS*<sup>19</sup> and *B v Dr SS*<sup>20</sup>, that the *Herczegfalvy* test was not appropriate. Rather the orthodox three-fold test under article 8(2) should be applied, namely: was the interference (i) 'in accordance with the law', (ii) for a legitimate aim, and (iii) 'necessary in a democratic society'. Charles J held that 'in accordance with the law' required a consideration only of the statutory provisions of Part IV MHA, and that Silber J had erred in holding that it also required an application of the common law test of best interests. He suggested though, that in many cases there would be no effective difference between an application of the statutory and the best interests tests. In B's case however, the parties had proceeded on the basis that if it had been convincingly shown that the proposed treatment was a therapeutic or medical necessity, then all of the elements of Article 8(2) would be satisfied and no alternative arguments would be advanced. Nevertheless for completeness, Charles J added that the proposed treatment of B was a therapeutic or medical necessity, that it satisfied the test in s.58 MHA, it was justified under Article 8(2) and it was in the best interests of B.

Having dismissed the claim for judicial review on all grounds, the Court discharged the injunction granted by Silber J preventing treatment, subject to a stay pending appeal.

### **(c) Court of Appeal<sup>21</sup>**

Giving the reserved judgment of the Court, Lord Phillips CJ identified the five issues raised by the appeal:

- i) Was the judge wrong to find that B lacked capacity? If not:
- ii) Should the appeal be dismissed without consideration of the other issues, on the ground that these were academic? If not:
- iii) Will compulsory treatment of a patient with capacity violate Articles 3, 8 and 14, or any of them, unless it satisfies the 'threshold requirement' (i.e. that the treatment was necessary either to prevent the patient causing harm to others or to protect the patient from serious harm)?
- iv) Was the judge wrong to find that the proposed treatment constituted a medical or therapeutic necessity?
- v) What is the nature of the procedure that the court should follow when judicial review is sought on Convention grounds of a decision to administer treatment under section 58?

On the first issue, the Court emphasised the importance which English law attached to the freedom of the individual to decide what should or should not be done by way of physical interference or invasion of the body. However the law also recognised exceptions to this principle, such as where

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<sup>19</sup> See footnote 6 above

<sup>20</sup> See footnote 13 above

<sup>21</sup> *R (on the application of B) v S and others* [2006] EWCA Civ 28

the patient lacked capacity to consent to such conduct. The particular position of mental patients was provided for in the MHA. In the section in question, s.58, the relevant test of capacity seemed to be laid down when it spoke of the patient being 'capable of understanding the nature, purpose and likely effects of' the treatment. The Court recognised that these words may not go far enough to define capacity and that in *Wilkinson* [66], it had been suggested that the *Re MB*<sup>22</sup> test of capacity used in relation to physical disorders was suitable for assessing capacity for the purposes of s.58(3)(b). Without appearing to apply this test rigorously, the Court held that:

*"Whatever the precise test of the capacity to consent to treatment, we think that it is plain that a patient will lack that capacity if he is not able to appreciate the likely effects of having or not having the treatment."*

After anxious scrutiny of the evidence, Charles J had found that this was the position in B's case, and had therefore been correct to conclude that he lacked capacity.

On the second issue, the Court held that even though B had been found to lack capacity to consent to treatment, he may, with treatment, reach a state where his capacity was restored. The remaining issues, relating to the lawfulness of the compulsory treatment of a capacitated patient, should therefore be considered.

In addressing the third issue, the Court first made some general observations. The Court suggested that the submissions of B's counsel, Mr Bowen, had implicitly been based on two premises, both of which were unsound:

- *The 'threshold' requirement had to be demonstrated at the stage when it is proposed to administer treatment.* The Court pointed out that at this point the patient would have been detained and thus in a secure environment where his capacity for causing or experiencing harm was inherently reduced. Anyway, the Court would show that this premise was at odds with the scheme of the MHA
- *Autonomy, and thus capacity, was of critical importance in deciding whether a particular treatment could be imposed upon a detained patient.* The Court observed that with the fluctuating nature of B's illness this premise could lead to an absurd scenario in which B might regain capacity *only* with treatment, at which time he would be entitled to refuse treatment and consequently relapse and lose capacity once more. Charles J had therefore been correct to hold that capacity was not the critical factor in determining whether treatment could be given without consent, and that the fact of its compulsion was more significant.

The Court then explained that the MHA provided for an integral package of detention and treatment, and imposed restrictions to ensure that individual treatment was justified. If the detention of a patient for treatment pursuant to s.3 was justified on the ground that the treatment was necessary for the protection of others, it was not logical to consider treatment in isolation from the overall objective of the package, nor to apply a higher standard to justify the administration of treatment itself. The Court cited approvingly the dicta of Baroness Hale in

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22 *Re MB (An Adult: Medical Treatment)* [1997] 2 FCR 541

*R (B) v Ashworth Hospital Authority*<sup>23</sup>, a case dealing with the scope of treatment permitted under s.63 MHA:

“Once the state has taken away a person’s liberty and detained him in a hospital with a view to medical treatment, the state should be able (some would say obliged) to provide him with the treatment which he needs.”

The Court also approved the observations of Silber J in *PS*,<sup>24</sup> that the compulsory treatment of a detained patient should be considered in the context of the likelihood that it would lead to the patient’s rehabilitation and return to society. The objective of rehabilitation itself militated against any approach which ignored the overall object of the MHA package and imposed a separate ‘threshold requirement’ on treatment.

Following these general observations, the Court then considered the compatibility of the express provisions of the MHA with the ECHR. The leading authority was *Herczegfalvy*, in which the ECtHR had held that a measure which was a therapeutic necessity cannot be regarded as inhuman or degrading. The court nevertheless had to satisfy itself that the medical necessity had been convincingly shown. Though this case related to a patient who lacked capacity, in the more recent case of *Nevmerzhitsky v Ukraine*<sup>25</sup>, the ECtHR had applied the same principles where the applicant was not mentally ill.

Moving to the fourth issue, the Court held that in the light of the findings of fact made by Charles J, he had been entitled to conclude that the proposed treatment of B was in his best interests and that it had been convincingly shown that it was a medical necessity. The Court did not feel it necessary to decide whether these tests were the same, nor whether Charles J had been right to hold that ‘in accordance with the law’ in Article 8(2) required consideration only of statutory provisions and not the best interests test. The Court observed though, that the best interests test should not be equated with that under s.58(3)(b) which was much narrower, but suggested that common law and medical ethics should ensure that SOADs would always apply it anyway before authorising treatment.

In addressing the final issue, the Court acknowledged the principle established in *Wilkinson* that in judicial review proceedings of human rights challenges to compulsory treatment under s.58, the claimant was entitled to require the attendance of medical witnesses to give evidence and be cross-examined. The Court noted though, that both in *Wilkinson* [62] and *N v Dr M* [36], there had been observations that cross-examination of medical witnesses should be ordered only *if necessary*. The Court reflected that it was undesirable that medical practitioners should have to attend court as witnesses rather than attend to their patients, and suggested that if s.58, which imposed clear preconditions for compulsory treatment, was properly complied with, then issues requiring cross-examination of medical witnesses should not often arise. This would require that the SOAD should give a truly independent assessment and not merely approval of the RMO’s decision on the basis that it was not manifestly unsound.

Having thus dealt with all the issues raised, the Court duly dismissed the appeal.

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23 *R (on the application of B) v Ashworth Hospital Authority* [2005] UKHL 20 at [31]. See Kris Gledhill’s consideration of this case: ‘The House of Lords and the Unimportance of Classification: A

*Retrograde Step*’; *JMHL* November 2005, pp 174–185

24 See *PS*, *op.cit.* at [134]

25 *Nevmerzhitsky v Ukraine*; Application No. 54825/00



## Discussion

While the Court of Appeal may have determined the appeal, the judgment seemed to contain little new law. Somewhat disappointingly, it also failed to clarify or resolve a number of the undecided points or apparent contradictions in earlier judgments, particularly in the following areas.

### (a) Capacity

The capacity of psychiatric patients remains problematic both in terms of its assessment and its significance.

The assertion of Silber J in the Administrative Court that the threshold of capacity for mental patients is not only low, but actually lower than for non-patients, surely cannot be correct. His use of the dicta of Hale LJ in *Wilkinson* [80] to support his assertion would seem to be a misrepresentation of her Ladyship's comments, since she did not appear to be talking specifically about mental patients, but more generally when she said: 'Our threshold of capacity is rightly a low one'. Indeed, even this is debatable for, as Bartlett<sup>26</sup> has observed, 'the threshold of capacity in England is not low at all...it is exceptionally high'. And Silber J's reference to the wording of s.58 to infer that the test of capacity of detained patients requires only *capability* to understand rather than *actual* understanding, seems at total variance with current practice. The MHAC has long held that SOADs should require both capacity and actual understanding of the treatment and its consequences – a view endorsed by Jones<sup>27</sup>, who advises that the common law test of *Re MB* should be applied. The MHAC<sup>28</sup> has now specifically expressed concerns about Silber J's comments, and emphasised that different legal criteria should not be applied to the determination of capacity in detained patients and others. But in not addressing this element of Silber J's judgment, and also in itself not seeming inclined to apply the *Re MB* test rigorously, the Court of Appeal has allowed uncertainty about assessment of the capacity of psychiatric patients to continue.

On the significance of capacity though, the Court was crystal clear that it is not determinative of the authority to impose treatment under s.58, even where nobody is at risk from serious harm. Their reasoning merits closer scrutiny however. The Court aligned itself with the recent judgment in *R(B) v Ashworth Hospital Authority*<sup>29</sup> in believing that the MHA provided a package in which the authority for detention essentially provided the necessary authority for compulsory treatment – it was illogical to apply a higher standard to justify the administration of treatment itself. Yet deprivation of liberty is a quite different matter than violation of the person. As Gledhill<sup>30</sup> has commented, this type of reasoning comes close to implying that the loss of liberty due to mental disorder carries with it a consequent loss of any right of self-determination. Bartlett<sup>31</sup> has pointed out that there are jurisdictions where no patient with capacity, even a detained psychiatric patient, may be treated without his informed consent. In these jurisdictions, detained capacitated patients

26 Bartlett, P. 'The Test of Compulsion in Mental Health Law: Capacity, Therapeutic Benefit and Dangerousness as Possible Criteria', *Medical Law Review* 2003 11(3) pp 326–352 at p 335

27 Jones, R.M. 'Mental Health Act Manual', 9th Edition, London, Sweet & Maxwell, 2004 at paras 1-713 and 1-714

28 Mental Health Act Commission, 'Eleventh Biennial

Report 2003–2005: "In Place of Fear?", London, TSO, 2005 at paras 1.56–1.59

29 See footnote 23 above

30 Gledhill, K. 'The House of Lords and the Unimportance of Classification: A Retrograde Step', *Journal of Mental Health Law*, November 2005, pp 174–185 at p 184

31 See Bartlett (2003), *op.cit.* at pp 333–334

apparently rarely refuse treatment, but rather tend to negotiate a mutually acceptable treatment solution with their psychiatrists. Despite the strenuous advocacy of lawyers like Mr Bowen however, the capacity of detained psychiatric patients has not reached this level of significance in the domestic jurisdiction. Nor is it likely to achieve any greater significance in future mental health legislation. For while the Richardson Committee<sup>32</sup>, in developing proposals for reform of the MHA, had suggested that treatment be imposed on those with capacity only where this was necessary to prevent a substantial risk of serious harm to the patient or other persons<sup>33</sup>, this recommendation was not incorporated in the White Paper<sup>34</sup> nor subsequent drafts of the now aborted Mental Health Bill<sup>35</sup> <sup>36</sup>. Nor does it appear to be included anywhere within the Government's subsequent proposals for amendments to the MHA.

### **(b) Best Interests and the Role of the SOAD**

It is unfortunate that the Court of Appeal failed to clarify the status of the best interests test within Article 8(2) for, as Fennell<sup>37</sup> had much earlier pointed out, the legal test under s.58(3)(b) of likelihood that the treatment will alleviate or prevent deterioration, is very much looser than the best interests test. It had been further diluted by DHSS guidelines<sup>38</sup> so as to require SOADs effectively to apply only the *Bolam*<sup>39</sup> criteria of reasonableness rather than seek the best treatment option for the patient. That this had in fact been their approach, Fennell inferred, was evidenced by the consistently high level of agreement between RMOs and SOADs.

Since then, in *Wilkinson*<sup>40</sup>, the judiciary have criticised the operation of the SOAD role as an effective safeguard for patients, regarding it as too much a review of the RMO's proposal and assessment of its reasonableness, albeit that this was in line with the then current MHAC guidelines<sup>41</sup>. Rather the SOAD was expected to exercise his own independent view of the desirability and propriety of treatment, and demonstrate a less deferential approach than appeared to be the norm. Despite this, the high level of agreement between RMOs and SOADs has continued to the present<sup>42</sup>. The MHAC has suggested, without evidence, that this attests to the success of the second opinion process and the care with which RMOs prepare their treatment plans.

Yet, in terms redolent of those used in *Wilkinson*, the Court of Appeal has again urged SOADs to conduct a truly independent assessment. On the other hand, it has also assumed that SOADs

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32 Department of Health, 'Review of the Mental Health Act 1983: Report of the Expert Committee', (*The Richardson Report*), London, DoH, November 1999 at paras 5.94–5.97

33 This, of course, had been precisely the basis of Mr Bowen's submissions in *B v Dr SS*

34 *Reforming the Mental Health Act – Part 1: The new legal framework*, Cm 5016-I, Department of Health, London, TSO, December 2000

35 *Draft Mental Health Bill*, Cm 5538-I Department of Health, London, TSO, June 2002

36 *Draft Mental Health Bill*, Cm 6305-I Department of Health, London, TSO, September 2004

37 Fennell, P. 'Treatment Without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845', London, Routledge, 1996 at pp 204 and 208

38 Department of Health and Social Security, *Dear Doctor Letter DDL 84(4)*, DHSS, 1984

39 *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118

40 See *Wilkinson*, *op.cit.* at [32]-[33] and [71]

41 Mental Health Act Commission, 'Advice to Second Opinion Appointed Doctors', Nottingham, MHAC, April 1999 at para 11

42 Mental Health Act Commission, 'Tenth Biennial Report 2001–2003: "Placed amongst strangers"', London, TSO, 2003 at para 10.37 and MHAC Eleventh Biennial Report, *op.cit.* at para 4.67. The number of second opinions where a significant change had been made to the RMO's treatment plan has in fact remained essentially static at about 2–3% of the total for over a decade.

would anyway not be certifying treatment under s.58 unless satisfied that it was in the patient's best interests.

The judiciary really cannot have it both ways. If the SOAD's role as a safeguard for patients is operating effectively, such exhortations to independent judgment are unnecessary. If it is not, as the Court of Appeal inferred, and as the MHAC statistics might more probably suggest, then the Court has lost an opportunity to reinforce it by enshrining the best interest tests, with its associated requirement to seek the best possible treatment option, firmly within the meaning of 'in accordance with the law' in Article 8(2). While it is acknowledged that this test was developed within the common law principles of treatment of those without capacity, it is submitted that it should be equally applicable in the context of capacitated patients where their capacity is to be overridden and treatment decisions are to be made on their behalf, and imposed without their consent, under s.58(3)(b).

### (c) Role of the Court

*Wilkinson* had established the principle that in judicial review proceedings of human rights challenges to compulsory treatment under s.58, the court must reach its own view on the facts. The observations of Hale LJ in that case, that cross-examination of medical witnesses should be ordered only if necessary, have since been cited and interpreted by the Court of Appeal in both *N v Dr M* [39] and the instant case [68] to suggest that the need for oral evidence and cross-examination in such cases would be exceptional. The lower courts have been somewhat more inclined to accept the benefits of such evidence. Silber J found it essential in *PS* [23], and Charles J<sup>43</sup> in his judgment in the Administrative Court specifically observed that, contrary to *N v Dr M*, cross-examination of medical witnesses would be helpful and informative in many cases. However, Collins J only reluctantly accepted the need to move beyond the court's normal review obligations in *R (B) v Haddock*<sup>44</sup>, and in *R (Taylor) v Haydn-Smith*<sup>45</sup> he declined applications for oral evidence. (Both of these were s.58 challenges.)

As Bartlett<sup>46</sup> noted when commenting on the *PS* case though, even where the court has allowed oral evidence, there has been a tendency to deal with it in the manner of traditional judicial review, based more on assessment of witness credibility rather than the substantive engagement with the facts required by *Wilkinson*. And in respect of witness credibility, we should also note the inherent deference of the courts to the treating physicians. This has its origins in the dicta of Simon Brown LJ in *Wilkinson* [31]:

*"Certainly, however, courts will not be astute to overrule a treatment plan decided upon by the RMO and certified by a SOAD following consultation with two other persons."*

This view was endorsed by the Court of Appeal in *N v Dr M*<sup>47</sup>, and has since been echoed by Silber J in *PS* [82] and by Charles J in the Administrative Court in the instant case [68]–[70].

The Court of Appeal appeared to acknowledge the ambivalence of the judiciary concerning their

43 See *B v S (HC)*, *op.cit.* at [235]–[236]

44 *R (on the application of B) v Haddock and others* [2005] EWHC 921 (Admin) at [15]. As acknowledged later on in the text, this case has subsequently been considered by the Court of Appeal.

45 *R (on the application of Taylor) v Haydn-Smith and*

*another* [2005] EWHC 1668 at [8]

46 See Bartlett (2004), *op.cit.* at pp 57–58

47 See *N v Dr M*, *op.cit.* at [38] per Dyson LJ: "Courts are likely to pay very particular regard to the views held by those specifically charged with the patient's care."

approach to hearings of treatment challenges and admission of oral evidence, though unfortunately its own comments were not conclusive, and it specifically declined to comment on the observations of the first instance judges in the case. Nevertheless the inference of the Court's comments regarding both oral evidence and the status of the treating physicians, would clearly suggest that its position aligns with that of the appellate court in *Wilkinson and N v Dr M*. All this inevitably implies that in such judicial review proceedings, the odds will remain stacked against the claimant, since he can have little confidence that his own medical evidence will receive either adequate or impartial consideration.

More recently though, the judiciary were given a further opportunity to consider, inter alia, the nature and intensity of the review to be carried out by the court in such cases, when *B v Haddock*<sup>48</sup> was heard by the Court of Appeal. Their judgment has really done nothing to rebalance the odds, however. On the issue of oral evidence and cross-examination, the Court endorsed the view of the Court in the instant case in perceiving no inconsistency of approach between the decisions in *Wilkinson and N v Dr M*, and held that the Court in *Wilkinson* could never have intended or contemplated that every such case would require the hearing and testing of medical evidence [65]. And again the Court approvingly noted the dicta of earlier judgments regarding the particular deference to be shown by the courts to the views of treating physicians [14].

## **Conclusion**

Contrary to what might have been anticipated, previous challenges under the HRA had afforded detained psychiatric patients no substantive rights in respect of their treatment – only some modest procedural protection. The judgment of the Court of Appeal in this case should therefore have come as no surprise. In its reasoning, it follows the earlier s.58 judgments. In its tone however, it aligns closely with the recent judgment of the House of Lords in *B v Ashworth*. In summary, the courts have now made it very clear that, provided due process is observed, the HRA will provide no impediment to the exercise of the wide-ranging powers of compulsory treatment under Part IV MHA, even where the patient has capacity and irrespective of whether refusal of treatment poses a risk of serious harm to the patient or others. The courts have shown little inclination to limit these powers and, though perhaps a topic for a different article, it might be argued that they have even sought to broaden them beyond the legislative intent. It would be of some comfort to think that the judiciary have been motivated by paternalism – true concern for the patients. It is hard to avoid the conclusion though, that it has become more an issue of power – and that it is much more convenient for everyone when the balance of power is left firmly in the grasp of the authorities.

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<sup>48</sup> *R (on the application of JB) v Haddock and others* [2006] EWCA Civ 961