ISSN 1466-2817

Journal of Mental Health Law

A model law fusing incapacity and mental health legislation – is it viable; is it advisable?

NORTHUMBRIA LAW • PRESS

Special issue – 2010

Journal of Mental Health Law

Special issue Edition No. 20. Pages 1–140

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Foreword

Publication of the 20th issue of the Journal calls for a Special Issue, and as can be deduced from both the cover and the contents page, that is exactly what is offered on this occasion.

The issue is confined to one consideration, namely the viability and advisability of '*A model law fusing incapacity and mental health legislation*'. Given the significant role afforded to 'capacity' in the Report of the Expert Committee appointed by the Government in 1998 to advise on the direction of mental health law reform, it seemed highly appropriate both to Professor George Szmukler (the Editorial Board member who proposed the issue) and myself that the involvement of Professor Genevra Richardson (the Chair of the Expert Committee) should be sought. I am very grateful to her for her acceptance of the invitation to co-edit the issue, and the consequent very significant role she has played both in devising the structure and in co-ordinating the production of this issue.

John Horne
Editor

Preface

The possibility of a single statue to replace our current dual approach must now be the most fundamental issue confronting mental health and mental capacity law reform. I was therefore delighted to be offered the opportunity to co-edit this Special Issue.

The question of a single statute was already live when the Expert Committee started its work in 1998 and, although it did not fall within our narrow brief, we were conscious both of its enormous potential and of the practical difficulties involved in turning it into reality. George Szmukler, Rowena Daw and John Dawson by presenting both the arguments in principle and a model legislative framework have provided an invaluable opportunity to explore this central issue in all its aspects. I am immensely grateful to them and to the Journal for providing the ideal public and interdisciplinary forum for this vital debate. I am also extremely grateful to the commentators for engaging so seriously with the issues raised. They represent an outstanding body of expertise in both law and psychiatry from across the UK and beyond, and their thoughtful comments have contributed vitally to the quality and breadth of the debate.

This Special Issue opens with an introduction by *Szmukler*, *Daw* and *Dawson* outlining the case for "fusion" and describing the structure of a model statute designed to demonstrate the legislative feasibility of the fusion project. The following section contains the commentaries engaging with the underlying rationale (*Appelbaum* and *Burns*); the interface with the criminal justice system (*Buchanan* and *Gledhill*); the role of the tribunal (*Robinson*); the safeguards for "informal" patients (*Holland* and *Weereratne*); and the experience in Scotland and Northern Ireland (*Atkinson and Patrick*, and *McCallion and O'Hare*).

As editors we were keen to provide *Smukler*, *Daw* and *Dawson* with the opportunity to respond to the many important issues raised by the commentators, and the third section of the Issue contains their response. This is then followed by the text of the draft model statute in the original form in which it was sent for comment and an Addendum, subsequently drafted by *Smukler et al* to take account of some of the points raised. The final section contains an overview by *Gledhill* of the law reform debate to date.

Between them the contributors to this very Special Issue have provided us with an authoritative and thought provoking analysis of a fundamental debate. It is also extremely timely. The implementation of the 2007 revisions to both the *Mental Health Act 1983* and the *Mental Capacity Act 2005* have illustrated all too clearly the practical difficulties involved in managing the interface between the two parallel structures. This Special Issue provides us with a valuable opportunity ask whether there is in fact another way.

Genevra Richardson

Guest Editor

The Proposal

A model law fusing incapacity and mental health legislation

George Szmukler[1], Rowena Daw[2] and John Dawson[3]

Acknowledgement: We are grateful to the Institute of Social Psychiatry, London, for a grant in support of this project. We also thank Genevra Richardson and Jill Peay for their valuable comments on the subject.

An outline for a model law is presented here that would govern the non-consensual treatment of people who lack the capacity (or competence) to consent due to mental impairment[4], whether this is due to 'mental disorder' or 'psychiatric disorder' as conventionally conceived, or due to a 'physical disorder'. Our aim in drafting this model law is to give coherent and practical expression to the case, previously made by two of the current authors, that separate legislation authorising the civil commitment of 'mentally disordered' persons is unnecessary, and discriminatory, and should be replaced by new, comprehensive legislation that would govern the non-consensual treatment of both 'mental' and 'physical' conditions[5]. This new scheme – which we have described as the 'fusion' proposal – would be based squarely on incapacity principles: that is, on the impaired capacity of a person to make decisions about treatment, from whatever cause – whether this is due to schizophrenia, Alzheimer's Disease, a learning disability, a confusional state due to infection, a cerebrovascular accident, a head injury, or any other mental impairment.

A model statute of this kind, drafted largely by Rowena Daw, is presented here in skeleton form.

Justifications for the 'fusion' proposal

In the UK, as in most jurisdictions, treatment for 'mental disorder' is largely governed by mental health legislation. Under that legislation, the usual criteria for intervention – by way of both detention and involuntary treatment – are that the person concerned is 'mentally disordered' (or 'mentally ill') in the necessary sense and that they present a serious risk to themselves or others. If a person meets those complex criteria, the legislation will usually authorise their certification by medical practitioners, their emergency detention and transportation to a hospital or clinic, their compulsory assessment, their

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3 *Professor of Law, University of Otago, Dunedin, New Zealand.*

4 *The term 'mental impairment' is used in its broad sense here and is not limited to the legal definition of the term which was to be found in section 1(2) Mental Health Act 1983 prior to the Mental Health Act 2007 amendments*

5 *Dawson J, Szmukler G (2006). 'Fusion of mental health and incapacity legislation'. Br J Psychiatry, 188:504–509.*

involuntary psychiatric treatment, and their compulsory community care, provided the person's involuntary status as a whole is kept under regular, continuing review by a court or tribunal. Patients who retain, or regain, their capacity to consent may still receive psychiatric treatment without their consent as long as they remain involuntary patients under the scheme.

When it comes to the treatment without consent of non-psychiatric medical conditions, on the other hand, different criteria and different procedures are followed that are grounded in different sources of law. Treatment without consent is not permitted for those with capacity; for those who lack capacity reliance is placed on common law powers (or justifications) for intervention whose origins lie in the defence of necessity in the law of crime and tort, or we act under adult guardianship (or incapacity) legislation, such as the *Mental Capacity Act 2005* (MCA 2005). Under these regimes the fundamental criterion for intervention is not the presence of any specific disorder or the imminent threat of harm. Instead, the test for intervention is the incapacity of the person to make necessary treatment decisions. If the person lacks that capacity, treatment that is in their 'best interests' may generally be provided without their consent.

We have argued that the maintenance of these separate regimes is no longer acceptable. In particular, this 'two-track' approach is inconsistent with general principles of health care ethics and with basic notions of human rights, particularly the right of people with mental disorders to be free of unnecessary discrimination in the law. Mental disorder is *not* always associated with incapacity to consent, and the capacity of mentally disordered people is already assessed for many other legal purposes. Furthermore, there is good research evidence that the assessment of capacity in people with a 'mental disorder' is as reliable as for those with a 'physical disorder'[6].

The 'fusion' framework

The alternative approach that we advocate is to abandon the two-track approach, and, instead, to fuse the two together into a single comprehensive involuntary treatment scheme, which preserves the strengths of each. A major strength of non-consensual treatment schemes that are based on incapacity principles is the respect shown for the autonomy of those patients who retain their capacity; but these schemes are, nevertheless, often weak on the regulation of emergency treatment powers, detention in hospital, and forced treatment. These are the areas, in contrast, in which civil commitment schemes are strong. The use of force, and the detention and involuntary treatment of objecting patients, is clearly authorised and regulated by mental health legislation. We therefore advocate a legal regime that retains the strengths of both, but still relies squarely on the incapacity of the person to make necessary care or treatment decisions as the primary justification for intervention in their life.

Our proposed 'fusion' legislation deals with all persons who lack capacity who may require treatment or care; compulsory powers will only affect a subset of those covered. Provisions for the treatment and care of informal patients include safeguards for those requiring 'serious medical treatment', protections for informal patients in residential care, and requirements for informal patients lacking capacity who need to be 'deprived of their liberty' in their best interests. A single regime is thus provided that specifies the conditions for both treatment under compulsion and treatment under circumstances amounting to a 'deprivation of liberty'.

This paper demonstrates how we may fuse the central elements of these two distinct schemes into one comprehensive piece of legislation. The basic criterion for intervention under 'fused' legislation is

6 *Cairns R, Maddock C, Buchanan A, David AS, Hayward P, Richardson G, Szmukler G, Hotopf M. (2005) 'Reliability of mental capacity assessments in psychiatric in-patients'. British Journal of Psychiatry 187: 372–8.*

incapacity to make necessary treatment decisions. The usual meaning of 'incapacity' applies: that is, inability to understand, recall, process, use or weigh relevant information: inability to communicate a decision; or inability to reach a decision that is sufficiently stable for it to be followed. This incapacity test must be defined in a manner that is sufficiently flexible to cover the complex and subtle forms of incapacity found in some mental disorders. The test is not linked to any specific disabling condition, even if it is linked in a general manner to an impairment or disturbance in the function of the mind, as in section 2(1) MCA 2005 for England and Wales. In addition, for intervention under this test to occur, no less restrictive resolution of the apparent problems should be available.

In emergency circumstances, a 'reasonable belief' that the patient lacks capacity in this sense is sufficient to authorise intervention. Suitably qualified professionals could then intervene, using similar powers to those provided by a civil commitment scheme: that is, powers of entry, detention of the person, transportation to assessment, use of reasonable force, and so on.

The patient then enters a staggered compulsory assessment process, during which immediately necessary treatment can be authorised. A more structured assessment of the patient's capacity can then take place. If the patient's involuntary treatment is to continue, further downstream decisions about the details of their treatment are required: decisions, for instance, concerning the need for their detention for treatment purposes, the appropriate place of treatment – which includes the community – the contents of the treatment plan, and the value of any continuing care.

Comprehensive review and accountability mechanisms also apply. All involuntary patients must have ready access to rights advice and to independent review of their status before a court or tribunal. A substitute decision-maker for treatment is appointed (and parameters for the patient's treatment set). Serious treatments require special regulation, through mandatory peer review of treatment, for instance. But this kind of requirement does not apply only to psychiatric treatment; it should apply to all treatments of a similarly controversial or intrusive kind.

In our proposed scheme, with some minor exceptions (see below), involuntary treatment is restricted to patients who lack capacity. This does not preclude involuntary treatment for the protection of others, which is permitted in two sets of circumstances – first, where treatment for the protection of others is in the patient's best interests, and second, where in the course of providing treatment in the best interests of the patient, there arises a risk of harm to others.

Note that we are not advocating the intermediate (or hybrid) legal position now followed in many parts of North America and continental Europe that involves the application of different legal criteria to the detention and involuntary treatment decisions[7]. Under that approach, mental disorder and threat of harm criteria may be applied to a person's detention, while incapacity criteria may be applied to their treatment. That approach has the significant disadvantage that it can lead to a position wherein a person may be lawfully detained in a psychiatric facility on the basis of their mental disorder, but cannot then be treated if they retain or regain their capacity to consent to psychiatric treatment. Instead, we argue that the test of incapacity to consent should be applied to both a person's detention and their involuntary treatment.

7 *Dawson J, Kampf A (2006). 'Incapacity principles in mental health laws in Europe'. Psychology, Public Policy and Law, 12, 310–331.*

Forensic care in the 'fusion' framework

The consequences of applying capacity principles to forensic care may appear problematic. The matter is complicated by the existence of different categories of forensic patient – some on remand, some convicted of criminal offences, some found not guilty by reason of insanity, or unfit to plead. The matter is also complicated by the fact that some forensic patients can be returned to prison if they regain their capacity and refuse treatment, while others cannot be returned to prison, because they are not currently subject to a prison sentence. If the detention of a person in that latter group was no longer authorized, they would have to be immediately released, which is an outcome that may not be politically or socially acceptable if the person concerned is deemed to still present a serious risk of harm.

This points to the fact that protecting the autonomy over treatment of patients with capacity is not the only important ethical principle in this field. Another important principle concerns the need to protect other people from serious harm. So some modification of pure capacity principles may be required in the forensic field.

Nevertheless, most of the difficulties in the forensic area can be overcome if the following principles are applied. First, any mentally disordered offender with capacity who consents to their treatment could be treated in an appropriate facility (and any sentence they were under could continue to run). Secondly, any mentally disordered offender who lacks capacity could be treated involuntarily like any other incapacitated patient. Thirdly, any criminal defendant found unfit to plead or not guilty due to insanity might still be treated without their consent, even if they retain or regain their capacity, if certain conditions apply:

- the person has committed acts or omissions constituting a serious offence; and
- a serious mental impairment or disturbance has contributed significantly to that conduct; and
- an effective treatment can be offered that could be expected to reduce the risk of that disorder's reoccurrence.

This compromises pure incapacity principles, in narrowly defined circumstances, in order to prevent harm to others. It may also be the most humane disposal, as the option of prison would be inappropriate for a person with a mental impairment of such severity, and indeed would be impossible without a conviction. However, we believe that the number of persons likely to fall into this category who retain capacity is extremely small.

Further we propose that a mentally impaired offender who has been convicted of a serious criminal offence could be sentenced to the usual period of imprisonment, but if they were found to lack capacity and need treatment, they could be transferred to hospital for necessary care. If capacity is regained in hospital, the person has the choice of continuing treatment with consent; if not, the person would be transferred to prison for the remainder of their sentence. An alternative position, which we are not proposing in our draft statute, is that a convicted person could be placed under a hospital order on disposition from the criminal court, and be directed immediately to psychiatric treatment for a limited term, proportionate to the seriousness of their offence. During that limited term involuntary treatment could proceed on the same conditions, specified above, as would apply to those found not guilty by reason of insanity or unfit to plead; that is, treatment could be given involuntarily even for someone who has capacity, under the specified conditions. This would be a pragmatic response to society's demand that a person who has committed a serious offence – even with a mental disorder, and even one that might respond rapidly to treatment – should be detained for a proportionate time. We have proposed the former

option to preserve as far as possible the centrality of incapacity as the justification for involuntary treatment. But we also retain the option of disposal to a compulsory treatment order without a concurrent sentence, which would deem the person to be subject to an equivalent civil order, and which would be terminated by the responsible clinician when the necessary conditions were no longer met.

In the manner outlined above, capacity principles can be followed in most forms of forensic care, subject to some limited modifications that would be required to respect the competing ethical principle of preventing serious harm to others.

The Northern Ireland Bamford Review (2007)[8], with which our proposals share much in common, took an uncompromising approach to the forensic aspects, recommending that only people who lack capacity should be subject to a statute that authorises treatment without consent. We might favour the Bamford position, if their suggestion were adopted that there should be a "new legislative framework to incorporate future measures in relation to the risks posed by people suffering from an impairment or dysfunction of mind within a wider and independent risk management framework that addresses the full range of people who pose a risk of serious harm to the public" (p 79); that is, within a framework that does not discriminate against those with mental disorders. Whether such a scheme would be politically acceptable in England and Wales, or, in the absence of an offence, would be compatible with the European Convention on Human Rights, is questionable.

Our precedents

It is not possible in a paper of this type to present a fully drafted statute, but we have attempted to provide sufficient detail in key areas to show that the concept of fused legislation can be given coherent expression. We take as our base *the Mental Capacity Act 2005* (MCA 2005) for England and Wales. The recommendations of the Richardson Committee (1999)[9] established to review the *Mental Health Act 1983* for England and Wales (MHA 1983) have also been influential, as has the *Mental Health (Care and Treatment) (Scotland) Act 2003*, which incorporates an 'impaired decision making' criterion into a civil commitment regime. Other concepts are drawn from the MHA 1983, from proposals of the Mental Health Alliance for new mental health legislation[10], and from the draft mental health bills of 2002 and 2004[11], which appeared during the law reform process. In the event, these drafts met with substantial resistance and a different *Mental Health Act 2007* was eventually passed for England and Wales (MHA 2007). This act substantially amends the MHA 1983 but is not based on incapacity principles. In addition, we have drawn on the report of the Bamford Review of Mental Health and Learning Disability for Northern Ireland[12], which recommended the adoption of a 'comprehensive legislative framework' for non-consensual treatment that is very similar to our fusion proposal.

8 *Bamford Review of Mental Health and Learning Disability (Northern Ireland) (2007). 'A comprehensive legislative framework'. www.rmhldni.gov.uk/legal-issue-comprehensive-framework.pdf.*

9 *Department of Health (1999). Report of the Expert Committee (Richardson Report): Review of the Mental Health Act. HMSO: London.*

10 *Daw R, Cobb A, Spencer-Lane T, (2005) 'Towards a Better Mental Health Act', Mental Health Alliance, http://www.mentalhealthalliance.org.uk/policy/policyagenda.html*

11 *Department of Health (2002). Draft Mental Health Bill. HMSO: London. Department of Health (2004). Draft Mental Health Bill. HMSO: London.*

12 *See n.8 above.*

Some outstanding issues

Many other contentious matters besides those relating to patients' capacity arise, of course, in the design of non-consensual treatment legislation. Many of these matters were extensively debated during the law reform processes that preceded the passage of the MCA 2005 and the MHA 2007. Should a 'treatability' or a 'best interests' test be included? Should compulsory treatment in the community be authorised? Should the 'responsible clinician' always be a medical practitioner (except where the expertise of a medical practitioner is clearly required, to comply for example with requirements of the European Convention on Human Rights). What is the right structure and frequency for the process of independent review? Should elected politicians continue to exercise statutory powers over the release of forensic patients?

Some position must be taken on such issues when a model statute is designed. In our model statute, we have included both a treatability and a best interests test as preconditions for intervention; our statute would authorise compulsory community treatment; and we have given tribunals the power to direct the release of some forensic patients. Some contentious positions have therefore been taken that go beyond the capacity issue and each would require extended justification. Regrettably, due to the constraints of space, we do not have the opportunity to present those justifications here.

This omission is not fatal to our current purposes, however. Our current aim is not to convince readers of the correctness of our model law on every point of detail. It is to demonstrate that our fusion proposal could be turned from concept to reality. The draft model law we present here is sufficient, we believe, to make this point: that our fusion proposal can proceed from drawing board to prototype. This prototype needs to be located in a particular jurisdiction, with whose wider laws it must be integrated. We have chosen for this purpose the jurisdiction of England and Wales.

We accept that some details of our model law will be contentious for some readers. If they would only want to change the details, however, we would have succeeded in our primary task: making a case that a comprehensive statute giving effect to our fusion proposal could be satisfactorily drafted, with only arguments of detail to remain. We hope we have convinced readers of this and have shown that a non-consensual treatment statute, applicable to both 'physical' and 'mental' disorders, could be constructed satisfactorily on the foundation of an incapacity test.

An outline of the Model Statute

We now discuss the general principles behind each major aspect of the model statute. It is in eight parts.

I THE PRINCIPLES

We have included an opening statement of principles because these are helpful to practitioners in exercising their powers and duties, to courts in interpreting the law and to individuals who may be affected by the provisions in giving them confidence in the purpose of the law.

The **'best interests'** principle applies to any act done, or decision made, under the Act for or on behalf of a person who lacks capacity, *unless* different principles are applied by specific provisions of the Act. The specific provisions cover exceptional instances where contrary actions may be justified by the competing ethical requirement for the **protection of others**. This occurs in the forensic section (Part VI; Clause 45) where a person found 'not guilty by reason of insanity' or 'unfit to plead', but who has capacity, may be detained in hospital if a number of further conditions are met.

The protection of others is also addressed in Clause 4 (10). When a patient's treatment is authorised in his or her best interests, but during the course of such treatment a serious threat of harm is posed to another person, the patient may be provided with such treatment as is immediately necessary to prevent such harm occurring and is proportionate to the likely seriousness of that harm.

In many cases where a person lacking capacity may present a danger to others, it will, of course, be in that person's best interests that this harm be prevented.

II GENERAL PROVISIONS

This part of the Act provides definitions for the terms and concepts that underpin the main provisions.

The definition of **capacity** generally follows that of the MCA, but is broader in referring to the ability of a person to 'appreciate' the necessary information. This will give clearer recognition of the fact that a person may be able to use information for some purposes but still not be able appreciate the manner in which the information pertains to their own situation.

Further elaboration of the concept of capacity could be provided in an accompanying Code of Practice which would make it clear that a person is to be regarded as able to understand the information relevant to a decision if he or she can understand an explanation provided in a way that is appropriate to the circumstances (for instance, by using simple language or visual aids or any other means). It should also make clear that relevant information includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision.

The concept of **best interests** is a central concept underpinning the Act and requires full elucidation. The formulation of best interests follows that in the MCA. It makes the person's wishes, feelings and values a primary consideration. Nevertheless, a decision may be in a person's best interests although it is not in accordance with the person's present wishes, and although the person objects to the treatment.

The general **requirement to consult** relevant people with respect to a person's best interests applies throughout the Act but this is supplemented in different clauses by additional consultation requirements.

The **'general authority'** permits people caring for a person who lacks capacity to do certain routine acts without requiring specific authority under other provisions. A proportionate degree of **restraint** of the person in their best interests is permitted under this section. The general authority covers such routine acts for all patients lacking capacity, including those receiving care or treatment under Part IV, V or VI of the Act. A similar form of authority was previously provided by the justification of 'necessity' under the common law.

Generally, where **medication** is to be administered over the person's objection, or to prevent harm to others, the compulsory treatment process under Part V should be initiated. Medication may only be administered using force under the 'general authority' if it is immediately necessary to prevent serious harm to the patient. In the case of persons treated under Parts IV, V, or VI it applies to medication that is not authorised under an approved care plan.

III SERIOUS MEDICAL TREATMENT

This Part is intended to ensure protections for the patient who lacks capacity who is to receive **treatment that is 'serious'** because it is particularly invasive, irreversible or likely to carry special risks. Some treatments of this kind are listed – ECT or medication under the Act lasting beyond three months; others may be specified in Regulations.

Before treatment is provided it is important to seek the agreement of the **substitute decision maker (SDM)** for the person. In the absence of such a person, or the ability to appoint such a person, an **advocate** must be appointed so that the person's interests are independently represented. The person's **primary carer** should also be consulted.

It is not considered appropriate that serious medical treatment should go ahead immediately if there is a disagreement between the clinician and the substitute decision maker or primary carer. Here the opinion of a **second opinion approved doctor** must be sought. The clause also gives a SDM, advocate or primary carer the right to seek a second opinion.

IV PROTECTIONS FOR INFORMAL PATIENTS LACKING CAPACITY AND NEEDING CARE AND TREATMENT[13]

This Part applies to people who **lack capacity** in relation to their care and treatment and who are **in hospital or a care home** (or are going to be admitted to residential care). In addition, they must be in residential care for a period of at least 28 days. They should not be people for whom the compulsory assessment and treatment process should be initiated under Part V.

If these conditions are satisfied following examination by an **approved clinician**, a **responsible clinician** must be appointed, a **care plan** provided and the person **registered** with an appropriate authority (for instance, the local authority). Before completing the care plan the responsible clinician must **consult** the persons's SDM or primary carer. The care plan must be regularly reviewed.

If the person needs to be **deprived of liberty** in his or her best interests, extra conditions apply. The person must be **examined** by a **medical practitioner and another health or social care practitioner** to decide if the conditions are met, including that the person has an impairment or disturbance in the functioning of mind and that deprivation of liberty is a proportionate response to the harm the person is likely to suffer if not so deprived. A right of **appeal** to the Mental Capacity Tribunal is included. These conditions should satisfy the ECHR's requirements resulting from the case of *HL* (2004).[14]

V COMPULSORY PROVISION OF CARE AND TREATMENT[15]

Before a person is placed under compulsory care and treatment a set of conditions must be met. These provide a proper legal basis for a person to be treated involuntarily and to be detained, if necessary, for treatment to occur.

Illustrating the value of the 'fusion' approach, impaired capacity is a necessary condition, but the processes of emergency assessment and treatment, detention, the use of force, and compulsory treatment are clearly regulated.

The **conditions** are: 1. the person has an impairment or dysfunction of the mind; 2. the person lacks capacity to make a decision about his or her care or treatment; 3. the person needs care or treatment in his or her best interests; 4. the person objects to the decision or act that is proposed in relation to his or her care or treatment and that decision or act is not authorised by the 'general authority'; 5. the proposed

13 *Following a consideration of the commentaries on the statute, we propose a number of amendments that simplify Part IV. These are presented in the Addendum at the end of the Model Law*

14 *HL v UK (2005) EHRR 32.*

15 *We also propose possible amendments to Part V that simplify the process of compulsory treatment, also presented in the Addendum at the end of the Model Law.*

objective cannot be achieved in a less restrictive fashion; 6. treatment is available that is likely to alleviate or prevent a deterioration in the person's condition; and, 7. the exercise of compulsory powers is a necessary and proportionate response to the risk of harm posed to the person or any other person, and to the seriousness of that harm, if the care or treatment is not provided.

Compulsory treatment follows a staggered set of phases, although not every patient will pass through all of them: 1. Preliminary Examination (up to 24 hours); 2. Initial Assessment (up to 7 days); 3. Assessment Order (up to 28 days); and, 4. Compulsory Treatment Order (up to 6 months). The assessments and compulsory treatment order can apply either in hospital or, if it is judged safe and effective, in the community.

1 Preliminary Examination

If there is a reasonable request for a person to be assessed and a medical practitioner, after examining the person, considers the necessary conditions appear to be met, the person may be detained in hospital for **up to 24 hours** and urgent treatment provided. Appointment of a **responsible clinician** and **consultation** with the primary carer or SDM are provided for, along with the need to advise of the availability of **advocates**.

There are also **powers for the Police to take a person to a place of safety**, if necessary, by **entering private premises**. The conditions for the latter are that the person appears to lack capacity; and is being, ill treated or neglected, or kept otherwise than under proper control, or, while living alone, is unable to care for himself or herself and is in need of care and attention. The phrase 'under proper control' could cover concern about the risk to another person in the household. A warrant must be issued by a justice for such entry. There is also a **power to convey** the person to hospital.

2 Initial Assessment

After 24 hours of Preliminary Examination, the person must be discharged unless a **second mental health professional** examines the person and determines that the conditions for Initial Assessment are met. The person can then be **assessed and given urgent treatment** for a further **7 days**. This can take place either in hospital or in the community to which the person can be returned.

During the Preliminary Assessment and Initial Assessment, **treatment** to which the patient objects may be given to save life or prevent serious and immediate deterioration in the person's health or to protect another person from harm. (Treatment under the General Authority may also be given, and if 'serious treatment' is to be given it is subject to the conditions noted above (Part III)).

3 Assessment Order

In order for a person to be assessed and treated for longer than a total of 8 days it will be necessary for a **Tribunal** to authorise a further period of detention. A **single person Tribunal** can authorise a period of detention for **up to 28 days**. Before applying for such an order the **responsible clinician** must prepare a **preliminary care plan** in **consultation** with the SDM or primary carer. The Assessment Order shall state the length of the assessment period and the treatment proposed. It also includes the **appointment of the SDM** if there is not one already.

If assessment is to take place in the **community** this shall include a limited set of **conditions** that will need to be placed on the person in order for treatment to take place or to protect the health and safety

of the patient or other persons. There is a requirement for consultation with the person (unless inappropriate or impractical), the SDM and any person who will have care of the patient in the community. The responsible clinician has a power of recall to hospital.

Treatment may be given without the consent of the patient if it is included in the approved care plan, is covered by the General Authority, or needs to be provided as a matter of urgency in order to save the patient's life or to prevent a serious and imminent deterioration in the patient's health.

In some circumstances such a period of further assessment under an Assessment Order will be unnecessary and it will be appropriate to **apply directly for a Compulsory Treatment Order** (see below). In that case the hearing must be before a full Tribunal. There are restrictions on the right to apply directly for a compulsory treatment order. It may only be made where the SDM agrees or the patient is an existing patient of the relevant health service.

4 Compulsory Treatment Order

A Compulsory Treatment Order is made by a **Full Tribunal**, consisting of a legal, medical and lay member, and may last for **up to 6 months**. The order will be based on the **recommendations of a medical practitioner and another health or social care professional** that the conditions are met. If the order is to take place in the **community** the order will include conditions, possibly including proportionate restrictions on the person's conduct and freedom of movement. Before deciding that a person shall be a compulsory patient in the community the responsible clinician must be satisfied that this would be compatible with safe and effective care, and that appropriate treatment is available. The patient's views must be considered, as well as that of the SDM and carer.

Before applying for the order a written **care plan** shall be drafted, in consultation with the SDM and the primary carer. The **Tribunal must authorise the care plan**, and may make amendments to it, but if these include changes to the treatment regime they should be approved by the Responsible Clinician and the medical member of the Tribunal. Copies of the care plan must be provided to the patient and the SDM.

Subsequent **changes** may be made to the care plan with the **agreement of the SDM**. Any changes to the compulsory treatment provisions or to the conditions attached to the patient's treatment in the community, or a change in the location of treatment, must have the agreement of the SDM. If the SDM does not agree it is necessary to obtain the approval of a doctor appointed to give a **second opinion**.

Treatment may be given without the consent of the patient if it is included in the approved care plan, or is covered by the General Authority, or needs to be provided as a matter of urgency in order to save the patient's life or to prevent a serious and imminent deterioration in the patient's health.

A Compulsory Treatment Order can be renewed or discharged by the Tribunal.

VI FORENSIC PROVISIONS

The Forensic provisions deal with a situation in which a person with an apparent impairment or dysfunction of mind comes before a criminal court charged with an offence and is then remanded for assessment or treatment, or convicted of the offence. These provisions also cover situations in which an accused person is found unfit to stand trial or 'not guilty by reason of insanity'.

1 Remand for report on mental condition or for treatment

A **person who is charged with an offence** may be sent to **hospital for a report** on his or her mental condition or be **remanded to hospital for treatment** at any time before the conclusion of their trial. Such assessment or treatment may also take place **on bail**. If the person has **capacity**, this must occur with their consent; if the person lacks capacity, it must be in the person's best interests.

The duration of an **order for treatment** in these circumstances is limited to 6 months. The person or their SDM may request a second medical opinion as to whether the conditions are met.

During a remand to hospital, **treatment** may be provided to a person with their consent; or, in urgent circumstances (where it is necessary to save life or prevent serious and immediate deterioration in the person's health, or to protect another person from harm) when there are reasonable grounds to believe the person lacks the capacity to consent. For the incapable patient the General Authority applies. The **Tribunal**, as the authority on capacity, best interests and definitions of impairment or dysfunction of mind, has the power to discharge a remand order and the person has the right to seek a **second medical opinion**.

2 Persons convicted of an offence

A **person convicted of an offence** may be put on a **hospital order with a concurrent criminal sentence**, with that sentence continuing to run while the person is treated in hospital. Where the person lacks capacity, he or she may be treated under this regime without consent. However, for the person who retains capacity, the regime is consensual; the person must agree to the treatment order being made and to any treatment provided. If that agreement is withdrawn, the person will be transferred to prison, or released into the community, to serve the remainder of their sentence. The **Tribunal** has the power to discharge from this treatment order but the person would then be required to serve the remainder of his or her criminal sentence.

The court may also decide to impose a **hospital order alone**, without a concurrent sentence, if that is considered a satisfactory disposition of the case. The effect of this order is to deem the person to be subject to a **Compulsory Treatment Order** under Part V. Treatment could then take place in hospital or the community. The person would have to be released from that order by the responsible clinician or Tribunal in the usual way, if the necessary conditions ceased to apply, and that possibility should be taken into account by the criminal court when deciding to impose an order under this clause.

3 Persons found not guilty by reason of insanity or unfit to plead

The court may order the person's detention in hospital if it considers it in the interests of the person or to protect the safety of other persons. Where the court orders detention in hospital, treatment can be given in the patient's best interests, if the patient lacks capacity. However, for this group of patients, an **exception** is made concerning involuntary treatment for a **person who has capacity**. Treatment may be given to such a person where the responsible clinician is satisfied that: the person needs treatment in his or her own interests or for the protection of others; and the person is suffering from an impairment or dysfunction of mind that contributed significantly to the offence; and, that treatment is available that is likely to reduce the risk of recurrence of such an offence.

Alternatively, for such persons, a **Compulsory Treatment Order** can be made deeming them to subject to compulsory treatment under Part V, as a civil patient, provided the conditions are met.

4 Transfer from prison to hospital

A person may be **transferred from prison to hospital** where he or she has an impairment or disturbance of mind and requires treatment and where, having capacity, the person consents to the treatment, or where, lacking capacity, the treatment is in the person's best interests.

A person who is accused or convicted of an offence and becomes subject to the provisions of this Part should have the same rights to a SDM, a care plan and an advocate as those who are subject to Parts III, IV and V. More detail on such matters would be included in a full statute.

VII MENTAL CAPACITY TRIBUNAL

The Act establishes a Mental Capacity Tribunal with both original and appellate jurisdiction. The Primary Division will hear most cases at first instance and will sit as a 3 person Tribunal except when otherwise provided. The Appeal Division will hear appeals from the Primary Division.

VIII PATIENT SAFEGUARDS

This Part of the Act deals with an essential patient safeguard, the **substitute decision maker (SDM)**. An adult with capacity may appoint an SDM to take decisions about his or her care or treatment in the event of loss of capacity. An SDM may also be appointed by the Tribunal.

Advocates play a key role under the Act and must be made available to people who are subject to its provisions. The Act specifies the functions of advocates and places responsibilities on authorities to ensure they are appointed.

Advance decisions to refuse treatment must be signed and witnessed by a person when the person has capacity. They apply when the person has lost capacity but have effect as if the person had capacity to make the decision over any health care issue to which the advance decision applies. So long it is clearly applicable to the circumstances the advance decision has effect as if the person had the capacity to make such a decision at the later time. Such decisions may still be overridden when treatment without the consent of the person is expressly authorised by the Act. A clause should be added concerning a process for replacing a SDM should that be required.

The full model statute we have drafted to illustrate the viability of the fusion proposal, is produced towards the end of this issue.

The Commentaries

Harnessing the power of fusion? A valiant but flawed effort to obviate the need for a distinct mental health law

Paul S. Appelbaum, MD[1]

When it comes to involuntary interventions, the notion that people with mental disorders should be treated identically to persons with general medical disorders has an undoubted appeal. As Dawson and Szmukler have argued previously, principles of fairness and non-discrimination would appear to be well served by basing involuntary hospitalization and treatment in both contexts on incapacity to provide consent.[2] In this commentary, I take note of some of the intellectual forebears of the Szmukler, Daw, and Dawson proposal,[3] and ask why – despite the formidable intellects that have lined up behind similar approaches in the past – they have not been adopted. I also consider some aspects of the current proposal itself, including the unresolved tensions between equal and differential treatment of persons with mental disorders, and the potential practical consequences, especially for persons with general medical disorders.[4] I conclude that the rationale for fusing two disparate bodies of law may itself be irremediably flawed, and the undesirable consequences significant.

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The author expresses his great appreciation to Dr. George Szmukler for taking the time to respond to his many questions about the proposal examined here, and for his careful reading of an earlier draft of this paper.

2 *John Dawson & George Szmukler, 'Fusion of Mental Health and Incapacity Legislation', 188 Brit. J. Psychiatry 504 (2006).*

3 *George Szmukler, Rowena Daw & John Dawson, 'A Model Law Fusing Incapacity and Mental Health Legislation', Journal of Mental Health Law (this issue).*

4 *I write, necessarily, from the perspective of a U.S. psychiatrist, and many of my comments will reflect the peculiar legal and clinical context of the United States. I regret my lack of an intimate acquaintance with the situation in the U.K. and New Zealand, whence this proposal derives.*

The History and Status of Incapacity-Based Approaches to Mental Health Law

It was not always the case that people being hospitalized for treatment of mental disorders were dealt with differently than people with general medical disorders, at least not in the United States. As I have written elsewhere:

> Prior to the 1830s, only a few hospitals of any sort existed in the United States, and these generally made no distinction between the admission of patients for treatment of physical disorders and the admission of patients for treatment of mental disorders. The same doctors cared for both. Private institutions established their own rules for admission, which often required only that a family member or friend guarantee payment of the patient's bill, and that one of the hospital's attending physicians certify the patient for admission. Family members usually requested admission for patients who were too confused or debilitated to speak for themselves, blurring the distinction between voluntary and involuntary hospitalization. The right of family members and friends to act in patients' interests was supported by a number of early court decisions.[5] [internal citations omitted]

In those early days, hospitals were reserved only for the most seriously ill, whether afflicted by mental or general medical disorders, and the assumption that neither group was in a condition to make decisions for themselves was probably reasonable.

This situation began to change as specialty psychiatric facilities, both public and private, proliferated in the middle of the 19th century, and as general hospitals became more common as well. With larger numbers of general medical beds available, medical and surgical admissions were more likely to involve patients at an earlier stage of illness who might be more capable of making their own treatment decisions, and hence who were given the opportunity to do so. The exception involved patients who lacked capacity, for whom family members continued to provide consent. In contrast, in the separate psychiatric system, even as the numbers grew of those hospitalized, the presumption remained that persons with serious mental disorders – especially those who were subject to involuntary admission – were incompetent, and hence could be treated without their agreement.[6] These two distinct systems, running in parallel, operated in these disparate ways for more than a century.

Among the earliest signs of an impetus for change was the Draft Act Governing the Hospitalization of the Mentally Ill, produced by the U.S. National Institute of Mental Health in 1952.[7] Suggesting a marked deviation from the historical criteria for involuntary commitment – need for care and treatment – the Draft Act proposed two alternative grounds for admission: a dangerousness-based criterion that looked to the likelihood of patients harming themselves or other people; and a capacity-based criterion for people who needed hospitalization, but could not make their own decisions.[8] Although much discussed, the

5 *Paul S. Appelbaum, 'Almost a Revolution: Mental Health Law and the Limits of Change', 18–19 (1994).*

6 *Indeed, in many U.S. jurisdictions, involuntary commitment to a state facility rendered the person incompetent as a matter of law for many purposes, including managing financial affairs, writing a will, voting, and marrying, or produced a presumption in that regard. See Frank T. Lindman & Donald M. McIntyre, Jr., 'The Mentally Disordered and the Law' 220-222 (1961). Not all authorities, however, agreed with this approach. See, e.g., the comment of Isaac Ray, the father of American forensic psychiatry, in his major work, A Treatise on the Medical Jurisprudence of Insanity (1838/1983) at 471: "Restraint [i.e., hospitalization] is a measure entirely distinct from that of interdiction [i.e., depriving a person of the power to conduct his or her affairs on grounds of incompetence], and neither should be considered, as they sometimes are, necessarily dependent on the other."*

7 *Reprinted in Lindman & McIntyre, supra note 6, at 397–424.*

8 *The specific wording of the capacity criterion was: "[the proposed patient] is in need of custody, care or treatment in a mental hospital and, because of his illness, lacks sufficient insight or capacity to make responsible decisions with respect to this hospitalization." Id. at 402.*

Draft Act had relatively little impact on commitment law in the (then) 48 states over the next decade.[9] In particular, its innovative capacity-based criterion, which would have made the process of psychiatric hospitalization for many patients (excluding commitments based on dangerousness) more similar to admission of incompetent patients to general medical hospitals, was not widely adopted.

The 1970s in the U.S. were a time of great ferment in mental health law, with widespread concern that need-for-care-and-treatment standards for commitment were unconstitutionally vague and overbroad.[10] This might have been a time when capacity-based standards, with their promise of treating all patients alike, could have made significant inroads, especially given the precedent of the Draft Act. Indeed, in 1975, Alan Stone, the Professor of Psychiatry and Law at Harvard University, published a proposal to accomplish exactly that. In his model, a necessary criterion for involuntary hospitalization was that "the diagnosable [mental] illness impaired the person's ability to accept treatment"; going a step beyond the Draft Act, Stone would not have permitted dangerousness-based commitments in the absence of incapacity.[11] But in this pure form – much like the approach to involuntary hospitalization and treatment proposed by Szmukler and colleagues – the Stone criteria received little support.

When another leading expert in psychiatry and law, Loren Roth, published his proposal a few years later, he included a capacity-based criterion to "ensure that mental patients would be treated similarly to other medical patients, namely, in the absence of their incompetency to consent or refuse, or absent an emergency, patients may not be treated against their will."[12] However, Roth limited capacity-based commitments to 12 weeks, and included alternative dangerousness-based criteria for which commitment could be indefinite; for danger to others, incapacity was not required, while for danger to self it was.[13] In 1982, the American Psychiatric Association (APA) issued its model law on civil commitment, the outcome of a process guided by Stone but subject to the full influence of the diverse views in the Association, that yielded yet another variant on a capacity-based approach. Under the APA's standard, emergency commitment was based on immediate dangerousness, while longer-term commitment was predicated on both dangerousness to self or others *and* the absence of "capacity to make an informed decision concerning treatment," arguably the strictest standard of all.[14] Today, a handful of U.S. jurisdictions have models that appear to require incapacity or at least diminished capacity prior to involuntary hospitalization for mental disorders (usually without using those terms).[15] Although the application of the capacity criterion in these jurisdictions to my knowledge has not been studied, my contacts with at least some of these states suggest that incapacity (or the equivalent term) is usually presumed from a refusal of hospitalization, and hence plays a minimal role in the decision to commit.

Experience in the U.K. appears to echo the American reluctance to require incapacity as the basis for hospitalization. Thus, in England and Wales, the recent reform of the *Mental Health Act 1983* did not include a capacity criterion, despite the urging of an expert panel – and even that panel provided an alternative route for commitment based on "a substantial risk of serious harm to the health or safety of

9 *Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Special Information Bulletin No. 1, Psychiatric Points of View Regarding Laws and Procedures Governing Medical Treatment of the Mentally Ill (September 1962).*

10 *See the discussion in Appelbaum, supra note 5 at 22–28.*

11 *Alan A. Stone, 'Mental Health and Law: A System in Transition' (1975) at 66–70.*

12 *Loren H. Roth, 'A Commitment Law for Patients, Doctors, and Lawyers', 136 Am. J. Psychiatry 1121 (1979) at 1122.*

13 *Id. at 1124–25.*

14 *American Psychiatric Association, Guidelines for Legislation on the Psychiatric Hospitalization of Adults (1982) at 10.*

15 *See Treatment Advocacy Center, State Standards for Assisted Treatment: State by State Chart at http://www.treatmentadvocacycenter.org/storage/tac/documents/new_the_updated_state_standards_chart.pdf.*

the patient or to the safety of other persons…"[16] Scotland's recent *Mental Health (Care and Treatment) (Scotland) Act 2003* pairs a dangerousness requirement with what appears to be a "soft" incapacity provision, requiring that "the patient's ability to make decisions about the provision of medical treatment is significantly impaired because of his or her mental disorder."[17] How determination of "significantly impaired" capacity compares in practice to a straightforward requirement that capacity be lacking is unclear, though the U.S. experience suggests ample room for leeway with such standards.[18]

What accounts for the reluctance of jurisdictions to embrace a capacity-based approach to commitment, and what implications does that have for the current proposal? The concerns seem to run in two directions. First, a shift to a capacity-based model, with simultaneous rejection of dangerousness criteria, may be seen as broadening the scope of commitment to include large numbers of non-dangerous persons with mental illness who are not currently committable. Put differently, the dangerousness criterion may be the limiting factor in the commitment process, the removal of which would open the floodgates.[19] In fact, in the only study to examine the question, Stone's suggested criteria taken as a whole were shown to be markedly more restrictive than the usual U.S. dangerousness-based standard.[20] The possibility of widening the net of commitability is not likely to be of great concern in England and Wales, where existing criteria are much broader than those in the U.S., and the capacity requirement is likely to have a restrictive effect.

Of greater concern to those making mental health policy is that a capacity-based standard will exclude persons who are dangerous to themselves or (especially) to others, but who may retain decisional capacity with regard to treatment decisions. The spectre of losing a means of detaining mentally ill persons who are thought likely to wreak harm clearly raises anxiety levels among the general public, especially given widespread beliefs that persons with serious mental illnesses are particularly dangerous.[21] Efforts to persuade the public that, as a group, people with mental disorders present only a small elevation in the risk of violence – and that often due to substance abuse – largely have been unsuccessful.[22] Nor have studies indicating that dangerous mentally ill people who otherwise qualify for commitment are unlikely

16 *Report of the Expert Committee, Review of the Mental Health Act 1983 (November 1999) at Sec.5.95(v).*

17 *Mental Health (Care and Treatment) (Scotland) Act 2003, Sec. 44(4).*

18 *An expert committee report on reform of the Mental Health Act in Northern Ireland proposed a capacity-based model that resembles in its general approach the proposal by Dawson and colleagues. See The Bamford Review of Mental Health and Learning Disability (Northern Ireland), A Comprehensive Legislative Framework (August 2007), accessed at http://www.rmhldni.gov.uk/index/published-reports/cl-framework.htm. Although the government initially indicated its intent to propose separate reform of mental health and capacity legislation, it later announced a plan to introduce a single bill that would adopt a capacity-based approach. At this writing, the proposal has not yet been filed and its final form remains to be seen. See McGimpsey announces single bill approach for mental health, Northern Ireland Executive, 10 September 2009, accessed at http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-10092009-mcgimpsey-announces-single.htm.*

19 *Mary L. Durham & John Q. LaFond, 'The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment'. 2 Yale L. & Pol'y Rev. 395 (1985).*

20 *Steven K. Hoge, Paul S. Appelbaum & Alexander Greer, 'An Empirical Comparison of the Stone and Dangerousness Criteria for Civil Commitment', 146 Am. J. Psychiatry 170 (1989).*

21 *See, e.g., Bernice A. Pescosolido, John Monahan, Bruce G. Link, Ann Stueve, & Saeko Kikuzawa, 'The Public's View of the Competence, Dangerousness, and Need for Legal Coercion of Persons With Mental Health Problems', 89 Am. J. Pub. Health 1339 (1999).*

22 *For a brief summary of the data on the relationship between mental disorder and violence, see Paul S. Appelbaum, 'Violence and Mental Disorders: Data and Public Policy', 163 Am. J. Psychiatry 1319 (2006). Although not all research findings support the attribution of the excess risk associated with mental disorders exclusively to substance use, for recent confirmatory evidence see Eric B. Elbogen & Sally C. Johnson, 'The Intricate Link Between Violence and Mental Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions', 66 Arch. Gen. Psychiatry 152 (2009).*

to be excluded by an incapacity criterion had much impact on the debate.[23] Thus, capacity-based proposals have been and are likely to continue to be opposed by policymakers who fear that public outrage over a single episode of violence after a dangerous mentally ill person is turned away from the hospital because he or she is deemed decisionally capable would have catastrophic political consequences.

It therefore appears that the core of the Szmukler and colleagues' proposal with regard to mental health law, i.e., altering involuntary hospitalization criteria to comport with the capacity-based approach used in general medical care, is one of those academically attractive notions that – at least until the world is a substantially different place – is unlikely to garner sufficient support from policymakers and the public to be widely adopted.[24] One might note that this is not an entirely irrational posture for public policy: society may simply need to have a mechanism for detaining persons thought to be imminently harmful to themselves or other people – even if the risk is exaggerated – and the price, namely inconsistency in legal approaches to mental and medical disorders, may be one that society is willing to pay. Moreover, insofar as people with mental disorders can be treated and effective treatment lowers their risk of subsequent violence, there may be good reason to single them out from the universe of dangerous persons for this kind of intervention.

Differential Treatment of People with Mental Illnesses in the Current Proposal

Given the dedication of Szmukler and colleagues to parity in dealing with mental and general medical disorders, it is of interest to note two ways in which this proposal fails to achieve that goal, and to speculate on why that may be. One example involves the provisions for authorizing "serious medical treatment" (Clause 9). Although primary caregivers, who are most likely to be family members, are given general authority to consent to treatment for persons who lack capacity (Clause 6), they do not have such straightforward authority for a subgroup of those medical treatments deemed "serious." In such cases, "the agreement of an approved doctor qualified to give a second opinion on the treatment shall be obtained before treatment proceeds." (Clause 12) One might pose many questions about this process, including who gets to pick the giver of the second opinion, and whether failure by a second physician to agree ends the matter or the opinion of a third physician might be sought.

For our purposes here, though, the interesting issue to note is which treatments are included within that subgroup of "serious medical treatments" that require this special review. One might imagine that they would include major surgical procedures or interventions such as bone marrow transplants with their bimodal outcomes of curing or killing patients. Indeed, perhaps such procedures would be included, as the proposal gives the drafters of the implementing regulations authority to create the list of covered treatments. However, there are two exceptions: electroconvulsive therapy and "medication for mental disorder beyond the period of 3 months" are the only two procedures that are specified in the statute itself as requiring this extra level of review.[25] The authors are silent on why they created these two exceptional

23 *Hoge, Appelbaum & Greer, supra note 20; John Monahan, Mary Ruggiero, & Herbert D. Friedlander, 'Stone-Roth Model of Civil Commitment and the California Dangerousness Standard', 39 Arch. Gen. Psychiatry 1267 (1982). Note that the Monahan, et al. study showed a much greater impact of a competence criterion in the emergency setting than when longer-term commitment was at issue.*

24 *Northern Ireland's recently announced intention to introduce a capacity-based approach, may change these attitudes, if it is implemented as intended and succeeds in avoiding the generally feared outcomes, but it is likely to be some years before we can judge the consequences of the Northern Ireland experiment.*

25 *Clause 12 requires another level of review, by a Tribunal, for a second group of procedures, including withdrawing nutrition or hydration, organ or bone marrow donation, and non-therapeutic sterilization. The latter two traditionally have been deemed beyond the power of substitute decision makers to authorize, requiring court review. I consider withdrawal of nutrition or hydration below.*

categories, and why both involve treatments for mental disorders, although it is clear that level of risk alone cannot be the reason.

A second example of continuing disparate treatment of those with mental and general medical disorders deals with the only class of capable persons who, under this proposal, would be treatable against their will. Under Clause 45(2), persons found not guilty by reason of insanity or unfit to plead can be treated involuntarily if such treatment is in their interests or for the protection of others, their disorders were related to their offences, and treatment is likely to reduce the risk of recurrence of their criminal behaviour.[26] This group of persons who have committed – but not been convicted of – crimes are thus deprived of the right of a competent person to decide about treatment that otherwise motivates this entire proposal. Ironically, had these people simply been convicted of their offences, regardless of their need for treatment or its likelihood of reducing their recidivism, they could not have been treated against their will (see Clauses 43, 44, and 46). The authors explain the deviation from their principles embodied in this provision as justified "in order to prevent harm to others." [27]

What might account for this continued differentiation between mentally ill and medically ill persons? At some level, the authors seem to be acknowledging that traditional public concerns about being protected from persons with mental disorders – no matter how irrational their concerns may be – and avoiding abuse of persons with mental disorders create a different set of issues where psychiatric treatment is concerned, requiring different statutory and regulatory oversight. Perhaps they are wrong in this belief, and the anomalies can be corrected merely by eliminating these two outlying provisions from the proposal. But if they are correct, the exceptions noted here call into question the desirability of merging general health law as it relates to incapacity and mental health law. Looking at the proposal from the perspective of its effect on people with general medical disorders reinforces the concern that perhaps the project overreaches in its goal.

Effects on People with General Medical Disorders Who Lack Decisional Capacity

To this point, I have examined the proposal from the perspective of the impact it would have on the treatment of people with mental disorders. However, there is another – probably even larger – group of people who would be affected by the incorporation of provisions such as these into law: people with general medical disorders who lack capacity to make treatment decisions. As general hospitals admit a patient group that is, on average, sicker than in the past, the proportion of persons lacking capacity in this population is likely to be substantial.[28] Hence, we should be sensitive to the possibility that merging the rules governing their treatment with mental health law would work to their disadvantage.

Decisions about hospital admission and general medical treatment for incapable persons (e.g., elderly persons with Alzheimer's or other dementias) traditionally were made by their loved ones, and that continues to be true in the U.S. today. Indeed, in the early 1980s, urging that this practice continue, the

26 *As best I can determine, neither judicial nor Tribunal review is required under this Clause.*

27 *Note that those defendants found unfit to plead cannot be treated to restore their capacity to proceed to adjudication, unless also incapable of deciding about treatment, raising an additional set of policy issues that I do not have the space to consider here. I note, however, that the group of people who are unfit to plead but still have capacity to make medical treatment decisions may not be small. See Norman G. Poythress, Richard J. Bonnie, John Monahan, Randy Otto & Steven K. Hoge, 'Adjudicative Competence: The MacArthur Studies' (2002) at 104–110.*

28 *One English study estimated that more than 40% of patient in a general medical hospital lacked decision making capacity. See Vanessa Raymont, William Bingley, Alec Buchanan, Anthony S. David, Peter Hayward, Simon Wessely, Matthew Hotopf, 'The Prevalence and Associations of Mental Incapacity in Medical Inpatients', 364 Lancet 1421 (2004).*

President's Commission for the Study of Ethical Problems in Medicine noted that family members are generally the most concerned about the good of the patient and most knowledgeable about the patient's preferences and values, and that families deserve recognition in this context as important social decision-making units.[29] Yet, Szmukler and colleagues' proposal would infringe on the traditional prerogatives of families in a variety of ways.

"Serious medical treatment," however that is ultimately defined, would require the agreement of a second physician before it could be implemented, regardless of the family's desires. Perhaps more significantly, decisions "to withhold or withdraw artificial nutrition or hydration from a person in a permanent vegetative state or a minimally conscious state" – among the most sensitive of decisions with which families have traditionally grappled – will require review by a Tribunal (Clause 12(5)), with all the time, costs to the system, and stress for the already anguished family that this process implies.[30] Another clause of the document goes further, specifying that even a substitute decision maker appointed by the patient would not have the power of "giving or refusing consent to life sustaining treatment unless the power expressly so provides" (Clause 49(5)).[31] That suggests recourse to a Tribunal in these cases as well. The words of the President's Commission almost 3 decades ago, addressed to the possibility of judicial review of families' decisions, are *apropos* here:

> Judges may not feel that they are able to add very much to the decisions already reached by those most intimately involved, particularly in cases that are brought simply to obtain judicial sanction for an agreed course of conduct…Since this judgment requires substantial understanding of the patient's medical condition and options, the court may simply defer to the recommendation of the treating physician. The courts' vaunted disinterest may be closer, in practical effect, to lack of interest.[32]

Thus, the proposal is likely to complicate and extend the decision-making process at the most difficult period for family members, to no apparent gain.

Other areas where similar effects can be seen are treatment over objection and physical restraint. Given

29 *President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship, Vol. 1: Report (1982) at 181–184.*

30 *I am grateful to Dr. Szmukler for pointing out to me that both this provision and the provision addressed in the following footnote reflect current law in England and Wales. Recourse to the courts in these cases apparently has been required since the 1993 decision of the House of Lords in Airedale NHS Trust v. Bland ([1992] UKHL 5 (04 February 1993)). Thus, those jurisdictions would experience no change in relevant practices under this proposal. However, given that this statute is aimed at eliminating anomalies and improving the current system, I would commend to the authors the virtues of keeping these cases out of the courts, and would hope that other jurisdictions that might be influenced by this model law would avoid creating these complications for themselves. Moreover, I note that the Law Lords in Bland themselves appeared reluctant to require indefinite application to the courts, with Lord Goff's opinion expressing "the hope that the President of the Family Division…will soon feel able to relax the present requirement so as to limit applications for declarations to those cases in which there is a special need for the procedure to be invoked"; and Lord Keith's opinion suggesting judicial review "at least for the time being and until a body of experience and practice has been built up which might obviate the need for application in every case." Has 17 years been sufficient for that body of experience to have been developed?*

31 *This limitation is embodied in the Mental Capacity Act, Sec. 11(8)(a). However, perhaps on grounds similar to those offered in the previous footnote, consideration might be given in the model law to removing this restriction on powers of appointed surrogates. Note two other apparent anomalies created by this clause: 1) the preclusion of substitute decision makers appointed by the patient from giving consent to life-sustaining treatment, for which it is difficult to discern a policy justification and which in any event usually occurs in an emergent context and would be covered by the blanket authority provided to treaters under Sec. 11; 2) the application of this limitation to a surrogate decision maker appointed by the patient, but not (as best I can tell) to the primary carer or other person designated to make decisions for the patient, who may be less likely to know or represent the patient's desires than someone selected by the patient.*

32 *Ibid. at 186–187.*

the prevalence of patients with dementia and delirium in general hospitals who often resist treatment – with reactions that range from pulling out intravenous lines or nasogastric tubes, to attempting to get out of bed and leave, to refusing to swallow oral medication – restraint and involuntary treatment are a common and unavoidable aspect of acute medical care.[33] However, under this proposal, a need for compulsory detention and treatment is governed by Part V, and invokes an elaborate set of procedural protections, including assessment and registration with the local health authority (Clause 22), and by the end of 24 hours (during which only emergency treatment can be provided (Clause 28(1)(a)), a "health or social care professional" must examine the patient, report to the appropriate authority, and agree to the continuation of compulsory detention for another 7 days (but again apparently only emergency treatment (Clause 28(1)(a)). Before the end of a week, application must be made for review by a Tribunal, and the procedures go on from there. Similar procedural requirements appear to apply to a demented or delirious patient who needs hospital admission, but is resisting that option.

What is going on here? Routine decisions, most often made by family members and invariably taken in patients' interests, have been entombed under a pyramid of complex procedures at substantial costs to families, hospitals, and the broader society. I suggest that this outcome may be the result of attempting to deal at the same time with the mental health and general medical systems, with their very different histories of oversight and regulation. Treatment in general medical hospitals is generally consensual, and when it is not, i.e., when patients are incapable of offering consent, family members ordinarily provide consent on behalf of loved ones. Society is generally of the opinion that the system has worked well – that is, to patients' benefit – and there has been little reason or impetus to suggest radical change.

Regulation of the mental health system, however, has a very different history. Admission and treatment have often been non-consensual, with decisions taken away from both patients and families. Abuse and neglect have been all too common in the past, and periodic exposes have led to repeated calls for tighter regulatory oversight. Hence, an elaborate structure has developed to regulate mental health treatment, with distinct mental health acts. Since neither patients (because of the presumption that their capacities are impaired), families (because of the belief that they often will place their own interests above those of patients), nor treaters (because of the legacy of abuse) are trusted to make admission and treatment decisions, frequent resort is had to judicial or quasi-judicial processes. Despite endless debate over the substantive and procedural detail of mental health law, there appears to be no sentiment in favour of simply removing this legal superstructure.

These may be essentially incompatible bodies of law and regulation. Attempting to fuse them, as in Szmukler and colleagues' proposal, may inevitably result in overregulation of the general medical care system or under-regulation of the mental health system. Here, applying a model drawn from the mental health law tradition of tight oversight and external review of end-of-life decisions and of treatment involving restraint or compulsory treatment (with elements borrowed directly from the Mental Capacity Act), they create a structure that materially disadvantages the general medical system, patients, and families. The seeming inevitability of this outcome or its converse, namely a mental health system without adequate oversight, leads to the question of whether attempting to fuse mental health law with the law governing general medical treatment of incapable patients is an inherently quixotic endeavor.

33 *Paul S. Appelbaum, Loren H. Roth, 'Patients Who Refuse Treatment in Medical Hospitals', 250 JAMA 1296 (1983).*

Conclusion

Szmukler, Daw and Dawson justify their proposal on the grounds of fairness, and argue that disparate treatment of persons with mental disorders and general medical disorders violates that rule. However, fairness does not require that we treat all people equally, only that those persons who are similarly situated be treated the same. As the discussion above suggests, a case can certainly be made that the two groups in question here are situated quite differently. People with mental disorders evoke (not entirely irrational) concerns about violence and other criminal behavior, as Szmukler and colleagues recognize in proposing an exception to the general rule that competent persons cannot be treated over their objections. In addition, treatment of mental disorders is embedded in a system in which the quality and even the beneficence of the care being provided has been called repeatedly into question, leading to the development of an extensive regulatory structure. This too appears to be acknowledged in the proposal in singling out treatment with psychotropic medication and electroconvulsive therapy for special regulation as "serious medical treatments."

Fusing legal regulation of such different systems of care, especially when the costs are likely to be substantial (here largely imposed on the general medical system), may simply not make a great deal of sense. The work that would be involved in that effort might better be put to use improving each distinct body of law.

Mental illness is different and ignoring its differences profits nobody

Tom Burns[1]

Szmukler, Daw and Dawson have produced a detailed and carefully worded proposal for a new approach fusing mental health and capacity legislation. In practice their proposal abolishes separate mental health legislation. It aims to ensure that compulsory care for the mentally ill is provided, when needed, according to the same principles as in severe disabling physical disorders (e.g. toxic confusion states, acute head injury, dementia). Their proposal derives from two strongly held and clearly presented principles – respect for the autonomy of the psychiatric patient and removal of what they consider the stigmatising discrimination between mental and physical illness. Capacity becomes the threshold for considering any compulsory detention or treatment.

Their paper is in two parts. It starts with an introduction outlining the principles behind the proposed 'fusion' legislation and an overview of its practice. This is then followed by an extensive preliminary draft of their model statute in eight parts. These eight parts contain a detailed presentation of the mechanics and definitions of the processes of the statute; they cover details such as the different proposed orders, safeguards, operation of tribunals and even details of the transfer of patients to hospital. Drafting legislation is a complex and tricky undertaking and they appear to have made an excellent start.

I will restrict my commentary to their introduction. This reflects my primary sphere of competence as a clinical academic psychiatrist, not a lawyer. It is also my experience that few, if any, clinicians ever read the details of legislation. Most familiarise themselves 'on the job' with the mechanics of those parts of the Act they regularly use. They learn what they have to sign and complete in order to achieve what they have already clinically decided on. Gaining any understanding of the principles of the Act is usually through exposure to where it restricts their clinical decisions. Such learning is via simple, practical requirements such as confirming 'treatability' or 'danger to others' in the detention of specific individuals.

Where I describe 'what psychiatrists do' it is based on my direct experience of practice in the UK and in a range of international jurisdictions where I have worked alongside colleagues. These include various European countries, the USA, New Zealand and Australia and also in India and Hong Kong – in no way a scientific sample. However, I have been impressed by the strikingly similar decision-making processes and declared professional values of psychiatrists; this despite widely differing social and healthcare contexts and a range of mental health legislations. It will be clear that I do not believe that mental illnesses are 'simply social constructs' but have a consistency and reality beyond our diagnostic manuals and legal definitions. It is the nature of mental illnesses and their treatments that shape mental health legislation: not mental health legislation that shapes mental health practice (other than at the edges).

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My critique of this proposal is contained in four questions.

Is the case advanced for the importance of treating mental illness and physical illness in exactly the same manner convincing?

Does the proposed law accurately reflect and address the ethical challenges faced daily in mental health practice – will it provide a useful and accessible guide to the practitioner?

Does the proposed law bring greater clarity to our understanding of the nature of mental illness and how society can best relate to it?

Does the proposed law reduce ethical confusion in mental health practice; in particular can it reduce the risk of moral jeopardy?

Despite important insights and obvious merit I believe that, on balance, it fails on three of these four tests.

1. Is the case advanced for treating mental illness and physical illness in exactly the same manner convincing?

Szmukler and colleagues consider that differences in how mental and physical health care are delivered constitute unacceptable discrimination ' ..that separate legislation authorising the civil commitment of 'mentally disordered' persons is unnecessary, and discriminatory…', '..this 'two-track' approach is inconsistent with general principles of heath care ethics….'. They advance no specific reason why treating mental illnesses and physical illnesses differently is unacceptable or damaging. They rely on the implication that to discriminate between them is inherently unjust. Why should this be so?

Psychiatry is not a subspecialty of medicine in the same way that dermatology or nephrology derived from internal medicine. It did not arise from a necessary division of labour, driven by a rapidly expanding body of knowledge and skills. Its history is one of *convergence* with general medicine rather than *emergence* from it. Indeed the terms 'mental illness' and 'mental patient' have been in use for less than half of psychiatry's existence.

Modern mental health care is a product of the Enlightenment, most commonly identified with the emergence of moral therapy. This is dated from Pinel's striking off the chains from the Paris lunatics in 1793 and the opening of the York Retreat in 1796 by the Tukes, an English Quaker family. Both emphasised the irrelevance of the then current medical nostrums; the Tukes strove actively to keep physicians out of asylums for the following 30 years. The term 'Psychiatry' was first coined by Johann Reil in 1808 (from *psyche*, mind and *iatros* doctor) to stress its empirical rather than theological provenance[2,3]; Reil was mainly concerned to codify psychotherapeutic approaches[4]. Only as late as 1930 in the UK were the terms 'lunatic' and 'asylum' officially replaced by 'mental patient' and 'mental hospital'.

These earlier terms (and practices) do not indicate any ignorance of the physical basis of many mental illnesses. Asylum doctors were in no doubt of the organic origins of disorders such as General Paralysis of the Insane, alcoholic dementia and Pellagra. These constituted a significant proportion of their patients. Recognising substantial overlap between physical and mental illnesses but also essential difference has never been impossible. Ignoring these differences, or using terminology that obscures them, does not

2 *Ellenberger HF. 'The discovery of the unconscious: the history and evolution of dynamic psychiatry'. New York: Basic Books; 1970.*

3 *Marneros A. 'Psychiatry's 200th birthday'. British Journal of Psychiatry 2008 Jul;193(1):1-3.*

4 *Reil J. 'Rhapsodies on the Application of the Psychic Cure Method to Mental Disorders'. Halle: Curtsche Buchhandlung; 1803.*

make them go away. Whether the similarities between mental and physical illnesses are greater or less than their differences is more a philosophical than empirical issue. However few would deny it *is* an issue. The degree to which mental illness and physical illness have to be treated exactly alike in legislation has to be argued, not simply assumed from the similarity of the terms.

2. Does the proposed law accurately reflect and address the ethical challenges faced daily in mental health practice – will it provide a useful and accessible guide to the practitioner?

The UK's tortuous ten year attempt to update the *Mental Health Act 1983*, resulting in the 2007 amendment,[5] can be interpreted in two ways. One is as a failure of resolve to properly grasp the principles of the primacy of autonomy, using capacity as the threshold for compulsion, as outlined here and originally proposed by Richardson's expert committee[6]. The other is that the proposals were rejected as judged not to adequately address common, and serious clinical challenges, and to run the risk of unacceptable and unforeseen consequences.

Szmukler and colleagues comment '…protecting the autonomy of patients with capacity is not the only important ethical principle…..another concerns the need to protect other people…'. They are certainly right that protecting autonomy is not the *only* important ethical principle. Indeed it is the failure to explore the full range of important, and well recognised, principles of medical ethics that is so strikingly absent from this analysis. All ethical decisions include the need to balance several, often equally important and frequently conflicting principles (e.g. Liberty, Equality, Fraternity). In medical ethics respect for autonomy, beneficence, non-malfeasance and justice are generally considered to be a minimal ethical framework for decision making and analysis[7]. These may often be in conflict. Amartya Sen argues for humility and an empirical approach to derive an area of 'circumscribed congruence'[8] for making moral judgements about competing claims for different individual freedoms[9].

For most clinicians beneficence is at least as important as respect for autonomy. After all getting people better is the main purpose of medical care. Virtually all difficult decisions about coercion in mental health involve balancing the potential for beneficence against the overriding of autonomy for an individual patient. It is the silence of Szmukler et als' (and Richardson's) proposals on this tension that renders the capacity argument inadequate to many clinical readers. For example only with the most tortuous logic can the compulsory detention of a distraught adolescent intent on suicide because of a broken love-affair be justified in terms of capacity. However few psychiatrists would hesitate to use it if they 'had to'; beneficence so clearly overwhelms autonomy in this situation. Most compulsion is used in individuals with established, fluctuating psychotic illnesses. Patients with schizophrenia are usually detained because the doctor thinks that treatment will significantly enhance their well-being, not because they are at immediate risk of dying or hurting others.

We may dress decision up as risk, and sometimes have to. In some jurisdictions the language of risk has replaced that of therapeutic benefit. However, only the most disingenuous observer will believe that risk

5 *Draft Mental Health Bill, Session 2004–05, Volume 1, HL Paper 79-1, HC 95-1, House of Lords House of Commons Joint Committee on the Draft Mental Health Bill, (2005).*

6 *Department of Health. Report of the Expert Committee: Review of the Mental Health Act 1983. London: Department of Health; 1999.*

7 *Beauchamp TL, Childress JF. 'Principles of Biomedical Ethics'. 5th ed. New York: Oxford University Press; 2001.*

8 *Sen A. 'What Theory of Justice'? 7 A.D. May 30; Sheldonian Theatre, Oxford:OPHI Conference http://ophi.org.uk/subindex.php?id=video0; 2007.*

9 *Sen A. 'What do we want from a theory of justice'? The Journal of Philosophy 2006;CIII(5):215-38.*

assessment has genuinely replaced therapeutic considerations in the doctor's decision making. Where the legislation requires 'risk of harm' for compulsory admission I have watched psychiatrists emphasise suicidality (particularly when access to beds is restricted) whilst making exactly the same clinical decision where I use benefit to health as the justification. Neither of us is in any doubt that we are both making our judgements in exactly the same way based primarily on beneficence.

This proposal fails to engage with the central role of beneficence (indeed paternalism) that has always lain at the heart of psychiatric practice. The distortions of judgement and lack of personal choice in some mental illnesses complicate the assessment of beneficence in a way that it unique. Isaiah Berlin, in his essay Two Concepts of Liberty[10], proposes that sometimes 'liberty from' (i.e. autonomy from intrusion) has to be compromised to ensure the 'liberty to' (i.e. capacity to do, as Sen would use it). Nowhere is this dilemma more sharply drawn than in the practice of mental health and is explored in the next section.

3. Does the proposed law bring greater clarity to our understanding of the nature of mental illness and how society can best relate to it?

One of the great advantages of this proposal is that emphasising the careful assessment of capacity puts something of a brake on psychiatry's seemingly inexorable expansion. As 'mental illness' has been replaced by 'mental disorder' the concept has been diluted to the point where psychiatry's conceptual coherence and social legitimacy are seriously challenged. This is even more so as mental disorders are currently defined almost exclusively in terms of international classifications such as DSM IV[11] and ICD 10[12] where reliability completely overshadows validity. Requiring capacity for the detention of patients could force a necessary debate, for example, on the vexed issue of 'personality disorders', and the increasing long-term detention of 'PD' patients for public safety. The definition of incapacity presented by Szmukler and colleagues (despite the proposal that it be '…sufficiently flexible … [for] … the complex and subtle forms of incapacity found in some mental disorders.') would clearly preclude the detention of personality disordered individuals even without a 'treatability' test.

However this does not address the fundamental nature of mental illness. It is the impaired appraisal of the self and world with their impact on the individuals' behaviour that are central. Mental illness implies a *changed* state, a distancing from the normal self. Mentally ill patients are 'alienated' not so much from society but alienated from their normal selves. Treatment has always been aimed at '*restoring* to reason'. Severe developmental impairments and personality disorders can lie at the absolute extreme of social deviance and disability but we do not consider them mental illnesses.

When we speak of mental illness we implicitly use the concepts of first and second order desires clarified by the American philosopher Harry Frankfurt[13]. Frankfurt considers the defining characteristic of a human being ('personhood') that they can have desires or wishes about their wishes. Unlike non-humans we 'can want to want'. The alcoholic wants to drink (a first order desire) but he also wants to not want to drink (a second order desire).

The legitimacy of psychiatry as a discipline (and mental illness as a concept) rests on believing this, and believing that we can make reasonably meaningful judgements about an individual's second order desires.

10 *Berlin I. 'Two Concepts of Liberty'. Oxford: Clarendon Press; 1958.*

11 *American Psychiatric Association. Diagnostic and statistical manual of mental disorders (Fourth Edition). Washington DC: American Psychiatric Association; 1994.*

12 *World Health Organisation. The ICD-10 Classification of Mental and Behavioural Disorders. Geneva: World Health Organisation; 1992.*

13 *Frankfurt HG. 'Freedom of the Will and Concept of a Person'. Journal of Philosophy 1971;68(1):5-20.*

In short we believe we can construct an understanding of a person's 'healthy' state of being and contrast it with their current 'ill' state. The justification for over-riding their current declared wishes is that we believe that it is likely that when not ill they would think and act differently. Often this judgement has to be made without prior acquaintance with the individual and may be based on a current diagnosis from which it is extrapolated. This judgement balances the two liberties that Berlin distinguished[14] as his 'liberty from' and 'liberty to'. Just and moral action often requires us to make a judgement about what people are capable of and would want to do as we weigh up their dilemma (' .. to offer political rights or safeguards….to men who are …underfed and diseased is to mock their condition..')[15]. Decisions are made on a judgement of how the individual is now, compared to how we hypothesise they are 'normally'; rounded judgements are not made ahistorically solely on the dimension of their current capacity.

Obviously such judgements are not perfect – a significant proportion of patients (though not all by any means) persist in disagreeing with their treatment when recovered[16]. Continued disagreement is more common when recovery is only partial[17]. Szmukler and colleagues are also right that risk and consequences should enter into the equation but surely wrong to give them such prominence. It is striking that the only reference to treatment benefit is in the paragraph outlining the use of compulsion for dangerous but capacitous individuals.

In a laudable drive to reduce stigma and discrimination against the mentally ill this proposal risks blunting and obscuring our already limited understanding of what mental illness is. While this may bring some short-term gains the poor fit of the legislation with the reality of mental illness can only, over time, begin to chafe and distort practice. Mental illness has never been an easy concept. However, retreating from its complexity and substituting simpler, more easily quantified proxies, carries real risks for the profession and society and thus risks for patients.

4. Does the proposed law reduce ethical confusion in mental health practice; in particular can it reduce the risk of moral jeopardy?

Emphasising capacity certainly may reduce some of the ethical risks in psychiatry. This is particularly pressing in its involvement in the long-term incarceration of individuals with unacceptable personality disorders or sexual, addictive and violent behaviours. This is much to be welcomed. On balance it remains unclear whether or not the current proposal is an advance. The test will be whether capacity (backed up by risk) will serve better over the long term than the concept of mental illness (with its implication of impaired judgement and a distinction between the ill and normal self) in the hard, ethically ambiguous cases that will inevitably confront any legislation.

The concept of mental illness has certainly been abused both by the profession and by external agents (governments, pharmaceutical companies etc). Would we be better served by a sharper distinction between mental illness and mental disorder or should we accept (as here) mental disorder but with a clearer threshold for coercion? The former approach offers no short-term solution (mental illnesses inevitably require constant negotiation about their boundaries). It is also out of favour with a hard-line evidence-based approach that emphasises reliability and science rather than validity and the 'craft' nature

14 *Berlin I. 'Two Concepts of Liberty'. Oxford: Clarendon Press; 1958.*

15 *Berlin I. 'Two Concepts of Liberty'. Oxford: Clarendon Press; 1958.*

16 *Priebe S, Katsakou C, Amos T, Leese M, Morriss R, Rose D, et al. 'Patients' views and readmissions 1 year after involuntary hospitalisation'. British J Psychiatry 2009;194(1):49-54.*

17 *Katsakou C, Priebe S. 'Outcomes of involuntary hospital admission – a review'. Acta Psychiatr Scand 2006 Oct;114(4):232-41.*

of professions. Capacity is a reasonably objectively defined threshold, likely to achieve high reliability and durability.

The down-side of this otherwise very attractive proposition is evident in the paper. Having started off with a clear definition of capacity, the authors then fall back on the need for a flexible definition to cover the 'complex and subtle' forms of incapacity in mental illness. They avoid potential practices that might equate treatment with punishment. However their implied ethical hierarchy in which beneficence, justice and non-malfeasance seem secondary to autonomy and risk remains of concern. It distracts attention from the moral jeopardy of indeterminate psychiatric incarceration of individuals who neither have a mental illness nor any reasonable prospect of effective treatment.

Conclusion

The desire to create coherent, intellectually satisfying legislation to cover compulsory treatment in mental health is not new. I would argue that the messiness of mental illnesses, in particular the need for a high order, and inevitably speculative, judgement about a patient's 'normal self' defeats this admirable intention. The diagnosis of mental illness demands both a careful narrative and a descriptive framework and defies a simple cross sectional 'check list' approach. Current diagnostic manuals give a misleadingly optimistic impression as clinicians still use narrative thinking acquired in their professional training but use the check-list approach to improve reliability. This improved reliability has, however, been at the cost of a staggering increase in the number of people diagnosed.

A more robust MHA based solidly round capacity would initially improve consistency of practice. However, a reliance on a simple threshold (and one that will undoubtedly be stretched as expedient) and the removal of a professional judgement about whether the patient has an identifiable illness (not a disorder) and is no longer their normal self will probably lead to an increase in compulsion, not a reduction. We should not forget that (at least in the UK) it was the profession's stubborn refusal to bend the act to detain non mentally-ill, dangerous individuals that stimulated the most sustained pressure to change it.

The treatment of mentally disordered offenders under capacity-based mental health legislation

Alec Buchanan[1]

I agree that someone's lack of mental capacity, or their inability to make proper choices, as I would prefer, has an intuitive moral force as a criterion for coercing them to accept care.[2] The authors of "A Model Law Fusing Incapacity and Mental Health Legislation" (henceforth AML) are right also, I think, when they suggest that this moral force is reflected in the law's widespread use of "choice based" criteria to determine when and to what degree a medical patient's stated wishes will be respected. I also agree that bad legislation can contribute to the stigmatization of the mentally ill.

As AML points out, mental health legislation has to incorporate many principles, some of which are in tension with each other. AML uses, as an example, the balance that has to be achieved between maximizing patient autonomy, on the one hand, and ensuring their safety and that of others, on the other. An essential principle in mental health legislation is that mentally disordered offenders need treatment and that the law should seek to ensure that they get it. As would be the case for any law, other principles will need to be respected too; but this one seems crucial. I am not convinced that the need to ensure treatment receives sufficient attention in AML. I also have some concerns over the details of what is proposed.

Definitions and details

Definitions of capacity

The Introduction to AML states that the proposals use the "usual" definition of incapacity, one that includes, "the inability to reach a decision that is sufficiently stable for it to be followed". This definition may be usual in other jurisdictions, but it is not the one employed in England and Wales. *The Mental Capacity Act 2005* provides a test with four elements: understanding information, retaining that information, using or weighing information, and communicating a decision. In this respect the Act is consistent with an earlier literature that includes the Law Commission's "Mental Incapacity"[3] and the

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2 *Buchanan A (2002) 'Psychiatric detention and treatment: a suggested criterion'. Journal of Mental Health Law 35-41.*

3 *Law Commission (1995) Mental Incapacity. Law Commission No. 231 HMSO: London.*

green and white papers, "Who Decides"[4] and "Making Decisions".[5]

The difference is important because capacity fluctuates. More specifically, the illnesses that interfere with the ability to make a proper choice do so by virtue of symptoms and signs and those symptoms and signs vary over time, both in nature and intensity. Other legislative approaches to the problems of mental ill health, as the authors point out, make coercion contingent on the presence of "mental disorder" and a "risk of harm". While these terms carry their own problems of definition, and while "mental disorder" and "risk" each have their quantitative aspects, as currently interpreted they do not seem to fluctuate to the same extent as any legally defined "capacity". One still has schizophrenia even after one's symptoms have resolved with treatment. As a result, patients and services can make their plans in the knowledge of what the patient's legal status is likely to be and some consistency in treatment becomes possible.

By contrast, intuitive moral forces notwithstanding and as one of the authors of AML has pointed out elsewhere,

> "Respecting immediately the right to refuse treatment of patients who regain their capacity to consent after initial medication may mean that patients whose capacity fluctuates never receive the sustained treatment that they need."[6]

The implications of this for capacity-based approaches to mental health law are substantial. The problem is not solved by simply including, "the inability to reach a decision that is sufficiently stable for it to be followed," in the definition of incapacity because the hard question then becomes what is "sufficiently stable". In any case, AML is arguing that it is not the stability of the decision that is morally important, but the quality of the process by which the decision is made.

Nor do usual definitions of capacity include the requirement that appears here under clause 3 (1) (c), that in order to have capacity a patient must, not just "understand", but "appreciate" the information relevant to a decision. The change in wording may have important consequences. The substitution of "appreciate" for "know" probably increased the availability of the insanity defense in the United States.[7] Here, as AML points out, it would restrict the number of people found to have capacity. The change seems also to be a potential source of argument. Those advocating detention will presumably suggest that a patient's willingness to ignore medical advice is, in and of itself, evidence that they are unable to appreciate fully the implications of their decisions.

Details of the proposed provision

Clause 45 (2) of AML makes provision for those found insane or unfit to plead to be treated compulsorily even when they have capacity. Surprisingly, given the importance that the proposals attach to patient choice, an order to permit this can be made even if the offence is not serious. Clause 45 requires the offence to be punishable by imprisonment, but this would cover a large number of crimes including "threatening behavior" and "failing to answer bail".

Clause 45 (4) requires that the same patients be released where the order is either a) no longer necessary for the protection of others or b) has become "disproportionate to the seriousness of the offence with

4 *Lord Chancellor's Department (1997) Who Decides. Cm 3803 HMSO: London.*

5 *Lord Chancellor's Department (1999) Making Decisions. Cm4465 HMSO: London.*

6 *Dawson J and Kämpf A (2006) 'Incapacity principles in mental health laws in Europe'. Psychology, Public Policy and Law 12, 310-331, at 312*

7 *American Bar Association (1989) Criminal Justice Mental Health Standards American Bar Association: Washington DC, U.S, pp. 321–347.*

which P was charged". It is not unusual for someone charged with a minor offence to be regarded, clinically and by courts, as presenting a substantial risk: half of Imprisonment for Public Protection (IPP) sentences have had a tariff of less than 20 months.[8] In such a case the Tribunal will be faced with what amounts to a sentencing decision, deciding what is "proportionate", without having available the information which a court has when it passes a sentence. Where the patient has regained capacity and a Compulsory Treatment Order under clause 34 is, therefore, not available, the Tribunal will have to make this decision in circumstances where only by declaring the order "proportionate" can it protect the public.

Numerically, the most important question is what would happen to the 750 – 800 cases who are admitted annually to hospital under s.37 of the *Mental Health Act 1983* (MHA 1983).[9] The answer seems to be that they would either a) receive a prison sentence and then go to hospital (clause 43 of AML) under arrangements similar to the present "hospital direction" under s.45 A of the MHA 1983 or b) receive a treatment order (under clause 44 of AML) which could be discharged either by the responsible clinician or by the Tribunal. Under an "alternative position", described in the Introduction but not in the draft statute, the convicted mentally disordered could, again, be made subject to a hospital order for a period, "proportionate to the seriousness of their offence" provided that their mental condition had "contributed significantly" to what they did.

Since the "alternative position" is not included in the draft statute I will not dwell on it here. I would note, however, that establishing when a mental disorder does or does not "contribute" to the commission of a criminal offence has occupied U.S. criminal jurisprudence for many years, with little sign of resolution.[10] I would note also that keeping people in hospital, irrespective of their clinical condition, for a period proportionate to the seriousness of an offence is bound to distort clinical care and that many clinicians will be concerned about the ethics of recommending an order that formalizes such an arrangement.

The option of a treatment order that can be discharged by the responsible clinician (clause 44) is unlikely to interest the criminal courts when the offence is a serious one. Simply put, they will worry that the defendant could shortly be back on the street, untreated and unsupervised. This means that for mentally disordered offenders convicted on serious charges the consequences of AML would be similar to the making of a "hospital direction" under current provision. I discuss the implications in the next section.

The model statute makes no provision for people with capacity to receive supervised treatment in the community, as is presently provided for in the Mental Health Act 1983 by community treatment orders (s. 17A) and orders for the conditional discharge of restricted patients (s. 42(2) & s. 73(2)) A patient who regained capacity would have to be discharged from compulsion. Nor is there provision for increasing the level of scrutiny in serious cases, as happens elsewhere in medicine.[11] At present, Mental Health Tribunals in restricted cases are chaired by Queen's Counsel or a circuit judge as a, "safeguard for the public interest".[12] Clause 48 of AML describes two-level tribunals but the upper level, like the Upper Tribunal created by the *Tribunal, Courts and Enforcement Act 2007*, seems to deal primarily with appeals.

8 *'In the Dark. The Mental Health Implications of Imprisonment for Public Protection', Sainsbury Centre for Mental Health, London (2008).*

9 *Health and Social Care Information Centre (2008) In-patients Formally Detained in Hospitals under the Mental Health Act 1983 and other Legislation, England: 1997–98 to 2007–08 NHS Information Centre: Leeds.*

10 *Buchanan A and Zonana H (2009) 'Mental disorder as the cause of a crime'. International Journal of Law and Psychiatry 32, 142–146*

11 *Buchanan A (2004) 'Mental capacity, legal competence and consent to treatment'. Journal of the Royal Society of Medicine 97, 415–20.*

12 *Fennell P (2007), 'Mental Health. The New Law', Jordans, p224*

General considerations

Imprisonment is not treatment

Any mental health law has to choose its "legislative posture" with respect to the criminal law. AML suggests that difficulties will be minimized if mental health legislation adopts some of the principles of criminal justice. The justification offered for allowing the seriousness of the offence to govern how long someone should spend in hospital, for example, is that this would represent, "a pragmatic response to society's demand that a person who has committed a serious offence – even with a mental disorder, and even one that might respond rapidly to treatment – should be detained for a proportionate time."

IPP sentences under the *Criminal Justice Act 2003* seem to move criminal justice away from this 'just desserts' approach to proportionality. But I am not sure that it is necessary to invoke criminal justice principles in any case. With respect to mentally ill people who have committed serious offences, the primary concern of politicians and of the public is the same as the primary concern of clinicians. Sick people should receive the treatment they need and not leave hospital without arrangements to ensure first, that they can continue to receive it and, second, that risk has been addressed. If this does not happen, and someone re-offends, I cannot see that society will be comforted to be told that, at some earlier point, that person had been detained for a proportionate period.

The Butler Committee described what it thought was the correct legislative posture. Where a hospital order is made, the Committee wrote, the patient,

> "is being removed from the penal process; it is being decided not to punish him. The possibility of his early discharge must be taken into account by the court. If necessary for the protection of the public a restriction order should also be imposed … or a prison sentence may be indicated,"[13]

The Committee emphasized also the need for the receiving hospital to agree to whatever order was being made. This is an important and complicated area that would ideally be addressed in any review of forensic provision. It may be that present provision has allowed clinicians inappropriately to "gate-keep",[14] thereby reducing the number of mentally disordered offenders being admitted.

Two aspects of the Butler Committee's analysis seem particularly relevant to the suggestions contained in AML. First, as the Mental Health Act Commission has since reiterated,[15] there is value in making a clear distinction between treatment and punishment. The Butler Committee considered whether, in making a hospital order, the sentencing court might, "simultaneously impose a prison sentence as an alternative, to be served if the offender proved unresponsive to treatment or not to need treatment" (at 188). The possibility they were considering was very similar to clause 43 of AML and its "hospital order with a concurrent sentence". The Committee concluded that: "It seems to us undesirable that the court should not clearly decide, in so important a matter as the loss of a man's liberty, between a punitive sentence and an order for medical treatment" (at 189). The Committee noted also that it seemed "illogical and inappropriate" to send a patient to prison if he improved with treatment and that the prospect was unlikely to encourage anyone to cooperate.

13 *Home Office and Department of Health and Social Security (1975) Report of the Committee on Mentally Abnormal Offenders. Cmnd. 6244 HMSO: London (at 189).*

14 *Grounds A (2008) 'The end of faith in forensic psychiatry'. Criminal Behaviour and Mental Health 18, 1–13.*

15 *Mental Health Act Commission (2006) In Place of Fear. Eleventh Biennial Report 2003 – 2005 The Stationery Office: London.*

Experience of the "hospital direction" under s.45 (A) of the MHA 1983 suggests that these concerns persist. Only 30 such orders were made in the six years to the end of 2008, as against 3,999 orders under s.37 over the same period.[16] Part of the reason for the discrepancy may be unfamiliarity on the part of courts, lawyers and psychiatrists with legislation that is relatively recent. It is also possible that use of s. 45 (A) will increase following its amendment in 2007; hospital directions can now be applied to anyone with a "disorder or disability of mind", and not just the "psychopathically disordered". But psychiatrists were concerned at the prospect of such an amendment when the order was introduced,[17] and the change may not affect the number of orders made.

Second, the criminal courts are more likely to allow mentally disordered offenders who have committed serious crimes to go to hospital where those courts are confident that the public is being protected. In over half of the cases where a hospital order was made in 2007–8 the courts chose to add a restriction order.[18] Hospital is not the only alternative open to the courts. Where they do not see any other means of ensuring public safety they can send mentally disordered offenders to prison.

In addition to adopting an appropriate posture towards the criminal law, mental health statutes should foster the ethical practice of medicine. At present, at the sentencing stage of a criminal proceeding a doctor can testify to the clinical needs of the patient, and whether treatment in a hospital is appropriate. The court can then impose a restriction order if it feels that this is necessary to ensure the protection of the public. Lawyers can still ask a psychiatrist whether this would be a good thing, but the distinction in roles, between doctor and court, means that the doctor can answer in clinical terms and the court can reach a legal conclusion.

The situation envisioned by AML is likely to be more difficult for the psychiatrist. If the offence is minor, he or she might reasonably offer treatment on a treatment order under clause 44. If the offence is serious, however, the only option under AML that the court would be likely to accept would be that of the "hospital order with concurrent sentence" under clause 43. The psychiatrist would, presumably, be asked about prognosis and risk. The answers would be used by the court to set the length of the sentence. The psychiatrist would then be in a predicament, the prospect of which may have contributed to the lack of enthusiasm for s.45 A. He or she will effectively be recommending not just a prison sentence, but its length.[19]

Risk is not exclusively forensic

The commentary to AML states that different principles need to be applied in the forensic field in order to protect the public. The model statute itself reflects this belief, drawing a clear line between forensic patients, in respect of whom "some modification of pure capacity principles may be required", and other clients of psychiatric services. The modification will apply to four groups: those on remand facing criminal charges, found unfit to plead, found legally "insane" or convicted of a criminal offence. All other patients will require to be released if they regain capacity, irrespective of whether they present a risk to themselves or others.

16 *Health and Social Care Information Centre (2008) Inpatients Formally Detained in Hospitals under the Mental Health Act 1983 and other Legislation, England: 1997–98 to 2007–08 NHS Information Centre: Leeds.*

17 *Eastman N (1996) 'Hybrid orders: an analysis of their likely effects on sentencing practice and on forensic psychiatric practice and services'. Journal of Forensic Psychiatry 7, 481–494.*

18 *Health and Social Care Information Centre (2008) Inpatients Formally Detained in Hospitals under the Mental Health Act 1983 and other Legislation, England: 1997–98 to 2007–08 NHS Information Centre: Leeds.*

19 *Walker N (1996) 'Hybrid orders'. Journal of Forensic Psychiatry 7, 469–472.*

Whether this will be acceptable to lawmakers must be open to doubt. From the perspective of a commentary on the forensic aspects of the proposals I would point out only that risk of harm to others is not restricted to forensic populations as defined by AML. Nine percent of the high secure hospital population in England and Wales are detained on non-forensic treatment orders under s.3 of the MHA 1983.[20] For the medium secure population, the figure rises to over 20%.[21] There will be many other "risky" non-forensic patients who will be excluded by these criteria. In London, 10% of detained psychiatric patients appear to have sufficient capacity to make other medical decisions[22] and would presumably require to be released.

Also importantly, a group of psychiatric patients will be made subject to different criteria for coercion for reasons that are unrelated to their clinical condition. This happens to some extent at present, of course: the criteria for a hospital order under s.37 are not identical to those for admission under s.3. But the differences are much more marked under AML. This aspect of the proposals seems to be at odds with the "non-discriminatory" thrust of the Introduction. I am not sure that the problems of stigma, as they apply to psychiatric patients as a whole, can be addressed by hiving off some of those who are seen as presenting a risk to others. And I would be concerned that attempting to do so in the way that is proposed by AML could create an even more stigmatized forensic population.

Alternatives

These difficulties in fitting forensic provision into an overarching theory need not prevent the application of capacity principles in particular contexts. The Richardson Committee, while advocating an incapacity criterion for compulsion under the MHA, included an exception for those presenting "substantial risk of serious harm".[23] Other European jurisdictions also apply capacity and other principles simultaneously.[24] In England and Wales, the making of a hospital order, with or without restrictions, on a defendant with capacity could be made to require the defendant's consent.[25]

The rights of a defendant with capacity would then be respected because he would be able to choose whether or not to accept treatment. Public safety concerns would be respected because the defendant would be making the choice at the sentencing stage of the proceedings when the court could make an alternative disposal, including imprisonment, if the defendant did not want to be admitted to hospital. The law would then need to permit re-sentencing if the convicted defendant subsequently changed his mind. The Butler Committee considered reference back to the sentencing court or to the Court of Appeal where a hospital order had been made but where it subsequently became apparent that the patient did not intend to cooperate. The Committee rejected this course because they thought that the interim hospital order would address the problem. It may not have.[26,27]

20 *Harty M, Shaw J, Thomas S, Dolan M, Davies L, Thornicroft G, Carlisle J, Moreno M, Leese M, Appleby L, Jones P (2004) 'The security, clinical and social needs of patients in high security psychiatric hospital in England'. Journal of Forensic Psychiatry and Psychology 15, 208–221.*

21 *Coid J, Kahtan N, Gault S, Cook A and Jarman B (2001) 'Medium secure forensic psychiatry services. Comparison of seven English health regions'. British Journal of Psychiatry 178, 55–61.*

22 *Cairns R, Maddock C, Buchanan A, David A, Hayward P, Richardson G. Szmukler G, Hotopf M. (2005) 'Prevalence and predictors of mental incapacity in psychiatric in-patients'. British Journal of Psychiatry 187, 379–385.*

23 *Department of Health (1999) Report of the Expert Committee: Review of the Mental Health Act HMSO: London.*

24 *Dawson J and Kämpf A (2006) 'Incapacity principles in mental health laws in Europe'. Psychology, Public Policy and Law 12, 310–331, at 312*

25 *Buchanan A (2007) 'Correspondence. Mental health and incapacity legislation'. British Journal of Psychiatry 190, 176–177.*

Catering for patients changing their minds is more laborious than failing to do so, but it is an inevitable consequence of respecting their choices. If capacity principles are to be introduced into forensic psychiatric practice the issue will have to be addressed more generally. Forensic care can be long-term and involve several changes of service. It is one thing to agree to treatment in one's local regional secure unit but quite another to agree to live in a high-secure hospital. Clinicians are not going to be able to guarantee what lies in store. Some provision for review and reconsideration will be required.

Because compliance is often partial, there would still be cases under such a "hospital order with consent" where the doctor's subsequent decision, that a failure to participate in treatment amounted to withdrawal of that consent, would be seen as declaring the patient "fit for punishment".[28] Such a scheme would also have to overcome objections that s.37 of the Act already provides an efficient way of getting treatment to people who need it, resources permitting. But by making the court-ordered treatment of a defendant who has capacity dependent on that defendant's willingness to accept treatment the scheme would bring care of the mentally disordered more into line with that of patients elsewhere in medicine while addressing some of the additional discrimination that forensic patients seem otherwise likley to suffer under AML's capacity umbrella.

Conclusion

Two aspects of current provision that are not contained in AML seem particularly important and should be preserved in any new legal framework. First, the MHA 1983 has a clinical emphasis. The Act contains no reference to detention proportionate to the seriousness of an offence, no reference to whether a mental condition contributed significantly to what happened and no requirement that a court pass a sentence that will determine what happens when the patient leaves hospital. Instead, it permits the passing of a hospital order where it is appropriate for the patient to be in a hospital, where treatment is available and where such an order is the most suitable way of dealing with the case. This embodies a level of judicial and medical discretion. Most importantly, it emphasises clinical need.

Second, the MHA 1983 offers an alternative to a court that is considering sending a mentally disordered offender to prison. It offers this alternative while allowing additional steps to be taken to protect the public if the court chooses to send the offender to hospital. These steps include a restriction order that allows judicial scrutiny (but not judicial criteria) at tribunal hearings and recall to hospital if community treatment proves unsafe. They also include an increased level of scrutiny in serious cases. Mental health legislation should encourage courts to permit mentally disordered offenders to receive treatment. By adopting the correct legislative posture, it can do this without compromising the medical principles essential to the proper provision of care.

26 *Mawson D (1983) 'Psychopaths in special hospitals'. Bulletin of the Royal College of Psychiatrists 7, 178–181.*

27 *Grounds A (1987) 'Detention of 'Psychopathic Disorder' patients in special hospitals. Critical issues'. British Journal of Psychiatry 151, 474–478.*

28 *Mullen P, Briggs S, Dalton T, Burt M (2000) 'Forensic mental health services in Australia'. International Journal of Law and Psychiatry 23, 433–452.*

The model law fusing incapacity and mental health legislation – a comment on the forensic aspects of the proposal

Kris Gledhill[1]

1. The Proposal Described

The proposal by Szmukler and others for a law that fuses mental health law and mental capacity law in England and Wales, both in the context of civil admissions to hospital based on the mental disorder of the patient and the making of orders by the criminal courts, can be summarised in the following quotes from their paper. They suggest

> "a legal regime that … relies squarely on the incapacity of the person to make necessary treatment decisions as the primary justification for intervention in their life."

By intervention is meant both detention and treatment under compulsion: so, rather than separate criteria for detention (based on the risk of harm) and treatment (based on capacity, at least in part), there would be a single incapacity test

> "that specifies the conditions for both treatment under compulsion and treatment under circumstances amounting to a 'deprivation of liberty'."

What is meant by 'incapacity'? It is an

> "inability to understand, recall, process, use or weigh relevant information; inability to communicate a decision; or inability to reach a decision that is sufficiently stable for it to be followed."

There would be a requirement that there be no less restrictive option available than intervention; for emergency situations, there would also be a safeguard for intervention based on a reasonable belief as to a lack of capacity.

This scheme would not preclude involuntary treatment aimed at protecting others, which may be a central concern in the forensic context. The proponents note that

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> "involuntary treatment for the protection of others … is permitted … first, where treatment for the protection of others is in the patient's best interests, and second, where in the course of providing treatment in the best interests of the patient, there arises a risk of harm to others."

The authors accept that the involvement in their proposed regime of those who are formally 'forensic' patients because they are in the criminal justice system has to take into account the fact that there are different categories of patient, namely those on remand awaiting trial, serving prisoners who have been convicted, and also some who have been found not guilty by reason of insanity or found unfit to stand trial but to have committed the actus reus of the offence and have been detained. A further complication identified is that some patients involved in the criminal justice system will be subject to an underlying prison sentence and so can be returned to prison if treatment is no longer possible because the individual regains capacity and declines to accept further treatment, whereas others might be detainable only in hospital for treatment. If lack of capacity were an essential pre-requisite to the lawfulness of detention, then those in this latter category would have to be released if they did not agree to remain in hospital. This, the authors note, "is an outcome that may not be politically or socially acceptable if the person concerned is deemed to still present a serious risk of harm". It also points, they say, to a further important principle, namely the need to protect other people from serious harm, which must be relevant in the forensic field.

However, the authors suggest that the pure incapacity principles should be compromised only in narrowly defined circumstances. Some groups could be treated without any modification of the basic principles: mentally-disordered offenders with capacity could be held in a suitable facility for treatment with their consent whilst their sentences continued to run; and offenders without capacity could be treated in the same way as non-offenders without capacity. So serving prisoners who needed treatment could be transferred to hospital if they lacked capacity or if they had capacity and consented. Although the authors propose that the courts could impose a compulsory treatment order without a concurrent prison sentence, which would have the same effect as a civil order, they also note that mentally disordered offenders convicted of a serious offence could be sentenced to imprisonment and then transferred to hospital if they were without capacity or if they consented.

They point to only one group in respect of whom a different approach would be necessary as they are not subject to a prison sentence, namely those found not guilty by reason of insanity or unfit to stand trial but to have committed the actus reus of the offence. Although people in this group without capacity could be treated on that basis, the authors would allow treatment even if there was capacity and no consent if a serious mental impairment or disturbance had contributed significantly to the conduct (the actus reus of a serious offence) and effective treatment could be offered that could be expected to reduce the risk of recurrence.

The proposals are accompanied by a draft bill: the parts relevant to the forensic setting are as follows. (i) Those charged with a criminal offence may be sent to hospital for a medical report or treatment (if the aim cannot be achieved by bail conditions): but this must be based on the person's consent if he or she has capacity or the best interests of the person if he or she does not have capacity (which would be subject to review by a Mental Capacity Tribunal). (ii) Those convicted of offences could be made subject to a hospital order alone or with a concurrent criminal sentence. The hospital order would have the same effect as a civil compulsory treatment order (which may be on a community or in-patient basis, and may include treatment if it is in the care plan on the basis of which the order is made), and so would cease to operate if the criteria no longer applied, including the recovery of capacity: if there was a concurrent

criminal sentence that had not expired at that stage, the patient could be placed in prison if they did not need further treatment or did not consent to it. The proposal does not contain any equivalent of the current regime allowing the imposition of a restriction order[2]. (iii) Prisoners needing treatment can be transferred to hospital if there is either consent or lack of capacity and transfer is in the best interests of the person. (iv) For those found not guilty by reason of insanity or unfit to stand trial, detention in hospital can be based on the best interests of the person if he or she lacks capacity or to protect other persons if the person has capacity, the impairment or dysfunction of mind contributed to the offending behaviour and treatment would be likely to reduce the risk of the behaviour recurring. An alternative would be possible, namely the making of compulsory treatment order, giving them the equivalent status to a civil patient.

2. Commentary

(i) The Legislative Context

New legislation has been adopted recently, or significant amendments have been made to existing legislation, in Ireland, Scotland and England and Wales; there is a process of reform ongoing in Northern Ireland. There are some significant differences in approach as to the role of capacity in determining whether a patient should be detained. In Scotland, civil detention requires a finding that the patient's mental disorder leads to a significant impairment in the making of decisions about treatment in addition to other criteria based on the risk posed[3]; it seems that the Northern Ireland Assembly will have proposals put to it that a similar test be adopted there[4]. In Ireland, the *Mental Health Act 2001* has impaired capacity as an alternative to a risk of serious harm test as a basis for civil detention[5]. However, there is no role for impaired capacity in the test for detention in England and Wales, attempts to adopt the Scottish approach having been rejected during the passage of what became the *Mental Health Act 2007*[6].

Even where capacity is part of the test for civil detention, it is not a feature for those who are placed in hospital via the criminal justice system. So impaired capacity is not a feature of criminal orders in the amended regime in Scotland, the main concern expressed being that a person in front of a criminal court who was willing to accept treatment would be deprived of it if a capacity test was in place[7]: a pragmatic need to ensure that treatment was available was felt more important. Equally, in Ireland, prisoners may

2 *and so the dual key of the consent of the Secretary of State for transfer and leave, and the different regime as to release (see ss41 and 73 Mental Health Act 1983) would cease to operate.*

3 *Section 64 of the Mental Health (Care and Treatment) (Scotland) Act 2003.*

4 *The Bamford Review – see http://www.rmhldni.gov.uk/index.htm (last accessed 29 August 2009) – suggested that mental health law and capacity law be fused; the Northern Ireland Executive has indicated that it plans to introduce two bills at the same time to update or replace the Mental Health (Northern Ireland) Order 1986 and also introduce capacity legislation – see "Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland", www.dhsspsni.gov.uk/legislative-framework-for-mental-capacity.pdf (last accessed 19 October 2009)*

5 *Section 3 of the Act, in the definition of what amounts to "mental disorder".*

6 *The process leading to the 2007 Act started with the Expert Committee appointed to advise the Secretary of State for Health on the Mental Health Act 1983 for England and Wales (also known as the Richardson Committee), which reported in November 1999. Its report – available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009576 (last accessed 29 August 2009) – included an indication that it supported the view of the majority of respondents to it that protection of the public was a valid reason for over-riding capacitated decisions to refuse treatment in the civil context (and so it would have supported an arrangement such as that in place in Ireland).*

7 *Paragraph 191 of the Scottish Executive's Policy Memorandum accompanying the Mental Health (Scotland) Bill (SP Bill 64), 16 September 2002, available at http://www.scottish.parliament.uk/business/bills/billsnotInProgress/index.htm#64 (last accessed 29 August 2009)*

be transferred to hospital against their consent if two doctors indicate that treatment is not available in the prison setting[8]: this no doubt reflects a similar pragmatic approach. In England and Wales, in relation to the forensic setting, the Richardson Committee – which provided the initial impetus for reform – had not reached final conclusions: although it was more cautious about allowing criminal justice patients to be in hospital without either agreement and cooperation or lack of capacity, this was premised on the basis that most of those who caused problems would be personality disordered and could be made subject to a prison sentence with the prospect of transfer to prison if they did not succeed in hospital. But given the legislators' concerns about capacity in the civil context, using public and patient safety as the key feature, the absence of any reference to capacity in the formal forensic setting is not surprising. As for Northern Ireland, the Bamford Committee indicated that its proposal for linking mental health law and capacity law would require further thought as to how that linked with the criminal justice setting[9]: it remains to be seen what will be the outcome of this process.

What is apparent from this brief review of the legislative context is that it will be difficult for the authors of the proposal to persuade legislators that the approach they suggest should be adopted in the forensic setting. This is, of course, a matter of pragmatic concern: there are also issues that are more matters of principle.

(ii) Discrimination and Public Safety

The underlying premise of the proposal to place impaired capacity at the centre of the criteria for detention, whether in a forensic or non-forensic setting, is that there should be an equivalence of treatment on account of mental disorder and physical disorder: just as doctors cannot treat without consent those who do not take sensible advice to deal with a physical ailment, so they should not be able to treat those with a psychiatric ailment who chose not to accept treatment if that choice is a true choice. Putting words into the mouths of Szmukler and others, the response to those who raise their eyebrows at this suggestion on the ground of risk to the public would be two-fold: there is, first, the point that mental disorder is not particularly associated with risks to others[10]; and, secondly, there is the ethical point of non-discrimination, namely that it is wrong to have a different regime in place on account of a mental disorder[11], given that the criminal law is there to deal with risks to others from those who cannot be helped by the hospital system because they have capacity but chose not to accept assistance.

But how far does this non-discrimination point go? In the first place, it may assume too much in relation to the absence of powers to treat physical disorders without consent when there is capacity. In fact, there are well-established bases for preventive detention based on the risk of harm to others arising from physical disorders. Article 5 of the European Convention, which authorises the lawful detention of "persons of unsound mind" in Art 5(1)(e), also allows detention to prevent the spread of infectious

8 *Section 15 of the Criminal Law (Insanity) Act 2006*

9 *"A Comprehensive Legislative Framework", paras 5.5. and 5.6*

10 *The Bamford Committee, for example, at paras 5.58–5.59 of its Comprehensive Legislative Framework report (cited above) noted that "The vast majority of people with mental illness are no more likely than anyone else to commit a violent crime. … The greatest risk of harm … is to themselves. Nevertheless, there is a modest link between mental illness and violence, particularly in some individuals who are currently experiencing symptoms of severe mental illness, not using effective medication and abusing alcohol and/or drugs. In such cases violence can be a reflection of insufficient treatment and support services." It also noted research as to the raised risk of violence from those with some forms of personality disorder.*

11 *A pejorative version of the same idea is that doctors have enough to cope with in dealing with patients who do take advice: the additional effort of dealing with patients who are not willing to cooperate is not something that should be forced upon them. This is not necessarily a viewpoint that is selfish: the therapeutic environment, and hence the assistance that can be provided to other patients, is compromised by having to deal with recalcitrant patients, and the proper place for them is another setting – which can be prison if detention is necessary.*

diseases. Consistently with this provision, the *Public Health (Control of Disease) Act 1984* creates a list of notifiable diseases (s10) and a justice of the peace may order the detention of a person with a notifiable disease to prevent the spreading of infection (s38)[12]. Since passing on such a disease with a criminal mens rea would be a criminal offence[13], the criminal law is also available in that situation, as is tort law: but prevention is permitted by the law in England and Wales, including the preventive detention of recalcitrant patients with capacity.

Whilst avoiding any crass comparison between mental disorder and a serious infectious disease, there can be little doubt that the 1984 statute reflects a principle that it is ethical to provide for compulsory steps against those who present a danger to others from a medical condition: whilst it is important to undermine any prejudiced view that mental disorder is to be equated with danger to the public, it must also be accepted that there are a number of instances where such a risk does arise. The key is to ensure that the proportionality of the intervention is maintained as between a physical illness that might pose a risk to others and mental disorder that might pose a similar problem.

Also worthy of mention in this context is another part of Art 5(1)(e), the detention of "alcoholics". In *Litwa v Poland*[14], the European Court of Human Rights concluded that the term covered not just those addicted to alcohol but also those who were intoxicated: the reason for this broad interpretation was that Art 5(1)(e) was a provision designed to allow detention of those whose condition might cause dangers to themselves or to others[15]. The Court then found a breach of Art 5 on the basis that there had been no consideration of the proportionality of detention on the facts, which was in a sobering-up centre, rather than an alternative course permitted by domestic law such as taking Mr Litwa home[16]. Again, the important question is the proportionality of taking preventive action.

Another area of public safety law is relevant. The European Court of Human Rights has made it clear that the criminal law and its deterrent effect might not always be sufficient to protect against assault by others. The right to life in Art 2 requires specific preventive action when the authorities know or ought to have known of an identifiable danger to life: see *Osman v UK*[17]. This clearly applies when the risk arises from the mental disorder of an individual, as a breach of Art 2 was found when a mentally-ill prisoner killed his cell-mate following an inadequate assessment of the risk he posed: see *Edwards v UK*[18].

12 *It is a criminal offence to breach an order; and the court may order return to hospital. There is no provision for compulsory treatment, so the common law principles allowing only treatment in the best interests of those with capacity apply.*

13 *See, eg, R v Dica [2004] 2 CrAppR 2, [2004] QB 1257 – infecting someone with HIV could amount to the offence of inflicting grievous bodily harm contrary to s20 Offences Against the Person Act 1861.*

14 *[2000] Mental Health Law Reports 226, (2001) 33 EHRR 53*

15 *See para 60: "The Court observes that the word "alcoholics", in its common usage, denotes persons who are addicted to alcohol. On the other hand, in Art 5§1 of the Convention this term is found in a context that includes a reference to several other categories of individuals, that is, persons spreading infectious diseases, persons of unsound mind, drug addicts and vagrants. There is a link between all those persons in that they may be deprived of their liberty either in order to be given medical treatment or because of considerations dictated by social policy, or on both medical and social grounds. It is therefore legitimate to conclude from this context that a predominant reason why the Convention allows the persons mentioned in para 1(e) of Art 5 to be deprived of their liberty is not only that they are dangerous for public safety but also that their own interests may necessitate their detention (see Guzzardi v Italy (1980) 3 EHRR 333, §98 in fine)."*

16 *Paras 65ff.*

17 *(2000) 29 EHRR 245, [2000] Inquest Law Reports 101: the Court did not find a breach on the facts. The same principle has been applied to dangerous municipal activities, namely the operation of a rubbish dump, where a breach was found: see Oneryildiz v Turkey (2005) 41 EHRR 20, [2004] Inquest Law Reports 108.*

18 *[2002] Mental Health Law Reports 220, (2002) 35 EHRR 19.*

It also extends to self-harming behaviour[19]. And Article 3, the duty to avoid inhuman or degrading treatment, might also be engaged by failing to prevent an assault or failing to prevent someone acting out self-harming behaviour: so in *Keenan v UK*[20], the European Court found that the suicide of a mentally-ill prisoner did not breach Art 2 because it has not been possible to identify the specific risk to life, but did breach Art 3 because it revealed a lack of effective monitoring.

Again it is necessary not to overplay the connection between mental disorder and harm: but the well-established point that protecting people from themselves may be necessary cannot be ignored, nor can the fact that protecting people from others is also a duty of the state in certain circumstances, the duty extending beyond merely having a criminal justice system in place. Once these points are recognised, there is nothing inherently discriminatory about making mental disorder the feature on the basis of which preventive action is taken: what is needed is the existence of an appropriate level of risk, whatever the basis for the intervention, so as to avoid any intervention being disproportionate; and an equivalence of risk in different settings so as to avoid discrimination. This approach does, it has to be said, favour the line taken by the government during the debates on the *Mental Health Act 2007* that intervention is a question of risk rather than capacity. It may be that those Parliamentarians who concentrated on an assertion that it was discriminatory not to include the question of capacity missed what was the real argument, namely ensuring that there was no discrimination by applying a lesser test for detention on the ground of mental disorder than in relation to other risk-based grounds for detention[21].

In summary, the proposal to make the absence of capacity a central feature to all detention based on mental disorder, which rests on the basis that the absence of cooperation from patients with capacity can be left to the criminal law and the prison system, goes too far. The police-power basis for detention on the ground of mental disorder, both as regards harm to others and self-harm, is well-established and necessary under human rights law. Szmukler and others do accept that capacity principles can be amended to permit detention for those who do not have the safety net (from the public safety perspective) of a prison sentence, namely the group found not guilty by reason of insanity or to be unfit to stand trial but to have committed the actus reus of an offence: but these two exceptions still require a criminal action to have occurred, whereas public safety/police-power considerations allow and in some circumstances mandate an earlier intervention, based on the degree of the risk presented. So the authors of the fusion proposal, it is suggested, need to supply further arguments as to how the proposal can withstand this legitimate demand of public safety. In short, why should it not be a test of proportionality of intervention – such as a requirement that detention be necessary to avoid a serious risk to others – irrespective of capacity and consent (or as a long-stop if there is capacity and consent)?

(iii) Other Human Rights Arguments

There is at least one further human rights-based argument to which Szmukler and others need to respond in the forensic context, where doctors may have to have recalcitrant patients in their hospitals.

19 *The common law had already accepted that there was a duty to prevent suicide: see Reeves v Commissioner of Police [2000] 1 AC 360; for a recent instance of this in a mental health context and making use of Art 2 because negligence was not available on the facts, see Savage v South Essex Partnership NHS Foundation Trust [2009] 2 WLR 115.*

20 *[2001] Prison Law Reports 180, (2001) 33 EHRR 38*

21 *Capacity does not feature as a part of the criteria for the lawfulness of detention on the basis of unsoundness of mind under Art 5(1)(e): see, as the classic example, Winterwerp v Netherlands (1979) 2 EHRR 387. See also Megyeri v Germany (1993) 15 EHRR 584: the failure to put in place special procedural protections may breach Art 5(4) if a mentally disordered person is incapable of representing himself: this again does not seem to require a lack of capacity to act but rather a reduced ability to look after ones interests.*

In addition to the fact that protective detention is possible, including detention based on social welfare grounds[22], it is well-established that detention based on mental disorder must be in a suitable clinical setting. The example of this is *Aerts v Belgium*[23]: he was detained in a prison psychiatric wing following a finding that he had committed an assault but was not responsible in light of his psychiatric condition. The detention was supposed to be merely short-term, whilst a place was found in a clinic, but it extended for several months: this was found to breach Art 5(1)(e) because detention on the ground of mental disorder has to be in an appropriate therapeutic setting. Although Mr Aerts might have been found to lack capacity had such a test been applied to him – and indeed the Court rejected an argument that his detention could be viewed as being under Art 5(1)(a) because the finding of the domestic court negated the possibility of arguing that he was criminally convicted – the principle set out in the case does not seem to be limited to those who are without capacity or who wish to seek treatment[24]. This case supports the viewpoint that considerations such as the better availability of treatment in a clinical setting, and hence the prospect of assistance, are of importance in assessing the arbitrariness or otherwise of detention. Of course, under the fusion proposal, treatment will be available: however, it will depend on consent or lack of capacity to consent. Accordingly, the authors will have to explain why it is less arbitrary to detain a mentally disordered person with capacity in a non-therapeutic environment rather than to abide by the person's decision not to accept treatment and so – certainly if release rests on any prospect of treatment being provided and being successful – warehousing them in this non-therapeutic setting.

(iv) Another Pragmatic Argument

Although it is no doubt true that the presence of mental disorder that does not deprive a person of capacity does not extinguish criminal responsibility in the context of our view of responsibility arising from a choice to breach the law (or at least to engage in conduct that is defined as criminal, even if this is not known by the criminal defendant), the criminal process involved in applying this substantive law allows more shades of grey to be taken into account: it does not insist that conduct be viewed in the black and white terms of asking whether there is or is not criminal responsibility. A key part of the nuance is the discretion of the prosecutor as to whether or not to proceed with a criminal prosecution. For England and Wales, this is codified in the Code for Crown Prosecutors[25], and basically provides that a prosecution conducted by the Crown Prosecution Service should not proceed unless there is both a realistic prospect of conviction (an evidential sufficiency test) and also that there is a public interest in prosecuting[26]. The availability of alternatives to prosecution, of which diversion into the mental health system may be one, is a feature of the public interest that might militate against taking a prosecution. So, if a person has capacity but is nevertheless affected by mental disorder, the availability of civil detention justified by the risk posed to others, as evidenced by the conduct leading to the police intervention[27], may be a way to secure what would be considered a just solution, given that the responsibility retained by the accused is nevertheless diminished by reason of mental disorder. Szmukler and others need to explain further why it

22 *See Litwa v Poland, above n14.*

23 *(2000) 29 EHRR 50*

24 *See n21 above: capacity is not part of the Convention test for the lawfulness of detention.*

25 *The 2004 Code is available at www.cps.gov.uk/Publications/docs/code2004english.pdf (last accessed 29 August 2009)*

26 *The availability of the public interest test is long-established: see para 5.6 of the Code, quoting the 1951 statement of the then Attorney-General, Lord Shawcross, that "It has never been the rule in this country – I hope it never will be – that suspected criminal offences must automatically be the subject of prosecution."*

27 *This may arise from a specific report of a crime, or the police coming across a situation that allows them to take action under s136 Mental Health Act 1983, which will often involve conduct that could lead to an arrest and the criminal process being instigated.*

would be to the benefit of both the individuals affected and society as a whole to reduce the circumstances in which a prosecutor can take a view that a prosecution is not necessary because the public interest is served by diversion from the criminal justice system.

3. Conclusion

The reduction of discrimination and prejudice faced by mentally-disordered persons is of great importance. Respect for autonomy and non-discrimination are key features of a civilised society. A principled approach to mental health law that puts autonomy in the sense of capacity at the centre is to be commended in this regard because it emphasises that mental disorder ought not to be treated differently to physical disorder. However, it cannot hide the fact that there is another important basis for society to take action, namely the need to reduce harm: the importance of autonomy limits the right to prevent freely-chosen self-harm, but the need to intervene clearly applies in the forensic setting, namely in relation to harm caused by one person to another. This need may mandate action of a preventive nature, not merely responding to a past misdeed. If this need arises from the mental disorder of the person against whom action is taken, the fact that the risk posed arises from mental disorder is not by itself discriminatory so long as the test for intervention involves a risk of a similar magnitude as would allow intervention when there was a cause for the risk other than mental disorder. In addition, a focus on capacity as the filter for all intervention when mental disorder is in issue would deprive the legal system of the flexibility of making use of a hospital disposal when that is the just response to the situation, and possibly force prosecuting authorities to make use of the formal criminal justice system and force courts to condemn people to detention in inappropriate and non-therapeutic settings. The authors of the fusion proposal may be able to bring arguments to bear to suggest that the balance is still in favour of a capacity-based system: this review is aimed to provide merely a reminder that there are some other factors that ought to be addressed before starting in earnest on the task of persuading policy makers and legislators, who have been less than receptive in recent times to making capacity central to the forensic aspects of mental health law.

The mental capacity tribunal under the model law: what are we arguing about?

Robert Robinson[1]

The nature of mental health law

It would be a mistake to think of mental health law as a generic form of law directed at a particular class of people, those described as suffering from mental disorders. If a person who has a mental disorder will accept treatment, whether or not they have the capacity to consent to it, there is in general no need to have recourse to mental health law. *The Mental Health Act 1983* ('MHA') exists for the specific purpose of regulating, and ultimately adjudicating upon, the conflict between a person who objects to receiving psychiatric treatment and the professionals on whom the law confers powers of compulsion. But, as advocates of a capacity-based legal framework would surely agree, it is not the existence of mental health law that gives rise to this conflict. That we have a Mental Health Act but not, say, a Dental Health Act is explained by features characteristic of serious mental illnesses which are not, by and large, found in other medical conditions. Psychiatrists are routinely faced with patients who not only deny they are mentally ill, but whose denial can best be understood as an aspect of the illness which, in the doctor's opinion, merits treatment. And as they do not believe they have an illness, or at least not the illness described by the doctor, such patients may well object, sometimes forcefully, to being admitted to hospital for treatment. An analysis of this situation in terms of the patient's lack of capacity to consent to treatment obscures what is emblematic: that the features which lead to a finding of incapacity are at the same time symptoms of the illness which demands treatment. There are, moreover, two matters of wider public concern pertaining to mental disorder which any developed legal system has to accommodate. First, among those with mental disorders there is a significantly increased risk of suicide and self-neglect which arises both from the individual's experience of mental distress, for example severe depression, and from pervasive features of some chronic mental illnesses. Second, for a small minority, there is an association between the presence of the symptoms of a mental illness, such as delusions or hallucinations, and a risk of violence towards others. While these characteristics may not of themselves preclude a capacity-based mental health law, they do at the very least indicate that in the psychiatric field, to a much greater extent than in other areas of medicine, the law has to concern itself with the possibility of a

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conflict between doctor and patient, and to provide for circumstances where the justification for clinical intervention is not limited to the alleviation of the patient's suffering.

If the primary purpose of mental health law is to regulate the conflict between an individual and those who would detain and treat him against his will, the judicial forum in which that conflict is fought out is the tribunal. The territory over which the parties clash is that in which the psychiatrist is a recognised expert, but the justification for compulsion does not lie solely within the domain of medicine.[2] The matters in dispute may include whether or not the person has a mental disorder, whether hospital admission is necessary, whether treatment is likely to be effective, and the nature of the risks arising from an individual's mental disorder. It may also be in issue whether, regardless of his capacity to consent to it, the person would accept some or all of the proposed treatment if not subject to compulsion, thus obviating the need for MHA powers. At the heart of the conflict is an individual's assertion of his right to make his own choices as an autonomous being, regardless of the views of professionals about his mental capacity or what they consider to be in his best interests, against those who would seek to justify taking away his liberty and subjecting him to unwanted medical treatment. A comparison of traditional mental health law and any proposed capacity-based model needs to consider which legal framework is best suited to regulating this conflict. In relation to the role of the mental health tribunal the questions to be considered are those affecting the adjudication of the claims of the disputing parties, specifically whether the tribunal is satisfied that the patient's condition is sufficiently serious to warrant loss of liberty and compulsory treatment.

The tribunal's role under the *Mental Health Act 1983*

Case law (both domestic and European) offers a multiplicity of judicial statements about what tribunals do under the current law. First, the tribunal carries out a substantive and independent review of the patient's condition at the time of the hearing:

"[The tribunal is] *a body charged with reviewing the operative decisions of the responsible authorities to detain the patient, and its functions are to reappraise the patient's condition at the time of the hearing and in the light of its findings to do one of three things – to direct discharge as of right, to direct discharge in the exercise of its discretion, or to do neither.*"[3]

Second, the review requires the tribunal to look into the future and to assess the risks should the patient cease to be detained:

"The question that then has to be asked is whether the nature of that illness is such as to make it appropriate for him to be liable to be detained in hospital for medical treatment. Whether it is appropriate or not will depend upon an assessment of the probability that he will relapse in the near future if he were free in the community."[4]

Third, if it is to uphold a patient's detention the tribunal must be satisfied that this is a proportionate response to the risks, bearing in mind also the impact on the patient of deprivation of liberty:

2 *"Why should a doctor decide on the level of risk that is acceptable to an individual, or to a group? Medical training does not enable one to answer a question of this type, and it could never do so, because it is not that sort of question." Anthony Maden Treating Violence (OUP 2007) page 70. See also, for example, the judgment in R (on the application of Warren) v Mental Health Review Tribunal (London and North East Region)[2002] EWHC 811 (Admin) where, at paragraph 16, Jack Beatson QC referred to "the diagnostic question of whether there is a mental disorder and the policy question of whether it is safe to discharge".*

3 *R v Canons Park Mental Health Review Tribunal ex. parte A [1994] 1 All ER 481, at 490, per. Sedley J.*

4 *R v London and South West Region Mental Health Review Tribunal Ex p. Moyle [1999] MHLR 195, at para 36, per Latham J.*

"The appropriate response should depend upon the result of weighing the interests of the patient against those of the public having regard to the particular facts. Continued detention can be justified if, but only if, it is a proportionate response having regard to the risks that would be involved in discharge."[5]

Proportionality also requires the tribunal to satisfy itself that the risks could not be managed in a less restrictive way:

> *"The detention of an individual is such a serious measure that it is only justified where other, less severe measures have been considered and found to be insufficient to safeguard the individual or public interest which might require the person concerned to be detained."*[6]

Fourth, in considering the impact on the patient of a deprivation of liberty, the tribunal must also take account of the treatment which it enables:

> *"Thus the MHA provides for an integral package of detention and treatment and imposes restrictions designed to ensure that individual treatment is justified. It is not logical to consider the latter question in isolation from the overall objective of the package. The most important question is whether the package is justified, and that is a question that falls within the remit of the Mental Health Review Tribunal under Part V of the MHA."*[7]

But medical treatment in this context is not always benign, or at least may not be regarded as such by its recipient. A relevant factor for the tribunal may be the impact on the patient's human rights of medical treatment given without consent. The most important consideration here is whether the patient objects to the treatment:

> *"when considering the severity of the treatment the fact that it is imposed by compulsion is more significant than the question whether the patient has or has not capacity."*[8]

A capacity-based legal framework

If judicial statements are an accurate guide to the role of the tribunal under the MHA, there is no comparable source for understanding how tribunals would function under the Model Law which is proposed. The criteria which the tribunal would have to apply in deciding whether to uphold the treatment of a person's mental disorder without his consent, which might also include detention in hospital for the purpose of treatment, are to be found in clause 21(a) of the Model Law. The tribunal would have to be satisfied of the following:

(1) P has an impairment or dysfunction of the mind.

(2) P lacks capacity to make a decision about his or her care or treatment.

(3) P needs care and treatment in his or her best interests.

(4) P objects to the decision or act that is proposed in relation to his or her care or treatment …

(5) The proposed objective cannot be achieved in an alternative less restrictive fashion.

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5 *R (on the application of H) v Mental Health Review Tribunal, North and North East London Region [2001] EWCA Civ 415, at para 33, per Lord Phillips MR.*

6 *Litwa v Poland (2001) 33 EHRR 53, at para 78.*

7 *R (on the application of B) v Dr SS (Responsible Medical Officer), Second Opinion Appointed Doctor and the Secretary of State for Health [2006] EWCA Civ 28, at para 47, per Lord Phillips CJ.*

8 *Ibid, at para 50.*

(6) Treatment is available that is likely to alleviate or prevent a deterioration in P's condition.

(7) The exercise of compulsory powers is a necessary and proportionate response to the risk of harm posed to P or any other person, and to the seriousness of that harm, if the care or treatment is not provided.

Clause 21 (b) says that: *"If any of these conditions are no longer met P shall be discharged from compulsory powers."*

Apart from the most obvious difference, that the patient's mental capacity forms part of the criteria for compulsion, two other points stand out. First, the Model Law, unlike the MHA, does not link compulsory treatment to the requirement that the patient be detained, or liable to be detained, in a hospital. This is not, however, of fundamental importance because compulsion in the community is neither a necessary feature of a capacity-based law nor is it incompatible with traditional mental health law. Second, clause 21 of the Model Law goes beyond a bare best interests test for authorising treatment given to a person who lacks capacity to consent. It requires the tribunal, when the patient objects to admission or treatment, to consider a wider range of matters such as risk to other people and proportionality.

On further inspection, clause 21 of the Model Law can be seen to bear some resemblance to section 6 of the *Mental Capacity Act 2005* ('MCA') which requires, in relation to a person who lacks capacity to consent, that where restraint is used it is not enough that it is in the person's best interests, it must also be a proportionate response to the likelihood and seriousness of that person suffering harm. However, it should be noted that clause 21 takes us still further beyond a best interests standard to something which reflects features of traditional mental health law, including the power to compel the patient to accept treatment (which could include detention in hospital) for the protection of others. This is quite different from section 6 of the MCA which authorises restraint only where it is necessary for the incapacitated person's own safety. It is also somewhat disconcerting, although consistent with a concern for the protection of other people, that in relation to medical treatment that satisfies the criteria in clause 21 the Model Law abrogates a fundamental feature of a capacity-based framework by allowing what would otherwise be a valid and applicable advance refusal of treatment to be overridden.[9] It seems that the proponents of reform do not envisage a radically different role for mental health law but they appear to believe that by changing the legal framework they will get rid of what they regard as a form of discrimination against people who suffer from mental disorders. The contrary view is that the inclusion of non-consensual psychiatric treatment would cause any capacity-based statute to burst at the seams.

How a capacity-based law would change what tribunals do

Returning to the role of the tribunal, its function under any system of law is to adjudicate between the person subject to compulsion and those who would use the law to compel treatment. Two aspects of the tribunal process under a reformed law would be critical to all parties. First, whether it will be more difficult (or easier) to compel treatment against a person's wishes; and second, whether the law provides a clear framework in which the matters that are important to the parties will be given due weight by the tribunal in balancing the competing claims on which it has to adjudicate. A third consideration is that

9 *This is stated in the authors' paper: "So long as it is clearly applicable to the circumstances the advance decision has effect as if the person had the capacity to make such a decision at the later time. Such decisions may still be overridden when treatment without the consent of the person is expressly authorised by the Act." It is not, however, incorporated into the Model Law, clauses 53 and 54 of which make no reference to advance decisions being overridden in these circumstances. Neither the paper nor the Model Law says whether the decision of a person's substitute decision maker (SDM) could be overridden where the clause 21 criteria are satisfied.*

where compulsory treatment involves deprivation of liberty there needs to be a speedy hearing to determine the lawfulness of the patient's detention.[10]

With regard to the first aspect, advocates of a capacity-based law do not argue that current mental health law, which they consider to be discriminatory, results in a greater use of powers of compulsion than is necessary or that the incidence of non-consensual treatment of those diagnosed as suffering from mental disorders could be expected to fall under their preferred legal framework. Their proposal does not proceed from a criticism of psychiatric power and certainly not from an anti-psychiatry stance. Their unstated assumption is that much the same people in much the same circumstances would be subject to compulsory psychiatric treatment. What would change are the formal legal grounds which tribunals and mental health professionals invoke when justifying their decisions.

As to the decision-making framework, tribunals under the MHA are required to consider the seriousness of the patient's mental disorder ("of a nature or degree which makes it appropriate for him to be liable to be detained") and the risks to which it gives rise ("necessary for the health or safety of the patient or for the protection of other persons").[11] Judicial decisions of tribunals about detention and compulsion are necessarily expressed in these terms, the so-called statutory criteria, but in any particular case the decision maker has a broad discretion which in reality is little constrained by the language of the statute. The decision whether to impose compulsion on a person because he has a mental disorder requires a consideration of a variety of factors. These may include: "his state of health, his need for continuing treatment, his ability to take care of himself in the community and the threat that he might pose to the public, the availability of facilities in the community to give him any necessary care, treatment or supervision, and the support he would receive from family and friends"[12] – all matters on which a person with a mental disorder is likely to have his own views, just like anyone else. The tribunal hearing is the occasion when, in theory at least, such views are to be taken seriously. One matter which may be of particular concern is whether the person who seeks to be discharged from MHA powers can be relied upon to do what he says. This is a distinct issue from the question whether he has capacity to consent to the proposed treatment and it requires the tribunal to consider different kinds of evidence, such as the individual's past history of psychiatric treatment. A decision to override the patient's autonomy is by its nature paternalistic but its foundation is that the tribunal concludes that the risks associated with the patient's mental disorder are sufficiently serious to justify compulsion. The experience of tribunals under the current law is that this exercise can be conducted without an assessment of the person's capacity to consent to any or all of the proposed treatment.

The breadth of the discretion and the wide range of potentially relevant factors make it especially important that the framework within which competing views are weighed and adjudicated upon encompasses how the various participants think about the issues in dispute. Traditional mental health law is clearly directed towards matters of substance which despite the opacity of the statutory language can be readily understood by the participants, including the person subject to compulsion. That the current law fits with psychiatric thinking and practice is hardly surprising, but it also reflects how people with no medical training intuitively think about these issues. This can be seen when friends and relatives of a detained patient give evidence at a tribunal hearing. The way in which they express their views generally

10 *This is required by Article 5(4) of the European Convention on Human Rights.*

11 *In describing the legal test under the MHA I have deliberately omitted the appropriate treatment criterion ("that appropriate medical treatment is available for him") which was introduced by the Mental Health Act 2007.*

12 *Taken from: 'Mental Health: Tribunal Procedure', Gostin and Fennell Longman, 2nd edition., 1992 page 4.*

accords with the current legal framework, though not necessarily with the findings of the tribunal in any given case. That the law is directed to what professionals and lay people regard as relevant and important is the best guarantee, together with an effective and fair procedure, that people will not be unnecessarily – and therefore unlawfully – detained.

In contrast to the current law, a capacity-based statute would have as its starting point the question of capacity. The mental capacity tribunal would of necessity have to decide in every case whether or not P, who objects to receiving treatment, has capacity to consent to it. Having disposed of the issue of capacity, and if the finding is that P lacks capacity, the tribunal would under clause 21 then determine whether P is entitled to refuse that to which he objects. It does this with reference to the following test: that it is in P's best interests and the objective cannot be achieved in a less restrictive fashion, and that the use of compulsion is both necessary and proportionate.[13] A question that should concern us is as to P's input into this process.

Deciding whether P has capacity

A fundamental criticism that can be made of a law which allows compulsory psychiatric treatment only where the patient lacks capacity to consent is that a tribunal hearing is not the best setting in which to assess an individual's mental capacity. It will no doubt be pointed out that courts, in a wide variety of situations, are used to deciding whether someone has, or had, mental capacity to make a particular decision. However, where the issue of capacity is linked to non-consensual psychiatric treatment, it is not difficult to envisage cases in which the person subject to compulsion, knowing the law, will answer questions about their understanding of their illness with the legal test for capacity in mind. In such a case the tribunal may see its inquisitorial function as requiring it, through questioning the patient, to demonstrate to its own satisfaction his lack of capacity. As one has sometimes seen at tribunal hearings under the present law, something similar can happen when questions are directed towards exposing the patient's lack of insight into his condition. But while mental capacity is a binary concept – a person either does, or does not, have the capacity to make this decision at this time – insight is a matter of degree. Moreover, a finding that the patient's insight is impaired does not form part of the foundational criteria for compulsory treatment, though it may be relevant to an assessment of the likelihood that the patient would accept treatment if he were free to decide for himself, a question that can be answered without reference to the concept of mental capacity. The MCA rightly demands that findings of incapacity are made only after every practicable step has been taken to enable the person concerned to make the decision for himself. It is difficult to see how this could readily be achieved in a tribunal hearing. If the hearing was not considered to be a suitable occasion for assessing the patient's capacity, tribunals would instead have to rely on expert evidence. In most cases this would come from the treating clinician who will have been in a position to carry out a capacity assessment in circumstances sanctioned by the MCA. Where, however, the patient disputed the treating clinician's account of the interview at which capacity was assessed, or claimed that the position has changed since that interview, the tribunal would, unavoidably, have to make its own assessment of capacity. That a task could prove difficult is not, of course, a reason for its not being attempted, but it is a ground for questioning its utility.

13 *I have omitted the treatment criterion, "that the treatment is likely to alleviate or prevent a deterioration in the patient's condition". Although this is different from the MHA appropriate treatment criterion (see footnote 11 above) either formulation is compatible with either traditional mental health law or a capacity-based law.*

Deciding what is in P's best interests

Having dealt with the issue of capacity, and assuming it finds that the patient lacks capacity to consent to the treatment, the tribunal would then have to decide whether the treatment, possibly involving deprivation of liberty, is in the patient's best interests. The answer will be found by applying the principles of section 4 of the MCA and going through the items that are listed there. These include P's "past and present wishes and feelings" and "the beliefs and values that would be likely to influence his decision if he had capacity". Put simply, P's own views are among the factors the decision maker weighs in coming to a conclusion on what is in his best interests. Given that clause 21 of the Model Law is concerned only with cases where P is objecting to treatment, one must allow that among P's views is likely to be a strong wish not to have things done to him against his will.[14] This takes us back, by a different route, to the essential point in mental health law which is the justification for imposing compulsion on a person who has a mental disorder. If this is indeed the fundamental issue, we might wish to ask which route we prefer and how P is most likely to be able effectively to participate in the process. Although the distinction is blurred by the breadth of a best interests inquiry under section 4 of the MCA, there is an essential difference between a rights-based approach (people have rights which in certain circumstances society is entitled to override) and a paternalistic approach (P lacks capacity to make this decision so we must make it in P's best interests, taking account of P's wishes and feelings).

A related concern is how the change to a mental capacity and 'best interests' jurisdiction would affect the work of tribunals. That tribunals under the present law are able to get through the current volume of cases without breaching the detained patient's right to a speedy hearing is due to the narrowness of the inquiry. A typical tribunal hearing, with oral evidence, lasts about two hours. Experience of the High Court's former inherent jurisdiction and of the Court of Protection's jurisdiction under the MCA is that cases take many weeks, if not months, and that the Court depends heavily on expert evidence in its determination of both capacity and best interests. While it is true that in every case involving compulsory psychiatric treatment there is, in the person of the responsible clinician, a suitably qualified expert readily to hand, the responsible clinician is not a court-appointed expert but comes to the tribunal on behalf of a party to the proceedings to put forward evidence which is intended to show that the criteria for compulsion are made out. Given the different nature of the tribunal's inquiry under a capacity-based law, where the patient's capacity and best interests are in issue, the question arises whether the tribunal would routinely need independent expert evidence on these matters. If independent expert evidence were not available, one wonders how the tribunal would satisfy itself of the matters comprehended by section 4 of the MCA.

The problem of paternalism

Seen from the point of view of a person who is diagnosed as suffering from mental disorder, there is one potential advantage of a capacity-based law which needs to be faced. A person who has capacity will be entitled to refuse psychiatric treatment, just as he can refuse all other types of medical treatment, regardless of the views of professionals or members of mental health tribunals about the likely consequences of a refusal. It could be argued by its proponents that if a change to a capacity-based mental health law were to bring this about for only a small number of people it would be a vindication of their

14 *This point was articulated by Judge Marshall QC, sitting as a nominated judge of the Court of Protection, in Re S and S (Protected Persons), cases 11475121 and 11475138, Judgment given on 25th November 2008. The judge said that "having his views and wishes taken into account and respected is a very significant aspect of P's best interests". The converse of this is "the sense of frustration, impotence, anger and lack of self-worth" that P might experience in having his expressed wishes overruled.*

position. The tribunal would perform the necessary and important role of making principled decisions about capacity, unsullied by pragmatic concerns about risk. To put the case for a capacity-based law in this way, with its appeal to principle over pragmatism, would be disingenuous because it avoids what is fundamentally at stake in any system of law for compelling people with mental disorders to accept treatment. The subject matter of mental health law necessarily gives rise to questions about whether, either generally or in particular cases, we are detaining people unnecessarily or for excessive periods of time, and whether clinical arguments in favour of treatment provide justification for denying personal autonomy to the individual concerned. The elevation of mental capacity would do nothing to enhance the judicial consideration of these and related issues which, as we have seen, are at the heart of decision-making under the existing law.

One matter that should concern us when considering any proposal for reform is the tendency in the field of mental health law towards benign paternalism: the wish to do what is best for a person who is disadvantaged. This is compounded by an understandable aversion to taking risks with other people's health and safety, including risks that we ourselves might be willing to bear where our own health is concerned. If, as seems likely, the vast majority of those who are detainable under the MHA could be expected at the point of detention to fail a capacity test in relation to treatment of their mental disorder, a best interests approach would inevitably tend towards increased paternalism which in this field means less, not more, liberty. While, as we have seen, mental health law must necessarily allow a broad discretion, the application of legal standards which direct the decision-maker to what is essential in balancing risks and rights is a necessary discipline for us all.

The model law of Szmukler, Dawson and Daw – the next stage of a long campaign?

Anthony Holland[1]

Abstract

Except for the criminal justice system, the *Mental Health Act 1983* (as amended by the MHA 2007) is the most significant Statute in England and Wales that can be used to challenge a central principle of democratic society, that of the right of an adult to self-determination. Such legislation is considered necessary as there are circumstances when it is right and appropriate to admit individuals to hospital and to treat them for their mental disorders in the absence of their consent. The need for an option of non-consensual treatment for a physical illness is also apparent, such as in the case of unconsciousness where, for example, treatments without consent for diabetic coma or cerebral haemorrhage are likely to be life-saving. Whether the treatment is for a mental or physical disorder, the question is the same – when is it appropriate for someone else to take a decision on behalf of another? The paper of Szmukler et al and their proposal for what they refer to as 'fusion' legislation goes to the heart of the issues. What are mental health and mental capacity legislation there to do? What are the principles that should underpin such legislation? What safeguards should there be? In this paper the Szmukler proposals as set out are considered from a clinical perspective in the light of studies that have examined model capacity-based mental health legislation, internationally-based principles that should guide mental health law, and other proposals such as those of the Bamford report in Northern Ireland. Whilst the approach that is proposed is non-discriminatory and ethically defensible and desirable, the difficult issue is the balancing of the need for such legislation to be both versatile and non-bureaucratic and the need for an appropriate hierarchy of safeguards that protect the vulnerable from unnecessary or inappropriate interventions. The proposed Bill put forward moves away from the thinking behind the *Mental Capacity Act 2005* and is closer in its thinking to an expanded and capacity-based Mental Health Act. This requires further consideration.

Introduction

Szmukler et al have in this issue proposed what they refer to as a 'fusion' law that brings 'non-consensual' treatment, whether for treatment of a mental or physical disorder, within the framework of one Statute. What they are proposing should, in my view, be a development based on the general framework of the *Mental Capacity Act 2005* (MCA). As is now generally acknowledged such capacity-based legislation respects and promotes autonomy where a person has the ability and provides the lawful means for action

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when such capacity is impaired. As such, it is clearly in keeping with Government policy on promoting choice and inclusion, for example, for people with learning disabilities (see Valuing People, 2001[2], and Valuing People Now, 2008)[3], and it would be respectful of the principle of non-discrimination – i.e. the same principles apply for treatment of a physical and/or mental disorder.

At present, very different principles underpin mental capacity legislation compared to mental health legislation. In the MCA, with respect to 'Acts in connection with care and treatment', accepted common law principles have been brought into Statute and the MCA has set the criteria and standards which apply when a decision has to be made on behalf of an adult who lacks the capacity to make that specific decision at that time. The MCA has also established that any substitute decision must be in that person's best interests. The MCA does not give the authority to act rather it gives the justification for acting and with it protection from liability in the event of a subsequent challenge. In contrast, the amended *Mental Health Act 1983* (MHA) (like the pre-amended Act) does not generally[4] consider that decision-making capacity is relevant nor expressly[5] requires the person making the decision in question to act on the basis of best interests. This MHA vests authority in particular person(s) to take action on behalf of another under specific conditions. The different principles underpinning the two Acts are illustrated by the well-known case of *Re: C*[6]. When decisions were made about his physical illness (gangrene of the leg), it was his capacity to make that decision that was pivotal as to whether his refusal to consent had to be accepted. The same would not have been true for the treatment of his mental disorder, schizophrenia, under the *Mental Health Act 1983*.

The question arises as to why the Government insisted, against advice[7], that such contrasting approaches to mental capacity and mental health legislation should remain? The central point of disagreement can be seen, in my opinion, in the answer to the fundamental question 'What are the MCA and the MHA there to do?' I suggest that both Acts are about substitute decision-making – when and under what conditions is it appropriate and lawful to make a decision on behalf of an adult when that decision would normally have been for him/her to take? Whilst the Government would accept that this was the fundamental role of the MCA 2005, the MHA 1983 was seen by them as focusing on public protection. Whilst this might rightfully be the priority if someone is suspected of or found guilty of an offence, the need for assessment and treatment in that person's best interest should be the guiding principle for the use of civil orders under the Act. People without a mental disorder are not detained in order to protect the public unless he/she has been suspected of, or convicted of, an offence, with all the accompanying safeguards that come with Court proceedings. Why then should it be different for a person with a mental disorder? What is proposed by Szmukler et al acknowledges that in fact both the *Mental Capacity Act 2005* and the *Mental Health Act 1983* (as amended by the MHA 2007) are in essence about substitute decision-making. Once that is accepted, then it is clear that the two should be combined into one Act. The question then arises whether essentially to modify the MCA 2005 by strengthening the protections and powers or, alternatively, widen the scope of the MHA 1983, or to start completely afresh.

2 *Department of Health (2001) Valuing People: a new strategy for learning disability for the 21st century. Department of Health, London.*

3 *Department of Health (2007) Valuing People Now: from progress to transformation. Department of Health, London.*

4 *One exception is the central role given to 'capacity' in the application of the treatment provisions of community patients not recalled to hospital, as set out in Part 4A MHA*

5 *Although it should be noted that the Court of Appeal have insisted on a best interests test being satisfied when compulsory treatment is certified under section 58 MHA 1983 (R (on the application of B) v Dr. SS(RMO), SOAD and the Secretary of State for Health [2006] EWCA Civ 28.)*

6 *Re C (Refusal of Medical Treatment [1994] 1 AII ER 819.*

7 *Department of Health (1999) Report of the Expert Committee: Review of the Mental Health Act 1983. London: Department of Health*

Context for the Proposal

Legislation similar to that put forward by Szmukler et al was suggested by Zigmond and Holland in 2000 in their paper entitled '*Unethical Mental Health Law: History Repeats Itself*'[8]. Prior to the implementation of the MCA 2005 in 2007, and prior to changes in mental health legislation, Zigmond in particular, had argued that two new Statutes were needed but not in the form of the two proposed Statutes. Rather, the first required was mental incapacity legislation (as was being considered at the time) that would go beyond the proposed legislation and would also encompass what was covered in the civil orders of the *Mental Health Act 1983*. The second Statute proposed was Home Office legislation that would focus on mentally disordered offenders. For this second piece of legislation, if a person has been charged and/or convicted of an offence, then an additional consideration should rightfully be that relating to public safety. Szmukler et al consider possible options including keeping the treatment of mentally disordered offenders within the proposed fusion legislation and the option proposed by the Bamford Review[9] in Northern Ireland (see below). As they argue, capacity-based interventions could still be the proposed ethical framework for treatment without consent.

Bellhouse et al (2003, 2004)[10] [11] developed their own capacity-based mental health legislation, using it to assess a consecutive series of patients admitted to psychiatric hospital to determine the extent to which those admitted informally or formally under the then MHA 1983 had capacity to consent to admission and/or treatment. One central aim of this study was to address Government fears that capacity-based mental health legislation would not have allowed for the detention of those they felt needed to be detained – i.e. in the Government's view, those that may be a danger to the public. In addition, there was also the opposite concern that there may be those admitted to hospital informally who lacked capacity and who therefore had not formally consented to admission. This had just been highlighted at that time in the case of *R v Bournewood Community and Mental Health NHS Trust*.[12] This case subsequently went to the European Court of Human Rights and the UK was found at fault[13], thereby leading to the development of the recent Deprivation of Liberty Safeguards. Using methodologies based on previous work and the then Law Commission definition of incapacity, Bellhouse was able to interview 49 out of 67 people approached, the majority with a psychotic illness. Thirty-one of the 39 informal patients and two of the ten detained patients were judged to have the capacity to consent or refuse consent to admission. With respect to the capacity to consent to treatment, it was found that the vast majority of those admitted under Section lacked capacity at the time the decision had to be made, and therefore any capacity-based mental health legislation would have enabled their compulsory admission and treatment in the same way as the existing 1983 MHA had done. Of particular interest was the fact that there were eight informal patients who were judged to lack capacity to consent to admission – i.e. similar to Mr HL in the Bournewood case. Some years later Owen et al (2008; 2009)[14] [15] undertook a much larger study,

8 *Zigmond and Holland 'Unethical Mental Health Law; History Repeats Itself'. (2000) Journal of Mental Health Law, February, 49–56.*

9 *Bamford Review of Mental Health and Learning Disability (Northern Ireland) A Comprehensive Legislative Framework August 2007.*

10 *Bellhouse J, Holland AJ, Clare ICH, Gunn M, Watson P. (2003) 'Capacity-based mental health legislation and its impact on clinical practice: 1) admission to hospital'. Journal of Mental Health Law (July):9–23*

11 *Bellhouse J, Holland A, Clare ICH, Gunn M, Watson P. (2004) 'Capacity-based mental health legislation and its impact on clinical practice: 2) treatment in hospital'. Journal of Mental Health Law, (July):24–37*

12 *R v Bournewood Community and Mental Health Trust ex p L, [1999] 1 A.C. 458*

13 *HL v United Kingdom (2005) 40 E.H.R.R. 32*

14 *Owen GS, Richardson G, David AS, Szmukler G, Hayward P and Hotopf M. (2008) 'Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study'. BMJ 337: 448*

investigating the extent to which people admitted to psychiatric hospital had capacity or not. As in the Bellhouse et al study, they found that the majority of those detained and a significant minority who were informal patients lacked capacity to make treatment decisions. The same group have also reported that a significant proportion of people admitted to general hospital wards lacked capacity to make the relevant decisions (Raymont et al 2004)[16]. In a different setting – that of Accident and Emergency – Jacobs et al (2005)[17] reported that nearly two-thirds of people seen due to self harm appeared to initially lack capacity to consent to what would be seen as treatment for a physical disorder. However, when information was presented to them in a different and more structured way, the proportion was reduced significantly. As in the study of Owen et al (2009) it was also found that those who lacked capacity were more likely to resist the intervention.

Prior to the MCA 2005 coming into force in 2007, when action was required to intervene on behalf of an adult who lacked capacity, that action was justified on the grounds of best interests under the common law grounds of necessity as articulated initially in the case of *Re: F*[18]. This was the case of a woman with learning disabilities who, it was suggested, should have a sterilisation operation. This is hardly a case that should be generalised and set standards for how people should be responded to in less problematic circumstances! It was perhaps the *Bournewood* case that challenged the system in a rather different way. This case demonstrated just how potentially vulnerable people lacking capacity are, and how, in the absence of statute such as the MCA, there had been no ready means of challenge available to HL or his carers. The MCA and the subsequent Deprivation of Liberty Amendments[19] now provide for such an eventuality.

The above studies and cases that have come before the High Court all indicate that in health settings, for many reasons and in different circumstances, people may lack the capacity to consent to interventions. Similarly, outside of health settings this concept of 'decision-making capacity' is pivotal and those who lack that ability for a given decision may be at risk of neglect or of exploitation (see Suto et al 2006[20], re: financial decision-making by people with learning disabilities). The arguments in support for 'fusion' legislation, as Szmukler et al have proposed, are strong on ethical and legal grounds and also on clinical and practical grounds as described above.

Within the UK it is in Northern Ireland that the idea of 'fusion legislation' has been accepted in principle by the politicians if the requisite powers are devolved. The recommendation put forward in the Bamford review is that there should be '*..a single, comprehensive legislative framework for the reform of Mental Health legislation and for the introduction of Capacity legislation in Northern Ireland. This should be through the introduction of provisions for all persons who require substitute decision-making. A framework is proposed for interventions in all aspects of the needs of persons who require substitute decision-making, including mental health, physical health, welfare or financial matters*'. The review goes on to set out the importance of the principles of respect for autonomy; the participation of people who may lack capacity; the principle of justice in that

15 *Owen GS, Szmukler G, Richardson G, David AS, Hayward P, Rucker J, Harding D and Hotopf M. (2009) 'Mental capacity and psychiatric in-patients: implications for the new mental health law in England and Wales'. British Journal of Psychiatry 195, 257–263*

16 *Raymont V, Bingley W, Buchanan A,. David AS, Hayward P, Wessely S, Hotopf M. 'The Prevalence and Associations of Mental Incapacity in Medical Inpatients', 364 Lancet 1421 (2004).*

17 *Jacobs R, Clare ICH, Holland AJ, Watson PC, Maimaris C and Gunn M (2005). 'Self-harm, capacity, and refusal of treatment: implications for emergency medical practice. A prospective observational study'. Emergency Medicine Journal. 22 (11), 799–802*

18 *F v West Berkshire Health Authority [1990] 2 AC 1.*

19 *See Schedules 1A and A1 Mental Capacity Act 2005*

20 *Suto WMI, Clare ICH, and Holland AJ (2006).'Understanding of basic financial concepts among adults with mild learning disabilities'. British Journal of Clinical Psychology. 45 (2), 261–266,*

the law is applied fairly regardless of whether it is for treatment of a physical or mental disorder; that any action should benefit the person concerned and is undertaken in a manner that minimises harm. Much of what is then proposed for Northern Ireland is taken from the MCA 2005. Interestingly, it may well be those countries/provinces who have experienced discrimination and civil strife (such as South Africa and Northern Ireland) who take most seriously the need for just and non-discriminatory mental health legislation (Fistein et al 2009)[21].

The main proposal

What would be required of genuinely comprehensive legislation that would be both practicable and ethically and legally defensible? First, it would have to provide the means for making decisions on behalf of people who at the time lack the capacity to make such decisions for themselves, such decisions going beyond simply those relating to health, needing to include areas such as welfare and financial matters. Secondly, whatever the principles guiding such legislation, they must be compatible with international standards and with national and European law – this includes respect for human rights and a robust and efficient means of challenge. Thirdly, the legislation should not discriminate on the basis of whether the decision in question is related to a physical or a psychiatric disorder. Fourthly, it must be flexible enough to enable substitute decision-making under very different circumstances – the person in A & E who is drunk and lacks capacity; the unconscious, anaesthetised, or sedated person; the person with advanced dementia or with an acute psychotic illness; or the person with profound intellectual disabilities in need of day-to-day support and lacking the capacity to consent to this. It must also enable action to be taken (such as restraint or the transportation of a person), with the necessary safeguards, when such action is necessary and in the individual's best interests. Finally, it must have robust safeguards and a ready means of challenge.

Fistein et al (2009)[22] compared the Mental Health Acts of 32 Commonwealth countries with a common legal heritage and compared these against the standards for such legislation set by the World Health Organisation and by the Council of Europe. They identified the following as central:

1. The presence of a mental disorder based on functional impairments and symptoms informed by ICD-10;
2. Exclusion criteria to prevent the misuse of psychiatry as a means of political or social control;
3. A treatability test requiring that treatment that is likely to alleviate the effects of the disorder or prevent it worsening is available;
4. A risk test based on welfare interests – a relatively low threshold is proposed, providing it is combined with a capacity criteria (i.e. those with capacity may not be liable to detention if not wishing for the treatment);
5. A capacity test based on decision-making ability assessed in terms of the person's ability to make the decision in question, such as is the case in the MCA 2005. Under such circumstances a capacitous person refusing treatment could not be forced to come into hospital or to have treatment (for possible exception see 6 below).

21 *Fistein EC, Holland AJ and Gunn MJ (2009) 'A comparison of mental health legislation from diverse Commonwealth jurisdictions'. International Journal of Law and Psychiatry 32, 147–155*

22 *Ibid.*

6. Special provisions for the treatment of people posing a serious risk to others – under specific circumstances and with special safeguards it is recognised that there may be occasions when the detention of a person with capacity refusing admission would be justified. Such an eventuality is likely to be best managed through the criminal justice system, but another example, one relating to physical illness, might include the detention of a person with a serious infectious disease.

Szmukler et al have proposed tiered legislation, but in its proposed form it is still written in a manner that mental health practitioners will be familiar with, but not other medical practitioners and others from disciplines outside of mental health. The balance to be achieved, particularly with respect to health decisions, is to ensure that action can be taken when needed and that it is in the individual's best interests, on the one hand, and on the other, that there are safeguards and the means of challenge that are practicable, affordable, and accessible. For legislation that addresses substitute decision-making in diverse settings and circumstances, there clearly needs to be a staged approach with safeguards becoming more prominent as the consequences of any decision become either more serious or more contentious. In the Szmukler et al proposal they refer to 'compulsory care and treatment and compulsory detention' and suggest 'a staggered set of phases'. What they do not examine is how this would work in very different settings, such as intensive care. The MCA 2005 now provides some protection to the unconscious or heavily sedated person in intensive care and relatives have a right to expect to be consulted and would have leave to apply to the Court of Protection if they disagreed with the action of the decision-maker. At what point should a Tribunal be required whether in the case of a person lacking capacity being admitted to psychiatric hospital or to general hospital? In my view this has to be more nuanced than is proposed.

The following framework, based fundamentally on the MCA with added safeguards taken from the MHA, is a start.

First, the process outlined in the present MCA, as it stands, provides the legal basis for intervention in matters relating to day-to-day 'Acts in connection with care and treatment' (Szmukler et al use the term first used in earlier drafts of the Mental Capacity Bill – 'General authority' – which was changed on the advice of the Parliamentary Scrutiny Ctte), provided to people who lack the capacity to consent to such intervention. Under such circumstances issues relating to capacity and best interests should be part of regular care planning discussions.

Secondly, the framework similar to that of the MCA continues to provide the basis for routine and uncontentious healthcare decisions or urgent and emergency healthcare decisions, such as might be required in primary care or in A & E Departments, or occasionally in Intensive Care.

Thirdly, under specific circumstances additional safeguards would become available, much in the way that certain decisions, when someone lacks family or friends, require the involvement of an Independent Mental Capacity Advocate (IMCA), or most MHA-detained patients are entitled (since 1/4/09) to the allocation of an Independent Mental Health Advocate (IMHA). This might include situations where someone is actively resisting intervention, where serious medical treatment is required (as defined in the MCA and Code of Practice); longer term changes in accommodation (e.g. moving residence or remaining in or potentially being admitted to hospital for longer than a defined period, whether for psychiatric or medical treatment); and finally, further additional safeguards (such as compulsory application to the Court of Protection) for specifically named treatments where the person lacks the capacity to make the decision for him/herself e.g. sterilization; termination of pregnancy; experimental treatments, such as those for new variant CJD; and for those in a persistent vegetative state requiring decisions about continuation of treatment.

The safeguards would progressively include the protections provided by the best interests procedures, such as consultation and arbitration; the requirement to have a second opinion; the statutory duty to provide an independent advocate; the availability of a tribunal system (under the Court of Protection); and the right of appeal to, and/or a requirement for, referral to the Court of Protection for a ruling on capacity and/or best interests. In addition, surgeons and intensive care clinicians, for example, would be encouraged to discuss with and document the wishes of people who, whilst having capacity, are likely to have a period of incapacity or have a significant risk of incapacity arising through complications of the procedure – e.g. those having major cardiac surgery and who would be sedated and semi-conscious in Intensive Care for some days. This would ensure that the wishes of the person were clearly document and could guide subsequent intervention when the person later lacked capacity. The same approach would be encouraged for those caring for people with cyclical illnesses that result in potential periodic incapacity including bipolar disorder, confusional states that might arise in people with chronic physical illnesses, or those with metabolic or endocrine disorders such as diabetes mellitus.

The MCA 2005, except in particular circumstances (e.g. a Court appointed Deputy or a donee of a Lasting Power of Attorney), does not vest all decision-making power in one person, rather it is the person requiring the decision to be made that has the duty to assess capacity and to determine best interests, when the person concerned lacks capacity. Szmukler et al are proposing the appointment of a 'Substitute Decision Maker' (SDM) which in essence is similar to the above. However, elsewhere in the draft Act there is an indication that SDMs may be more widely used under these proposals. Whilst the appointment of an LPA donee is to be encouraged and the use of Deputies to take single decisions can be important safeguards, to what extent SDMs are able to achieve outcomes that are better for the individual in other circumstances is a matter of debate. What the MCA 2005 does is ensure protection (under certain circumstances) through the use of statutory advocacy. The advocate is not there to be a SDM, rather he/she is there to ensure that the 'voice' of the person lacking capacity is heard. This approach has had some qualified acceptance in medical settings (Luke et al, 2008)[23].

Conclusions

The basic idea that any mental health legislation should be capacity-based and therefore respectful of the principle of autonomy has had very wide support.[24] Such an approach essentially recognises that the MHA is fundamentally about substitute decision-making under specific circumstances. Once this step has been taken it is then logical to consider 'fusion' legislation as is proposed by Szmukler et al bringing together mental capacity and mental health law. This has the advantage of being non-discriminatory and may help reduce stigma experienced by people with mental disorders. Whilst the style of the draft Bill is close to that of the MCA 2005, its thinking is closer to the MHA 1983 (as amended by the MHA 2007). It moves away from the idea that decision-makers have to be able to justify their actions to instead vesting responsibility in others, such as Tribunals or substitute decision-makers. The test is whether such an approach is appropriate in those situations that are now governed by the present MCA 2005 and would be governed in the future by 'fusion' legislation, the best example being that of intensive care. As argued in this paper there is compelling evidence that 'decision-making' capacity is a pivotal issue in determining how, what may be complex and difficult clinical and social situations involving vulnerable people, are best

23 *Luke, L. Redley, M. Holland, A.J. & Clare, I.C.H.(2008). 'Hospital clinicians' attitudes towards a statutory advocacy service for patients lacking mental capacity: implications for implementation'. Journal of Health Services Research and Policy. 13 (2), 73–78.*

24 *Evidence submitted by the Mental Health Alliance to the Scrutiny Ctte examining the Draft Mental Health Bill 2004*

resolved. The options available in these situations may be finely balanced. No Act of Parliament can provide answers to all possible scenarios; what it can do is set the framework within which it is lawful to act and there is a duty to act in the best interests of the person lacking the capacity to make the decision in question. The tension is one between empowerment and protection. This is very familiar to those of us working in services for people with learning disabilities but goes well beyond this group of people. Vulnerability and the need for protection is both about inherent and situational risks and requires a very nuanced approach (Dunn et al 2008)[25]. The proposal of Szmukler et al is the next stage in what is likely to be a long campaign.

25 *Dunn MC, Clare ICH, Holland AJ (2008) 'To empower or to protect? Constructing the 'vulnerable adult' in English law and public policy'. Legal Studies 28: 234–253*

Safeguards for informal patients

Aswini Weereratne[1]

Who is an informal patient?

In light of the plethora of new provisions safeguarding patients who might previously have been cared for and treated informally, it may be instructive to consider who may now be considered a truly informal patient, i.e. one for whom neither process nor formality is needed.[2] When applied to an incapacitated patient requiring treatment for mental disorder, the word "informal" may now seem oxymoronic and possibly redundant. Can such a patient ever be truly informal? Part IV of the model statute suggests that an informal patient is one who lacks capacity and does not object to proposed treatment which is in their best interests, or a patient who may be treated without the use of compulsory powers; but even such a patient must now be subject to some formality if their care or treatment is to be long term or they are to be deprived of their liberty in order to ensure proper safeguards are in place.

Currently the boundary between the *Mental Capacity Act 2005* ("MCA") and *Mental Health Act 1983* ("MHA")[3] is essentially one determined by whether the patient objects to treatment and is defined with formidable complexity in schedule 1A to the MCA. A patient eligible for MCA deprivation of liberty ("DOL") safeguards, who could be an elderly person in long term residential care, is now subject to formal processes. There is little true informality for a patient lacking treatment capacity. It is questionable whether even a capacitated patient with mental disorder, who is by definition vulnerable, may be treated informally under the MHA[4] if they feel suborned into consenting by the possibility of coercion. The terminology offers a slightly deceptive impression of a benign approach with concomitant levels of autonomy, but while it is appropriate to highlight a difference from compulsory process and keep formality to a minimum for the sake of informality, it is also important not to overplay formality in the name of safeguards. The latter appears to be the vice in which the MCA and MHA is now arguably gripped.

1 *Barrister, Doughty Street Chambers (London); Part-time Judge of the First-tier Tribunal (Mental Health).*

2 *Shorter Oxford English Dictionary definition is "not done or made according to a recognized form; irregular, unofficial, unconventional or without formality or ceremony..."*

3 *Both as amended by the Mental Health Act 2007*

4 *Section 131*

HL v UK (2004)[5]

The unpicking of informal status was achieved in *HL v UK* which set the benchmark for safeguards for informal patients and the trigger for legislative reform culminating in the introduction of the MCA DOL safeguards by the MHA 2007. It is worth recalling the facts of that case:

HL was diagnosed with learning disability and mood disorder. He was admitted for treatment under the provision of the *Mental Health Act 1983* for informal patients[6] having self harmed and was taken initially under sedation to A&E where he continued to be agitated and very anxious. However, he was compliant with medication and not attempting to leave and so was not detained under the MHA, nor placed on a locked ward, but he would have been detained had he tried to leave. This presumption in favour of informal admission and treatment was promoted by the Percy Commission whose recommendations founded the MHA 1959, although Percy did not envisage a deprivation of liberty in the case of informal patients.[7] HL was regularly sedated in hospital and healthcare professionals exercised effective power over him. The House of Lords[8] decided by a majority that HL was not in fact detained, but that in any event, and whether he was or not, he could be lawfully treated under the common law doctrine of necessity as an informal patient.

The violation of article 5(1) found in *HL v UK* was not so much about the lack of substantive criteria for informal patients in relation to the common law doctrine of necessity developed over the centuries (from as early as 1772)[9], than about an insufficiency of procedural rules which cast doubt as to whether the requirement of lawfulness aimed at avoiding arbitrariness was satisfied[10]. Particularly striking was the "lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted." A specific contrast with the MHA 1983 was made. In particular what is needed was identified as:

- A formalised admission procedure which identifies who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions
- The exact purpose of admission e.g. for assessment or treatment
- Limits in terms of time, treatment or care
- A continuing clinical assessment of the persistence of the disorder warranting detention
- The appointment of a representative of the patient who can make objections and application on the patient's behalf.[11]
- A regular review of the legality of any deprivation of liberty.[12]

Interestingly, the ECtHR also specifically acknowledged the government's concern to avoid the "full, formal and inflexible impact of the 1983 Act", and curiously it endorsed, in that spirit, the provisions contained in the MCA Bill as providing for "detailed procedural regulation of the detention of

5 *[2005]40 EHRR 32.*

6 *Section 131.*

7 *Royal Commission on the Law relating to Mental Illness and Mental Deficiency 1954–1957, Cmnd 169 discussed in R.Robinson, 'Amending the Mental Capacity Act 2005 to provide for deprivation of liberty', Journal of Mental Health Law May 2007 pp 25–40.*

8 *R v Bournewood Community and Mental Health NHS Trust, ex parte L [1999] AC 458.*

9 *Ibid at 118*

10 *Ibid at 119*

11 *Ibid at 120*

12 *Ibid at 123*

incapacitated individuals"[13]. Of course the Bill[14] as introduced in fact only permitted restrictions on liberty[15] and later expressly excluded restraint amounting to a deprivation of liberty under article 5(1) ECHR.[16] Nevertheless this is a clear indication that formality as in the MHA is not what is required. The government's response has been convoluted and the subject of much criticism for its intricacy and prolixity, particularly of the provisions of MCA schedules A1 and 1A.[17] The decision in *HL* suggests that this level of formality was most probably unnecessary. The model statute offers a more elegantly minimalistic set of provisions for incapacitated patients in long term care (over 28 days) and those deprived of their liberty in their best interests (see Part IV).

Model statute and liberty

Given the importance of personal liberty, article 5 requires that national law should be "sufficiently precise to allow the citizen – if need be with appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action might entail."[18] The model statute has a straightforward registration procedure which relies upon agreement between a doctor and approved practitioner that four conditions for the deprivation of liberty are met. This leads to the P being registered with an appropriate authority, triggering a care plan to be written by the responsible clinician. There is consultation with others, including a substitute decision maker, and access to a tribunal. There seems to be little to criticise in the simplicity this offers.

Registration: timing and responsibility

What is less clear from the model statute is when the registration procedure must commence and it is not clearly stated that it must be completed in advance of any deprivation of liberty actually occurring. It is a pre-requisite of the model that treatment is either already taking place in a hospital or care home, or that such treatment is necessary, and can be lawfully provided without compulsion and it is reasonably believed that P needs to be deprived of liberty in her best interests. The importance of prior authorisation was high-lighted by the Joint Committee on Human Rights[19] and by the court in *Sunderland City Council v PS and CA*[20] as a requirement under article 5(1).

Additionally, it is not clear by whom or how the registration procedure is to be triggered, or who carries the obligation to trigger it. Someone is required to have addressed their minds to three pre requisites before an approved clinician must examine P and be satisfied that the conditions for registration are met: a) a reasonable belief as to lack of capacity, b) a need for long term residence or deprivation of liberty and c) no need for any compulsion. Without more clarity in this procedure as to who bears this responsibility there must be room for 'professional lapses' of the kind from which *HL v UK* intended to offer protection.[21]

The reality may well be that the approved clinician or care home manager will be the person to keep this under review, but the obligation must surely be that of the managing authority who would otherwise be

13 *Ibid at 122*

14 *The MCA Bill was introduced into the House of Commons on 17 June 2004 and is discussed in HL at paras 77–78.*

15 *Clause 6(4)*

16 *Section 6(5) MCA which was repealed by the MHA 2007, ss 50(1), (4)(a) and 55, Sch 11 pt 10.*

17 *The Parliamentary Joint Committee on Human Rights report on the Mental Health Bill, fourth report of session 2006–7, February 2007 at para 90, and fifteenth report of session 2006–7, May 2007 at para 1.26; see also the preface to R.Jones 'Mental Health Act Manual' 2008 11th ed.*

18 *HL at 114.*

19 *Fifteenth report of session 2006–7 para 1.28 and fourth report para 83.*

20 *[2007] EWHC 623 at 23.*

21 *HL at 121, citing Lord Steyn from Bournewood above.*

responsible for an unlawful detention. It is possible to envisage a situation where a patient could fall through the procedural net because there is no consensus between members of a care or clinical team as to these pre conditions, or where a P who has been in long term care which commenced at a point in time when she was not incapacitated and had some restrictions voluntarily impose upon her because she was confined to her bed for a period of treatment, but which crossed the boundary into a deprivation of liberty with the worsening of a dementia or other similar illness. In such situations it would be left to a concerned family member or friend to intervene.

At this early stage the threshold for examination by an approved clinician must presumably be low. Even so the concepts under consideration are complex, inevitably raising the spectre of error with the consequence of patients remaining unlawfully detained for a period of time.

P objects

Assessing whether or not an incapacitated P objects, or is likely to object to treatment or care if she could, is not likely always to be straightforward. Active resistance by a constant demand or attempt to leave a place may be easy enough to evaluate. Less easy will be passive or inconsistently expressed resistance. The default setting may well be to treat this patient as complying, but any treatment administered under the general authority in clause 6 may not be lawful. The requirement to evaluate P's objections, and the difficulties that causes, arises under the MCA also when a decision is being made between treatment under the MCA or the MHA. The test of ineligibility for the MCA under schedule 1A is notoriously difficult to encapsulate briefly but it does necessitate an evaluation of whether the patient is objecting to being a mental health patient or treatment. So if the patient is refusing to comply with treatment for mental disorder then they may be detained and subject to compulsory treatment under the MHA if necessary. More difficult might be a situation where there is a reason to believe that the person would object if able to do so. The Addendum to the MCA Code of Practice says they must be treated as objecting (paragraph 4.46). The Addendum highlights the difficulties under that Act when treatment is for mental disorder, and particularly where a person is unable to communicate, or has limited communication ability (chapter 4).

Deprivation of liberty

Unlike the MCA the model statute defines "deprivation of liberty". The MCA provides guidance in the addendum Code of Practice. The model statute uses a simplified formulation: P is to be considered deprived of his or her liberty if a) s/he would not be permitted to leave the hospital or care home upon expressing a wish to do so or attempting to do so, **or** b) effective control is exercised over P's care and his or her freedom of movement is so confined as to amount to a deprivation of liberty (clause 18(2)).

This form of words is by now familiar from the cases of *HL* and *JE v DE*[22]. The classic definition of an article 5 deprivation of liberty in Strasbourg case law requires consideration of a range of factors which are variable depending on the individual circumstances. This is the well known *Guzzardi/Ashingdane*[23] formulation which considers the concrete situation of the individual, taking account of the type, duration, effects and manner of implementation of the measure in question.

22 *HL above at 91 and JE v DE and Surrey County Council [2007] 1 MHLR 39 at para. 117*

23 *HL at 89.*

The inclusion of a definition accepts criticisms made of the MCA amendments by the Parliamentary Joint Committee on Human Rights ('JCHR') and others (particularly JUSTICE)[24] on the grounds that deprivation of liberty is a less flexible and elusive concept than the government insisted. They argued that reliance on the Code of Practice was inadequate because it may be departed from for good reason. Further, a lack of certainty is a double edged sword promoting the twin dangers of over inclusion and over exclusion. Certainty protects fundamental rights and there is a costs and time saving benefit if protracted argument is avoided over what the case law means. The JCHR specifically endorsed the approach taken by Munby J in *JE* (above) where he held that the crucial issue is whether or not the person is "free to leave".

This is a simple concept to apply and likely to identify a true deprivation of liberty with little exception. It is not clear what the second limb at clause 18 (2) (b) in the model statue adds to this save for offering an alternative test which does not depend upon whether a person is free to leave or not. This addition may be tautologous and even circular, leading to confusion especially because this limb is also defined by reference to a deprivation of liberty.

Although the facts of *JE* and *HL* are quite different, neither was free to leave. HL was compliant and not asking to leave, yet he would have been prevented from leaving and detained under MHA criteria. But for his compliance he was potentially sectionable. Under schedule 1A MCA criteria, HL would be within the scope of the MHA (he was eventually sectioned), but he would have been still capable of being subject to MCA DOL safeguards because of his lack of objection (compliance).[25] He would remain in the same situation under the model statute, and so subject to DOL registration while in hospital. If his compliance with treatment had been in doubt, or his history of compliance poor or he had been asking or trying to go home, the clinician in charge would have no choice but to apply the MHA . Under the model statute the choice to be made is based on a unified set of criteria extended to take account of the issues of compliance and proportionality.

In *JE*, DE was repeatedly asking to go home but was not permitted to do so. If he had been compliant as HL was, then if he would have been prevented from leaving, or from being removed by family, then he would not be free to leave and need DOL safeguards. He was in a care home and so not detainable under the MHA. The model statute applies to both treatment and care in a hospital or a care home and so does not suffer this distinction which under current legislation has the potential to produce arbitrary and discriminatory results with regard to charges applied for after care.[26]

An attractive feature of a fused model would be that if DE was DOL registered in the care home but needed compulsory treatment for mental disorder, then that should be achievable without a change in registration and by the extension of existing procedures. Again the unified set of criteria would assist in streamlining this transition. A less attractive and new feature, however, would be that compulsory treatment could be employed for conditions other than mental disorder. For example, an incapacitated diabetic patient may well refuse insulin, necessitating frequent restraint for its administration. Under the Szmukler scheme a question arises as to whether this is achievable under the general authority or if it should be authorised as compulsory treatment?

24 *Fourth report of session 2006–7, para 84*

25 *See schedule 1A case scenario E.*

26 *Lucy Scott Moncrieff, 'Two Steps Forward, One Step Back' Journal of Mental Health Law May 2007 pp 107–114; and JCHR fourth report at 91.*

HM v Switzerland[27] is the case the government is fond of utilising in favour of an argument not found in other Strasbourg cases namely that an apparent deprivation of liberty in a person's best interests may in fact be no more than a restriction of liberty.[28] In that case HM was found not to be deprived of her liberty. This argument was firmly dealt with by Munby J in *JE* when he said it "would seem to lead to the absurd conclusion that a lunatic locked up indefinitely for his own good is not being deprived of his liberty. And if beneficent purpose cannot deprive what is manifestly a deprivation of liberty of its character as such, why should beneficent purpose be of assistance in determining whether some more marginal state of affairs does or does not amount to a deprivation of liberty?"[29] The House of Lords recently revisited this argument, this time in the context of crowd control at a May Day rally in central London *(Austin v Commissioner of Police of the Metropolis)*[30]. Their Lordships decided that article 5 was not engaged at all because the detention (now known as 'kettling') of the crowd was in their collective best interests and the police were acting in good faith. The logical inconsistency highlighted by Munby J (above) is abundant in this approach which arouses questions regarding the need for any mental health legislation or DOL safeguards whatsoever.[31] A petition in *Austin* has been lodged with the ECtHR[32] and one can only hope that the court will re-establish some clarity around this definition.

Treatment safeguards

Although not required by the ECHR, a continuing disappointment with the MCA is that there are no treatment safeguards by way of supervision and review of treatment of serious one-off or ongoing treatments, for those incapacitated patients complying with treatment. The MCA relies on the protective effect of consultation with family and friends, or in their absence an IMCA to cover this deficit. There are no checks on serious medical treatment such as ECT also, or the long term use of psychotropic medication for mental illness which may be authorised under section 5 MCA.

The model statute provides specific safeguards for serious medical treatment (including ECT, medication for mental disorder beyond a three month period and other treatments to be defined by regulation) (part III) which broadly accord with those developed under part IV of the MHA. The provisions apply to every person receiving care or treatment under the Act or receiving treatment authorised by a substitute decision maker or tribunal. The safeguards therefore apply not only to those who are DOL registered or subject to compulsion, but also to patients in long term care or being treated under the general authority. They consist of consultation with P where practicable, the primary carer, the substitute decision maker or, where there is none, a suitable person appointed by the tribunal. In the event of disagreement, an approved doctor is to provide a second opinion, and may be instructed in any event where serious treatment is proposed by the primary carer, the substitute decision maker or an advocate. Persistent disagreement will be referred to the tribunal for a determination (clause 10(3)). MHA safeguards appear to go further for those lacking capacity to consent if medication is to be administered beyond three months: the second opinion doctor must consult with two people who have been concerned with the patient's medical treatment before issuing a certificate (section 58(4) MHA).

27 *(2002) 38 EHRR 314*

28 *HM (above) at para 48.*

29 *JE (above) at para 47, adopting somewhat unfortunate terminology.*

30 *Austin v Commissiner of Police of the Metropolis [2009] UKHL 5, per Lord Hope at paras 34 and 37, reigned in by the 'footnote' opinion of Lord Walker (43–4).*

31 *D.Hewitt, 'Whose liberty?' Solicitors Journal, 17/2/09.*

32 *This has been confirmed by junior counsel acting for Austin.*

The test to be applied by the second opinion doctor or tribunal is not set out in the model statute but must by default be the best interests of the person as a general requirement of the statute. This is probably sufficient within article 8 ECHR and the requirement for a "procedure prescribed by law". Under the proposals for informal patients compulsion will not be an issue, but proper understanding of the P's level of understanding when offering compliance would be, so that P is not mistakenly treated against her will. This brings one back to the issue of assessing what passivity amounts to in the context of an objection (see above). A beneficial extra precaution would be for the second opinion to re assess the patient's capacity to consent to the proposed treatment. But a difficulty with the provisions as currently drafted is that there will only be a second opinion in the event of a disagreement with a carer or similar person. In this regard the MHA safeguards in section 58 appear much stronger for a compliant incapacitated patient.[33]

The decision in *Storck v Germany*[34] emphasising the State's positive obligation to protect physical integrity under article 8 requires remedies that are prospective and not just retrospective. The model statute's provision of access to a tribunal probably takes account of that requirement.

Discussion

Subject to aspects of detail, the overall scheme in the model statute has an appealing simplicity which demonstrates that concepts of capacity and best interests as we know them are capable of founding the care and treatment of compliant incapacitated patients so that differences between mental and physical disorder are kept to a necessary minimum. The ECHR does tolerate differences of treatment if justified.[35] Some fine tuning is required, for example, there is no provision for taking and conveying a compliant patient. This point exercised the JCHR in relation to a similar absence in the MCA. This need acknowledged the situation where it was known that a person was being taken from their home into a deprivation of liberty which therefore was a continuation of the detention begun at home.[36]

Further, the potential for compulsory treatment other than for mental disorder, e.g. the insulin dependent diabetic patient referred to above, may need a degree of cultural adjustment in clinical practice.

33 *The need for strong protections of compliant incapacitated patients deprived of liberty under article 5 on the basis of the decision in HL and by parity of reasoning under article 8 for interferences with physical integrity, was highlighted by the JCHR, Fourth Report of session 2006–7 (above), para 96.*

34 *Appl no. 61603/00, 16 June 2005, at 150.*

35 *In Price v UK (2002) 34 EHRR 1, a four limb deficient thalidomide woman was held in a prison cell with no special facilities. She should have been treated differently to normal prisoners. Her treatment violated article 3.*

36 *Above, Fourth Report at 88–89.*

Balancing autonomy and risk: the Scottish approach

Jacqueline M Atkinson[1] Hilary J Patrick[2]

The impact of compulsory measures of medical treatment for mental disorders have for some time interested medical and legal commentators, possibly because of the complex ethical issues these raise. In a context where stigma and discrimination are realities for many of those who use mental health services[3] some people argue that holistic legislation, which places treatment for mental disorder within a more general framework of incapacity law, could reduce the stigma of mental ill health[4].

Szmukler, Daw and Dawson have made an interesting attempt to show how such a law might look in practice. They have built on and reflected the work of the Bamford Committee in Northern Ireland, which, while recommending a single legislative basis for mental health and incapacity law, fell short of producing a draft bill[5].

In looking at these proposals from a Scottish perspective, we have resisted the temptation to focus on points of detail and have attempted to discuss certain themes. In particular, we have looked at how Scotland has introduced a capacity-based threshold for mental health law and how this compares with Szmukler *et al*'s proposed approach.

Certain (probably non-controversial) principles underline our approach:

- Legislation should have a solid ethical foundation.
- Any law should attempt to reduce stigma and discrimination, if possible.
- Legislation imposing duties or restrictions on people with mental disorders should also grant them real reciprocal rights.
- The law should be workable for service users and for health and social care professionals.
- Legislation needs to balance respect for autonomy with the right to protection.
- The criminal justice system should also be non-discriminatory in the way it assesses risk and disposes of cases.

We have assessed the Szmukler *et al* proposals (and the Scottish legislation) against these principles.

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3 *Social Exclusion Unit Mental health and social exclusion: Office of the Deputy Prime Minister (2004).*

4 *M Gunn 'Reforms of the Mental Health Act 1983: The relevance of capacity to make decisions' Journal of Mental Health Law (2000) 39; Dawson, J, Szmukler G (2006) 'Fusion of mental health and incapacity legislation' Br J Psychiatry, 188:504–509.*

5 *Bamford Review of Mental Health and Learning Disability (Northern Ireland) (2007) A comprehensive legislative framework.*

Reducing stigma and discrimination

While clearly the use of compulsory measures can be both stigmatising and distressing, Szmukler *et al*'s proposed new model does not suggest that their use will cease, only that other people (those with physical illnesses) may now become subject to such measures.

We know that a diagnosis of mental illness, learning disability or personality disorder is linked to poverty, unemployment and discrimination[6]. It could be argued that a dedicated mental health act should properly target discrimination, by including positive measures to reduce inequalities.

The *Mental Health (Care and Treatment) (Scotland) Act 2003* makes some, albeit modest, moves in this direction, reflecting its principles of respect for diversity and reciprocity. It gives everyone with a mental disorder a legal right to advocacy[7] and imposes important duties on local authorities to provide not just support services, but help with accessing employment, recreation and supporting positive mental health[8].

While, clearly, much more could be done, there is a danger that a generic incapacity law would not tackle the wider needs of this group. A mental health act does not need to be just about detention, it could also, as a measure of reciprocity, confer real rights and benefits.

A single Act

Scotland now has capacity based mental health legislation (although the test is significantly impaired decision-making rather than incapacity)[9]. It also has separate capacity legislation, (the *Adults with Incapacity (Scotland) Act 2000*) providing a framework for decision making in the welfare, financial and medical fields, much wider than the scope of the draft bill suggested by Szmukler *et al*.

There is no doubt that, in practice, overlaps between the two are difficult. If a person needing care and treatment in a community setting resists this, is guardianship appropriate, or would a community based compulsory treatment order be preferable? Which forms of medical treatment require authorisation under incapacity legislation and which under the mental health act? In addition, of course, there are deprivation of liberty concerns.

The accepted wisdom in Scotland is that the only circumstances where an adult can be lawfully deprived of her liberty on grounds of mental disorder are under a mental health act order or with the use of guardianship under incapacity legislation. However guardianship was not designed with deprivation of liberty issues in mind and there are problems with its use in this way[10].

The Millan Committee in Scotland recommended that consideration be given to fusing mental health and incapacity law into one piece of legislation[11]. It would be true to say, however, that this has not been a priority for government, service users or academics. Of more interest has been the recommendation for a review of the place of learning disability within mental health law[12].

Such a review would look more generally at the use of compulsion in people with learning disabilities, the

6 *G Thornicroft 'Shunned: discrimination against people with mental illness' OUP (2007).*

7 *Mental Health (Care and Treatment) (Scotland) Act 2003, s259.*

8 *MH(CT)(S)A 2003, ss25–8.*

9 *See, for example, MH(CT)(S)A 2003, ss44(4), 63(5).*

10 *H Patrick 'Autonomy, benefit and protection: How human rights law can protect people with mental health conditions or learning disabilities from unlawful deprivation of liberty' Mental Welfare Commission (2008).*

11 *New directions Report on the review of the Mental Health (Scotland) Act 1984 Scottish Executive (2001), recommendation 2.1.*

12 *New directions (above) recommendation 4.6.*

use of guardianship to control risk and, in particular, the use of hospitalisation as a preventative measure for people who engage in inappropriate or criminal behaviour. It may be that dedicated legislation for people with learning disabilities, including those with mental illness as well as learning disability, could more appropriately meet their needs than the current legislation in Scotland (or England and Wales) or the wider incapacity law proposed by Szmukler *et al*.

Assessing capacity

Despite calls for a capacity test in the Scottish mental health act, the Millan Committee was unwilling to recommend a purely incapacity based test. It was concerned that there might be people on the borders of the definition who would 'pass' the incapacity test but who would be thus failed by services and would not receive they help they might need.

The Richardson committee recognised this dilemma. It left it to politicians to decide whether legislation should allow a competent patient's refusal to be overturned where there would be a substantial risk of serious harm to the patient if she remained untreated[13].

Millan was concerned that a purely cognitive test of capacity might not adequately reflect the role of emotion in decision-making, nor how capacity might be affected by an illness such as depression.

It might be that some of these concerns would be addressed by what appear to be changing definitions of incapacity (not generally accepted in 2001). In particular, it might be possible to argue that a person with depression is unable to 'appreciate' the true situation in which she finds herself, or properly to weigh up the options in her case. We are pleased that Szmukler *et al* include this new aspect of the definition.

However we remain concerned that any capacity test should consider the impact a mental disorder may have on a person's emotions as well as her cognitive functions. Richardson suggested one element of the test should be how far the decision is the 'product' of the disorder[14] and this is a concept the Scottish test attempts to capture.

We are currently carrying out research[15] into the way the significantly impaired decision-making test is operating in practice in Scotland, and whether it does, in fact, differ from a capacity test.

Patient safeguards

Respect for the wishes of the service user is a crucial principle of the Scottish legislation and rightly stressed by Szmukler *et al*. The Scottish Act attempts to implement this principle by, among other things, the right to advocacy, nomination of named persons and advance statements (although where a patient is subject to compulsory measures a statement can be overruled).

The implementation of these provisions has not been without problems and we outline these below. The recent McManus review of the Scottish Act[16] made further suggestions.

Substitute decision-maker: Under the Szmukler *et al* draft bill, the substitute decision maker (SDM) plays a vital role. This defaults to the primary carer if one has not been appointed and the patient does not

13 *Department of Health 1999, Report of the Expert Committee Review of the Mental Health Act 1983, para 5.97.*

14 *Ibid.*

15 *Funded by the Nuffield Foundation: An exploration of the understanding and use of the 'impaired ability' criteria for compulsory treatment in the Mental Health (Care and Treatment) (Scotland) Act 2003.*

16 *Published August 2009 www.scotland.gov.uk/Publication/2009/08/07143902/0.*

object, although if she lacks capacity at the time, it may not be clear whether she objects or not. The primary carer is consulted at various times in the provision of care and it is not clear what role she might have in a tribunal.

There is a clear potential for conflict of interest. The named person provision in Scotland, whilst flawed, does allow that person to represent her own views and not those of the patient. It is not clear who would be appointed the SDM by a tribunal where one does not exist.

The default position in Scotland has caused some concern, as have the responsibilities of the named person[17]. If it is intended that this work through a list of next of kin, there needs to be provision for a patient to make a blanket refusal of any nominated person, an issue which has been raised during the review of the law in Scotland[18].

In such cases, the necessity of the SDM role reverting to a public agency may be considered, as there will be three different scenarios: where a person never has had capacity, where a person who had capacity has lost it and will not regain it and a person with fluctuating capacity.

Independent advocates If advocates are to be 'instructed' to represent a patient, it is not clear when this is done or by whom. If it falls to the tribunal, the problem of interim hearings will arise, as the advocate seeks time to consult with the patient.

The draft bill is perhaps somewhat unclear how far the advocate is following her own agenda on behalf of the patient, rather than simply representing the patient's wishes[19]. Neither is it clear whether a patient can refuse the services of an advocate, particularly if she wishes to engage a lawyer. The resource implications of all patients at a tribunal having to have an advocate are considerable, and the Scottish experience could prove instructive.

Advance directives As described in the draft bill, advance directives have a narrow role, which is only to refuse certain interventions. Most mental health advance directives allow a person to consent to particular treatments as well as refuse, and many states in the USA allow for the appointment of a proxy decision maker[20].

Although there is general agreement that a patient cannot 'demand' a certain treatment, many people with recurrent illness which affects their capacity find it helpful to outline their preferred course of treatment at such times, as well as wider issues around treatment and management. It is the wider issues which seem of particular interest to many in Scotland[21].

Szmukler *et al* suggest that '*Such decisions may still be overridden when treatment without the consent of the person is expressly authorised by the Act*'. This suggestion, which would be weaker than the Scottish position[22], will lead many who would otherwise consider making an advance directive to question their value. It raises questions as to whether the overruling of an advance directive only applies to a recurrent mental illness or may apply to other advance refusals of treatment.

17 *Berzins KM, Atkinson JM. (2009) 'Service Users' and carers' views of the Named Person provisions under the Mental Health (Care and Treatment) (Scotland) Act 2003' Journal of Mental Health 18 207–215. Berzins K.M., Atkinson J.M (submitted) 'Perceptions of policy influencers and mental health officers of the Named Person provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003.'*

18 *See n.16 above.*

19 *At clauses 52(1)(d) and (e) of the draft bill.*

20 *For example, New York and Massachusetts.*

21 *Reilly J, Atkinson JM (submitted) 'The content of mental health advance directives: advance statements in Scotland'.*

22 *Where those authorising or exercising compulsory powers must 'have regard' to any advance statement and report any overriding of a statement to the Mental Welfare Commission. MH(CT)(S)A 2003, ss275, 276.*

If the advance refusal is upheld, consideration still needs to be given to whether a person can or should be detained (for her own or other's safety) and not treated. If advance and current capacitious decisions are to be treated equally, then maybe treatment and detention must be considered separately, where it is possible to refuse treatment, but not detention. The issue is then whether it is appropriate to detain someone because of risk, and whether the level of risk to self or others is the same to warrant detention. The ramifications of this are considerable.

Practicalities

Whilst practicalities should not stand in the way of safeguarding people's rights, the opportunity cost attaching to them must be considered.

Tribunals, although welcomed in Scotland, have also caused the most concern, mainly over their demand on resources, ranging from medical time (each tribunal requires two doctors) to the comparatively high involvement of legal representation at hearings, with consequences for the legal aid budget and a perceived contribution to an unacceptably high number of interim hearings[23].

An estimate is needed of the number of additional tribunals likely as a result of including treatment for physical conditions as well as mental disorders. A tribunal may be less threatening than a court, but in England family courts have a record of thoughtful decision-making and may be more appropriate for decisions such as end of life decisions or sterilization. We have seen similar trends in Scotland.

Where a tribunal is appropriate, it is not clear how quickly one can be requested and then held, for example, to deal with an end of life decision.

While the *Adults with Incapacity Act* was passing through the Scottish Parliament, campaigners urged that the safeguards on medical treatment for informal patients lacking capacity, whether in hospital or nursing homes, should mirror mental health act safeguards. The government argued that the resource implications made this impractical. However we would welcome such safeguards. Without them there is no check on the appropriateness of treatment such as the use of anti-psychotic medication. This has been a problem in Scotland and elsewhere[24].

Forensic issues

While importing the capacity approach to the criminal justice system is logically attractive, we have some concerns about its impact in practice. Scotland has not adopted this approach. If the courts decide that an offender has a mental disorder, that she could benefit from treatment and that this is the most appropriate disposal, it may make an order whether or not the person consents and whether or not she has the ability to consent[25]. It may, of course, pass no sentence or a lesser sentence (such as probation) where a person agrees to treatment.

It could be argued that this approach threatens the ethical principle of respect for the patient's autonomy, which is at the heart of the capacity test. However a person who has been convicted of a crime (or who

23 *F Dobbie, S Reid and others 'An exploration of the early operation of the Mental Health Tribunal for Scotland' Scottish Centre for Social Research (2009).*

24 *Ballard C, Lana MM, Theodoulou M, Douglas S, McShane R, et al. (2008) 'A Randomised, Blinded, Placebo-Controlled Trial in Dementia Patients Continuing or Stopping Neuroleptics' (The DART-AD Trial) . PLoS Med 5(4): e76. Prentice N et al (2002) presented at Royal College of Psychiatrists Old Age Section Annual Residential Meeting.*

25 *Criminal Procedure (Scotland) Act 1995, (as amended) s57A(3).*

has been found not guilty by reason of insanity) has already compromised her autonomy. These are not discriminatory provisions. A person with no mental disorder may similarly face detention in prison.

On the other hand, insofar as the suggestions from Szmukler *et al* reflect the principle of minimum necessary intervention, they require serious consideration. Could a hospital direction contain two strands: compulsory detention in hospital linked to a prison sentence, or voluntary admission to hospital linked to a prison sentence? Why should not prisons be able to transfer a prisoner to hospital where she agrees the need for treatment? The current provisions appear to discriminate against prisoners with mental health needs. If a prisoner has a physical health need, she will be treated voluntarily, unless she is incapable of taking the decision in question. The same should apply to prisoners with mental health needs, who should not become subject to mental health act provisions unless these are otherwise appropriate.

Other proposals appear somewhat more controversial. Should a capable person be able to refuse remand for psychiatric reports? And how is her capacity to refuse to be measured without such reports? If a person's mental disorder means that prison staff are unable to care for her, is it appropriate for her to be able to refuse a transfer to hospital, on the grounds that only she has the capacity to make the decision?

Any new legislation will involve a balancing of competing ethical priorities, and each jurisdiction must set the scales where it seems appropriate. We can only say that we do not think an approach based solely on capacity would be acceptable in Scotland.

Finally, Scotland has effectively reduced one important area of discrimination in the criminal justice system. Following the recommendations of the MacLean Committee[26], where a person has committed a serious, violent or sexual offence, the court may impose an order for lifelong restriction. This means that decisions about the person's discharge are subject to risk assessment by the Risk Management Authority, whose remit covers both those with and without mental disorders[27]. We welcome this approach, which singles out risk, rather than diagnosis, as the basis of decision-making.

Conclusion

Szmukler, Daw and Dawson have shown that a fused capacity law is possible, at least in the field of medical decision-making. While points of detail or emphasis may vary, this ambitious paper gives us a useful opportunity to discuss the form and purpose of mental health and incapacity law.

26 *Report of the Committee on Serious Violent and Sexual Offenders, Scottish Executive (2000).*

27 *CP(S)A 1995, s210F.*

A new legislative framework for mental capacity and mental health legislation in Northern Ireland: an analysis of the current proposals

Maura McCallion[1] and Ursula O'Hare[2]

Introduction

When the Bamford Review of Mental Health and Learning Disability completed its work in the autumn of 2007, it drew to a close an extensive consultation and analysis of mental health and learning disability services and the law in Northern Ireland. Its last report on *A Comprehensive Legislative Framework* made a compelling case for a major overhaul of the law that the Review team itself described as 'quite radical'.[3]

The Review identified the case for reform in the need to ensure that mental health law conforms to the requirements of human rights law, reflects changes to professional practice, reflects the needs of service users and their carers, and keeps pace with reform elsewhere in the UK. Alone of all the jurisdictions in the UK, Northern Ireland has been operating largely in a legislative vacuum in relation to mental capacity law. The Review's proposals for reform therefore extended to reform of mental health law and the introduction of mental capacity law.

In the autumn of 2008 the NI Executive published its response to the Bamford Review indicating that it intended to develop the law sequentially: reform of the *Mental Health (NI) Order 1986* by 2011 followed

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3 *Bamford Review of Mental Health and Learning Disability (NI), August 2007, available at www.mhldni.gov.uk*

by the introduction of mental capacity law in 2014. Responses to the Executive's consultation resulted in the Department of Health Social Services and Public Safety (DHSSPS) revising its approach and it signalled its intention to bring forward mental capacity and mental health legislation together.[4] This created a unique opportunity in Northern Ireland for fusion of incapacity and mental health legislation. A further consultation paper was issued in January 2009, setting out the key approaches to the content of two bills. However as a result of the consultation, the Health Minister Michael McGimpsey announced in September 2009 that there would be a single bill with an overall principle of autonomy. His press statement noted: " A strong body of opinion, particularly from professional groups and lead voluntary organisations, which considered that separate mental health legislation continues to be stigmatising and recommended that mental capacity and mental health provisions should instead be encompassed into a single piece of legislation"[5]

This short paper provides an overview of the current direction of travel on law reform in Northern Ireland. It comments on the policy climate and arguments for a fusion of mental capacity and mental health legislation. It also highlights some of the key policy issues that will need to be further explored as the Department develops its law reform proposals and concludes with some hopes and fears for the new legislation.

Reflections on the model law

When the Millan Committee reported on reform of mental health law in Scotland, it recommended that in due course the *Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003* should be consolidated in a single statute.[6] The potential interface difficulties between two pieces of closely related legislation (mental capacity and mental health legislation) that have been highlighted in England and Wales[7] made a strong case for the Northern Ireland administration to seize the opportunity to carefully explore the merits of a single bill for mental capacity and mental health. The value of Szmukler, Daw and Dawson's model law fusing incapacity and mental health legislation is that it shows that this can be done.

The model law of Szmukler et al, based as it is on incapacity principles, provides, in principle, a model that with suitable amendment, could be tailored to fit with the DHSSPS's policy proposal to reform mental health law on capacity principles and simultaneously introduce mental capacity law.

Current policy climate on key issues

Fusion of incapacity and mental health legislation

The principle of a fusing incapacity and mental health legislation is supported by a broad Mental Health and Learning Disability Alliance of user, carer, voluntary sector and professional organisations in both mental health and learning disability sectors in Northern Ireland. These include Action Mental Health,

4 *DHSSPSNI, Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland, A Policy Consultation, January 2009 available at www.mhldni.gov.uk*

5 *Northern Ireland Department of Health, Social Services and Public Safety press release, 10 September 2009, http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-september-2009/news-dhssps-10092009-mcgimpsey-announces-single.htm*

6 *See A Comprehensive Legislative Framework, supra n.4 at para. 2.33. A review of the operation of the Mental Health (Care and Treatment) (Scotland) Act 2003 was presented to the Scottish Government in March 2009. For details see www.mentalhealthactreview.org.uk*

7 *See for example, Richardson, G. 'Problems at the Interface: Lessons from England and Wales', paper to Law Centre (NI) Seminar, Mental Health and Capacity Law in Northern Ireland, February 2009*

Alzheimer Society (NI), Aware (Defeat Depression), the British Association of Social Workers (NI), the British Medical Association (NI), Bryson Charitable Group, CAUSE, Children's Law Centre, the College of Occupational Therapists, Disability Action, Equality Commission Northern Ireland, Federation of Experts by Experience, Law Centre (NI), Mencap, Mindwise, Participation and Practice of Rights and the Royal College of Psychiatrists.

The capacity approach

The Minister, in his foreword to the Departmental proposals, sets out his intention that "where a person has the mental capacity to make a decision, including a decision about treatment of their mental disorder, they will be allowed to do so".[8]

"The Department's aim is stated to be 'to produce a legislative framework, encompassing both mental capacity and mental health legislation, which places the right of individuals to make decisions about their own treatment, care, welfare and /or financial affairs at the centre of legislative reform."[9]

The current position is that the capacity test proposed for treatment would be one of 'significantly impaired decision making ability'. However consultation responses have suggested a capacity test based on the wording in section 2 and 3 of the *Mental Capacity Act 2005* for England and Wales.

Forensic provisions

Unlike the proposals put forward by Szmukler et al, the proposals for new legislation do not explain the interface between the new law and the criminal justice system and so it is difficult to anticipate the likely policy position on offenders who retain decision making capacity but who would benefit from mental health treatment. The Bamford review had advocated a common approach to all who require treatment.[10]

Deprivation of liberty safeguards

The Department will take this legislative opportunity to address the need for safeguards for those who lack the capacity to consent to care in a hospital or care home and who are deprived of their liberty in their best interests. At present, the detailed proposals have not been developed.

The Mental Health and Learning Disability Alliance has recommended a single system of safeguards to apply in a unified bill to those who lack capacity and are subject to compulsory interventions. It notes that the complexity of two separate systems of safeguards which apply under mental health and mental capacity legislation elsewhere in the UK need not be replicated in Northern Ireland.[11] They argue that legislation should ensure that all those who lack capacity enjoy equal protection of the law by being subject to one system of safeguards.[12] These safeguards should reflect the vulnerability of those subject to the legislation and should be commensurate with the gravity of the intervention.

8 *Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland – A Policy Consultation Document, January 2009, DHSSPSNI at p.3.*

9 *ibid at p.4, para.1.1*

10 *See A Comprehensive Legislative Framework, supra n. 4 at para. 5.55*

11 *New deprivation of liberty safeguards came into force in England and Wales in April 2009.*

12 *See Article 14(2) UN Convention on the Rights of Persons with Disabilities – 'state parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are on an equal basis with others, entitled to guarantees in accordance with international human rights law...'*

Key Issues to Address

Other issues, all of which are considered in the model law, that need to be explored further in the proposals for law reform in Northern Ireland are compulsory treatment in the community, safeguards, advance directives, and advocacy. Each of these is briefly discussed below.

Community Treatment Orders

Reform of mental health law envisages that compulsory treatment in the community may be authorised for an initial period of six months with provision for extension for a further six months and thereafter for twelve months at a time. The basis for the introduction of community treatment order is not well articulated in the Department's policy proposals and detail of the scope of community treatment orders, their application to children, and how community treatment orders will be regulated is as yet unclear. Questions arise as to whether there will be limits to the number of community treatment orders that may be applied to an individual, and how fluctuating capacity will be assessed where a person is subject to a long-term community treatment order. The introduction of community treatment orders for those with a mental health disorder who lack capacity to consent to treatment also raises questions about the system of safeguards that should be in place to protect those who fall within the ambit of the legislation.

Safeguards

Szmukler *et al* make the argument for comprehensive review and accountability mechanisms to apply in a 'fused' statute. As noted above, the Mental Health and Learning Disability Alliance has recommended a unitary system of safeguards to apply to all those who lack decision-making capacity about their care and treatment and who are subject to compulsory intervention. Outstanding issues to explore in the development of new law for Northern Ireland are whether there should be an independent *authorisation* mechanism for all compulsory interventions as well as the avenues for seeking a review of an initial authorisation of compulsory intervention and the frequency of review. The Bamford Review had recommended a role for the Regulation and Quality Improvement Authority to approve intervention plans.[13] The Department's policy proposals envisage 'an extended role for the Mental Health Review Tribunal'. The Scottish model of independent approval of interventions, care plans and compulsory treatment by the Scottish Mental Health Tribunal has much to recommend to Northern Ireland.[14] So too does Szmukler *et al*'s proposals for a Mental Capacity Tribunal with responsibility for authorising care plans, hearing applications for assessment orders and approving compulsory treatment orders and with an appeal jurisdiction.

Advance Directives

The Department proposes that the new bill will make provision for advance decision-making in relation to refusal of future treatment. It is important that the law makes provision to ensure that individuals may be supported in making an advance directive. It is not clear as yet how issues such as who may make an advance directive, the validity of an advance directive, and the burden of proof required to be shown to override an advance directive, will be addressed in the new legislation.

13 *The RQIA is responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland. From 1 April 2009, the functions of the Mental Health Commission for Northern Ireland have transferred to the RQIA.*

14 *For a recent analysis of the work of the Scottish Mental Health Tribunal see Dobbie et al, An Exploration of the Early Operation of the Mental Health Tribunal for Scotland, Scottish Government Social Research (2009)*

Advocacy

The Bamford Review gave particular emphasis to the role of advocacy. The Department envisage that enhanced advocacy services will be available to those falling within the ambit of the mental capacity and mental health legislation. There is strong support amongst mental health and learning disability groups in Northern Ireland for enhanced advocacy services. Since different groups of people falling under the reach of the legislation have distinct requirements from advocacy according to their needs and circumstances e.g. peer advocacy; self-advocacy; advocacy for carers etc, it is important that the law develops advocacy provisions according to the guiding principles that is independent, freely available and appropriate to the needs of the individual. The Mental Health and Learning Disability Alliance has recommended that the law should enshrine a right to appropriate and independent advocacy, and a corresponding duty on the relevant authorities to provide such advocacy services, including at assessment stage. Szmukler *et al's* model of an 'independent mental capacity advocate' may be sufficiently broad as to encompass a range of advocacy models that could apply under new law in Northern Ireland.

Hopes and fears for the new legislation

Continued consultation by the Department with stakeholders as it develops its policy direction will hopefully help to ensure that the new law enjoys a sense of widespread 'ownership' when it emerges. The Department now does not envisage the bill being ready for introduction to the Assembly until 2011.[15] Care will need to be taken to ensure that the reform timetable does not slip so far as to jeopardise progress that has been made to date. The law reform project will carry forward to a new administration (with the possibility of a new minister) and this introduces new uncertainties into the policy process.

All three expert reports on mental health law reform in the UK (Richardson, Millan and Bamford) have stressed the importance of service development alongside law reform.. Much of what may ultimately be included in the new legislation will require an investment in services and the training to support its implementation. It is hoped that the new legislation will be matched by corresponding commitment to an investment programme.

Conclusion

The reform project in Northern Ireland presents an opportunity to develop an ethically consistent framework for the treatment and care of all those who lack the capacity to consent to such treatment. It has been said many times already in this process that there is before us a once-in-a-generation opportunity to craft new legislation that could transform how we as a society address the care and treatment needs of those with impaired decision-making capacity. No other jurisdiction in the UK in recent years has seized the opportunity to develop new mental health and mental capacity legislation at the same time. The opportunity currently before us in Northern Ireland, calls for policy innovation and political determination to deliver the transformational approach to mental health and mental capacity law that will serve as a lasting legacy of the local administration.

15 *See DHSSPS press release, supra n. 5 and DHSSPSNI, Delivering the Bamford Vision: The Response of Northern Ireland Executive to the Bamford Review of Mental Health & Learning Disability – Action Plan 2009 – 2011, October 2009 at para. 6.3*

The Response

Response to the Commentaries

George Szmukler[1], Rowena Daw[2] and John Dawson[3]

We are immensely grateful to the commentators for their careful reading of the Model 'Fusion' Law (ML). The level of support for our proposal from most of the commentators is encouraging as is the news that Northern Ireland intends to introduce legislation along similar lines. The aim of the ML is to eliminate the unwarranted discrimination against people with mental disorder that is inherent in current mental health legislation in England and Wales and in many other jurisdictions. We remain convinced that the principles underlying the enterprise are right and that they can be translated into a practical form. At the same time, excellent points have been raised by the commentators that have stimulated us to think further and to propose a number of revisions.

The editors have invited us to respond briefly to the commentaries. We should have liked to engage with each of the commentators on a number of specific issues, but in our response we must focus on the major themes that have emerged.

1 Difficulties in applying capacity criteria in mental disorder

It has been questioned whether capacity criteria can be readily or reliably applied, especially in three sets of circumstances:

In emergencies

It is argued that making an assessment that someone suffers from a mental disorder and presents a significant risk to themselves or others fits well with common understandings of 'mental disorder'. Would capacity criteria be a practicable replacement? Our response is that one learns to apply the criteria that one is required to apply. In an emergency situation, the model law requires that the assessor determine whether there is a reasonable likelihood that the person lacks capacity (so that particular interventions might then follow). This assessment will often turn on whether a person behaving in an abnormal manner is able to give a coherent account of their reasons for doing so, whether they believe mental disturbance may be a cause (and why) and what kind of intervention (if any) might be appropriate. There is no reason to believe that this assessment is any more difficult than one that determines the person has a 'mental disorder' (with its ill-defined boundaries). Indeed one might claim that the assessment of capacity is focussed more precisely on what is of most interest when someone is acting strangely – what account could they give that would explain it?

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Where there is a commonly held intuition that an intervention is justified but where capacity may not be judged to be impaired.

One type of situation that is cited concerns persons at risk of serious self-harm, perhaps presenting a risk of suicide in response to a major adverse event such as a rejection in love. A second situation is where there is a serious risk as a consequence of a disorder, but where a 'cognitive' bias in the criteria for capacity might lead to the conclusion that it is retained.

The former type of situation is likely to involve an acute disturbance. Similar risks to the safety of a person or to others may arise from intoxication, or from a loss of control due to rage. This type of case could be handled through a general law of justified intervention in an emergency situation where serious harm may befall a person (as under the common law when there is an imminent risk of harm to others). The intervention would not be based on whether a mental disorder is present or not, but on the need to prevent imminent serious harm. The allowed emergency intervention might involve taking the person to a 'place of safety' so that a further evaluation could take place.

The second kind of situation raises the question of what should be tested in a capacity assessment. It has been argued that the conventional type of assessment may not pay adequate regard to emotional influences and questions of 'value'.[4] We agree there is still work to be done on the meaning and assessment of capacity. Hence we propose that an 'appreciation' criterion be added to the definition (as in the Scottish Code of Practice on the *Adults with Incapacity (Scotland) Act 2000*). This would point to a need to examine the influence of 'pathological values'. Despite any current limitations, an assessment of capacity is not necessarily less reliable than that currently required in assessing whether the criteria for a compulsory order are met. Indeed the research evidence shows that high inter-rater reliability can be achieved for patients with psychoses and other disorders resulting in inpatient psychiatric care.[5]

Fluctuating capacity

Some commentators hold that fluctuating capacity in 'mental disorders' may make capacity-based legislation problematic. In a series of studies of capacity in psychiatric patients recently admitted to hospital in which GS was an investigator this did not emerge as a significant observation.[6,7,8] Psychoses, unless caused by an acute, organic disturbance of brain function such as delirium, due to drug toxicity or withdrawal, do not fluctuate – recovery is generally progressive. Fluctuation of conscious level, even over the course of a day, is a well recognised clinical feature in acute disturbances of brain function and can be taken into account in determining when capacity is stably restored. An issue might arise in relation to the psychoses as to how long a period of restoration of capacity would be required before it could be judged 'stable'. One would not usually be thinking here in terms of hours, but of days or weeks, depending on the trajectory of recovery. This would involve the same kind of thinking as determining under the

4 *Tan DJ, Hope PT, Stewart DA, & Fitzpatrick PR (2006), 'Competence to make treatment decisions in anorexia nervosa: thinking processes and values.', Philosophy, Psychiatry and Psychology, 13 (4), 267–82.*

5 *Cairns R, Maddock C, Buchanan A, David AS, Hayward,P, Richardson G. et al. (2005), 'Reliability of mental capacity assessments in psychiatric in-patients.' British Journal of Psychiatry, 187 372–78.*

6 *Owen GS, Richardson G, David AS, Szmukler G, Hayward P, & Hotopf M (2008a). 'Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study'. British Medical Journal, 337, a448.*

7 *Owen GS, David AS, Richardson G, Szmukler G, Hayward P, & Hotopf M (2008). 'Mental capacity, diagnosis and insight in psychiatric in-patients: a cross-sectional study'. Psychological Medicine, 21, 1–10.*

8 *Owen GS, Szmukler G, Richardson G, David AS, Hayward P, Rucker J et al. (2009). 'Mental capacity and psychiatric in-patients: implications for the new mental health law in England and Wales'. British Journal of Psychiatry, 195(3), 257–263.*

current MHA how long a person should no longer present an apparent risk to their health or safety for it to be judged that such a risk no longer exists.

The 'exceptionalism' of mental disorder

Two major points have been raised questioning the applicability or value of capacity-based law in respect of mental disorder.

1 The associated risk of violence

Appelbaum, Buchanan and Gledhill suggest that the association of mental disorder with violence makes mental illness not comparable to physical illness. We address a number of points in the section below when we deal with specific forensic issues, but at this stage we wish to draw attention to a more general point.

Dangerousness is not a necessary condition of having a mental illness. It may be a consequence in a small minority of patients having a mental illness. The risk in the absence of alcohol or substance misuse, or of an antisocial personality, is modestly, if at all, raised – indeed two recent population-based studies have shown no increase in violence by people with a psychosis, in the absence of drug misuse or personality disorder.[9,10] We must avoid the damaging stereotype of mental illness as somehow necessarily entailing a risk to others. Dangerousness does not put those with a mental illness in a different place to other patients as Appelbaum maintains – it is an uncommon association.

2 Beneficence may be a higher value than autonomy

This claim is most strongly stated by Burns, but the idea is present in a muted form in some of the other commentaries. For example, both Gledhill and Buchanan state that since prison is a very non-therapeutic environment for persons with a mental disorder, they should be in a hospital, even if they have capacity and choose prison over hospital.

We cannot accept this proposition. It reinforces the stereotype of the person with mental illness being incapable of normal agency and is inconsistent with the respect for autonomy shown to all other patients in medical practice. A large measure of clinician discretion is introduced, as evidenced in the huge variability in rates of involuntary admissions across Europe (up to 30-fold), and changes in their rates over time (up 70% in England and Wales in the decade after 1995, down 40% in Sweden over the same period).[11] Doctors acting 'beneficently' in the past have subjected patients to damaging treatments – lobotomy, insulin coma therapy, removal of organs for 'focal sepsis'. We cannot see why persons who are capable of making decisions for themselves should be denied that privilege. They are the best judges of what is in their best interests.

It should also be noted that the 'best interests' determination, engaged when capacity is absent, is primarily concerned with beneficence. In the ML as in the MCA it is an important advance on the notion that best interests should be based on what the doctor considers to be in the patient's best interests. The decision-maker must take account of the medical, psychological and welfare aspects of an intervention.

9 *Coid J, Yang M, Roberts A, Ullrich S, Moran P, Bebbington P et al. (2006), 'Violence and psychiatric morbidity in a national household population – a report from the British Household Survey.' American Journal of Epidemiology, 164 (12), 1199–208.*

10 *Elbogen, EB and SC Johnson (2009), 'The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions.', Archives of General Psychiatry, 66 (2), 152–61.*

11 *Dressing, H and HJ Salize (2004), 'Compulsory admission of mentally ill patients in European Union Member States.', Social Psychiatry and Psychiatric Epidemiology, 39 (10), 797–803.*

We consider that the two kinds of appeal to the 'exceptionalism' of mental disorder outlined above rest on negative stereotypes of the mentally ill – that they are dangerous and that they are not worthy of the respect we accord to full persons.

But perhaps whether mental illness is 'different' in principle to physical illness may not be the fundamental issue in relation to capacity. We need to see autonomy in a broader context. People in our society are given a right to self-determination, whether it relates to what can or cannot be done to their bodies, whether they can make a contract, whether they can make a will, and so on. The significance of what is a 'mental disorder' thus recedes in importance. The question is whether there is an impairment or disturbance in the functioning of mind and whether it renders the person incapable of acting autonomously.

Remember also that people with mental illness and physical illness are treated within the same health system, from the same budget, administered by the same department of health, and treated by the same professionals with the same codes of practice, ethical standards and regulatory bodies. The assessment of capacity is a skill that all doctors must have, and that they must exercise under the MCA. That patients with a mental disorder should be subject to a different set of rules when it comes to making decisions about their health is thus difficult to support.

We note also that in marked contrast to those supporting a stronger role for beneficence, Robinson presents a strongly negative view of the 'paternalism' it entails. He highlights the centrality of a loss of liberty that an involuntary treatment order imposes, and sees the Tribunal for example, as regulating a "conflict" between patient and clinician. Such opposite poles of opinion are difficult to reconcile, but we believe that capacity-based law offers the best solution.

Forensic implications

A set of criticisms of the ML relate to our contention that conventional mental health law is discriminatory; to what are seen as inadequate protections of other people from dangerous persons with mental disorders; and to the implications of our exceptions in relation to fitness to plead (FP) and not guilty by reason of insanity (NGRI)

Mental health legislation and discrimination

Gledhill argues that the ECHR permits the preventive detention of persons with a mental disorder as long as it is proportional to the risk. He argues that there is no discrimination against those with mental disorder. He points out another group of patients can also be lawfully detained if presenting a risk to others – those with infectious diseases.

Indeed there is legislation permitting the detention of persons with infectious disease (though used less than 10 times per annum in England).[12] We agree it is not discriminatory. This is because there is no category of persons within the population of those who present a risk to others by virtue of their infectiousness who are singled out for detention. All persons who present an equal risk due to their infectiousness are equally likely to be detained. There is no law that authorises detention only of a category of those who are infectious, for example those who are drug dependent or who are homeless. This is quite different to the situation in respect of people who present a danger to others by virtue of their potential for violence. Consider a population of people in the community who have reached a

12 Coker RJ (2001), 'National survey of detention and TB.', Thorax, 56(10) (10), 818.

particular threshold of risk of violence to others. Of this population it is only those with a mental disorder – not, for example, those who are habitually aggressive when drunk or who regularly assault their partners – who are subject to preventive detention (under the MHA), even when no offence has been committed. It is the unequal treatment of people who are equally 'risky' that constitutes the discrimination (and contrasts with the treatment of all people who are equally infectious).

Gledhill also argues that a preventive intervention for dangerous people with a mental disorder is not discriminatory because it is appropriate to allow autonomy to be restricted (proportionately) when someone presents a risk to others. However, he fails to use the right comparator. For a person with a mental disorder who has capacity and who presents a significant risk to others, the right comparator is a person who presents the same level of risk but who does not have a mental disorder (and presumably has capacity). If preventive interventions are restricted only to those who have a mental disorder, this is discriminatory.

We have argued elsewhere that non-discrimination in relation to risk of violence to others can only be ensured through generic dangerousness legislation, in which the level of risk determines that an intervention is required, rather than the category of person.[13] Two key questions can be asked in relation to risk, and it is the order in which they are asked that is crucial. The non-discriminatory order is: 1. Does this person's behaviour pose an unacceptable risk to others; if so, then 2. If the risk is unacceptable, how should this be managed? This might be a mental health disposal if there a mental disorder and other criteria are met. The current order of the questions, that is – 1. Is there a mental disorder?; then 2. If so, is there an unacceptable risk to others? – is discriminatory.

A number of preventive sentence options have now been introduced into English law. These are sentences of life imprisonment, indeterminate 'imprisonment for public protection' and 'extended sentences' available for those convicted of specified categories of serious offence and who are deemed to pose a risk. There are thus means for protecting the public (in England at least) which are not discriminatory. We do not necessarily support preventive detention of this type, but at least it offers the possibility of non-discriminatory detention.

Protections from dangerous people with a mental disorder:

Concern is expressed that there is no equivalent within the ML of a hospital order buttressed by a 'restriction' order to ensure that the person is supervised and treated as long as is necessary. This kind of medical disposal is seen as beneficent as it removes the ill person from the criminal justice system. It is claimed that ML shifts the locus, or at least the conceptual focus, too much in the direction of the criminal justice system.

Under the ML if a person has been convicted of a serious offence there are two major options:

1. a compulsory treatment order under the healthcare system, with no long-term option of a restriction order

2. a sentence, the duration of which is determined by the seriousness of the offence – not by the psychiatric assessment as claimed by Buchanan – with the option of:

a. involuntary hospital treatment for the person who lacks capacity until he or she regains it, when they might continue as a voluntary patient, or if they decide against treatment, a transfer to prison for the rest of the sentence; or

13 *Szmukler G and F Holloway (1998), 'Mental health legislation is now a harmful anachronism', Psychiatric Bulletin, 22 662–65.*

b. if the person has capacity but has a mental disorder which might benefit from treatment, voluntary treatment with consent.

These are the options under the ML. But that does not mean that a dangerous person with a mental disorder will discharged with no further ado (apart from a likely referral to community mental health services). Under option 2, the sentence might be a life sentence or one of the extended sentences mentioned above. If so, the person will subsequently be under some form of supervision in the community following discharge: for example, on a licence for life following release from prison on a sentence of life imprisonment. Assuming that supervision does not compel treatment as one of its conditions, at the very least the person with capacity who might be a risk to others will be regularly monitored and appropriate action taken if there is a relapse of illness (this could be involuntary treatment if the conditions in Clause 21 are met) or a return to the court, and then perhaps prison. In effect this is a restriction order – but one which is non-discriminatory as it is applicable to all offenders with capacity, whether or not they have a mental disorder. Buchanan's objection that this form of restriction order uses the non-therapeutic framework of the criminal justice system must be set against the fact that restriction orders under the MHA are significantly under the control of the Ministry of Justice (MoJ), Mental Health Unit, which some would say in effect operates a form of tariff system, the order's duration being determined by the nature of the offence. The patient can appeal to a First-tier Tribunal (Health, Education and Social Care Chamber) (Mental Health), where the MoJ probably will present an argument for continuing the order. Thus the therapeutic framework may not be as therapeutic as appears at first sight, while its indeterminacy for persons with capacity is, we maintain, not justifiable.

The person with capacity, convicted of an offence, may of course agree to treatment in order to be released under supervision. Failure to comply with the treatment within the finite period of the sentence would result in recall to the court. This then becomes similar to Buchanan's proposal that a person may voluntarily submit to a kind of restriction order, but under the healthcare system. Under the ML the sentence is finite; it is not clear whether in Buchanan's proposal it would be finite or indeterminate.

A problem that might arise concerns the weight that might be given in the assessment of risk by the court to the mental disorder *per se*. It may be that the court will rate the risk as higher because the person has a mental disorder according to the stereotype of the mentally disordered as necessarily dangerous. This would need to be countered.

Fitness to Plead and Not Guilty by Reason of Insanity

These are the two exceptions to the governing role of capacity in the ML in which we allow involuntary treatment of people with capacity under certain conditions. However, rather than representing a flaw in the fabric of the ML as Appelbaum implies, we believe that it is almost inevitable that at some points of intersection, the different perspectives on human conduct from healthcare and criminal justice viewpoints will not allow tidy reconciliation. The problem resides just as much with the criminal law as health law.

The main problem that arises currently concerns the person with mental disorder, who is deemed dangerous, and who has capacity and who therefore cannot be subject under the ML to an involuntary order – but who, at the same time cannot also be under a sentence under the criminal justice system (because not convicted), even if found to have committed a serious offence on a trial of the facts. Under English law a Supervision Order can now be made, possibly with a condition of treatment or a requirement to see a psychiatrist, but it is non-punitive and our understanding is that there is no sanction

for non-compliance. Our exception is there until this problem can be resolved. But we expect this to be rarely necessary – unless reform of FP greatly expands the numbers of people who are found to be unfit to plead yet to have treatment decision-making capacity.

The problem with NGRI is similar. How does one deal with a person who was 'insane' at the time of the offence, but now has capacity, refuses treatment, but is deemed dangerous. Again a Supervision Order with uncertain powers can be made. And again this occurrence is likely to be rare.

If some kind of enforceable supervision order for FP and NGRI (which however, did not allow involuntary treatment) could be created under a 'third way', there would be no need to retain the ML exceptions.

Implications for tribunals

Robinson poses the important question of how the ML would affect the proceedings of tribunals. Matters currently considered by Tribunals are relatively well understood by all parties, and these would necessarily change.

Robinson is right that capacity would need to be established prior to any further considerations. Whether this will involve a more complex and longer determination is not clear. We do not see why the nature of the evidence relating to this would be qualitatively different to the evaluation of evidence currently considered by tribunals – whether there is a mental disorder, whether it represents a sufficient risk to the health or safety of the patient, or to others, etc. The idea of capacity has a long history in the law and we do not see why ordinary people should find the idea difficult to understand. Everyone believes they have a basic right, within limits, to self-determination. Insight is a closely related concept and tribunals regularly discuss it. Whether patients knowing the law will be able to 'feign' capacity is unknown, but we assume that sufficient evidence will be placed before the tribunal by the clinical team to allow this to be tested. Similarly the consideration of best interests is unlikely to be qualitatively different to the current discussions about the value of treatment, risks, the influence of social support and so on. There will be differences in content and emphasis, but we do not see why they should not be able to determined as readily as matters are determined currently. Even if they should turn out to be more complex, they are, as we have argued from an ethical standpoint, the right questions, and it will be necessary for tribunals to learn how best to deal with them.

Advance statements

There has been a misunderstanding by some of the commentators of our intention in saying that advance decisions may be overridden "when treatment without the consent of the person is *expressly authorised* by the Act". There are only two circumstances in which such treatment is *authorised* without consent – in relation to fitness to plead and NGRI.

The burden imposed by the ML on informal patients and those on general hospital wards

Holland and Appelbaum argue that the ML imposes a set of burdensome regulations governing informal patients who lack capacity, especially those on general hospital wards, some of whom will now require an involuntary treatment order. As a result we have rethought these matters and propose some amendments.

We remain convinced that the ML recognises the relevant domains that should be covered for all patients, wherever they are treated, and establishes the right principles. However, we agree that in the real world

there are resource limitations that unfortunately need to be taken into account. The challenge is to formulate a law that is practicable so that all cases with impaired capacity can be covered by the principles.

The domains covered in Parts III, IV and V can be governed by variations in requirements for a range of elements – second opinions, consultation with a range of others, advocacy, reviews, appeals and time intervals for their implementation. We believe that a combination of these requirements can be found that will be applicable across the whole range of services. A 'lighter touch' can be adopted at many points in the ML. A relevant moderating contextual factor to be considered is the accreditation and inspection of health and social care institutions and our confidence in these procedures.

In most places the ML has followed the MCA and we do not wish to reopen a debate about its provisions, established after a long period of consultation and generally welcomed.

Our proposed amendments[14] are influenced by the following:

1. The scope of the 'General Authority' (clause 6) is of central importance; for example, it could cover all routine interventions (including intravenous fluids and mineral replacement – and perhaps standard antibiotic regimes), blood transfusion, emergency treatments, and restraint of patients when there is an immediate risk to their health or safety.
2. What comprises 'serious medical treatment' can be specified in regulations following further debate.
3. Protection for those in long-term care homes could be dropped as a statutory requirement in favour of 'good practice' and accreditation and inspection of homes.
4. 'Deprivation of Liberty' safeguards are at present only required in countries under the jurisdiction of the ECHR. But, despite difficulties in defining loss of liberty, we believe there is a strong case for establishing safeguards for non-objecting persons without capacity who are not free to leave an institution. Our amendments to Part IV of the ML propose a lighter touch, especially during the first 28 days.
5. Involuntary treatment: The boundary with the General Authority is hugely important. A clear and consistent objection to treatment outside routine care would lead to the initiation of involuntary treatment. Our amendments to Part V of the ML make significant changes. In the original version of the ML we accepted the general structure of recommendations and tribunals as in the MHA, first established in 1959. However, mental health practice has changed substantially over the ensuing five decades. Patients are no longer confined for long periods, hidden, in large mental hospitals. Practice is more open to scrutiny and is now largely in the community. Our amendments propose a lighter touch in keeping with such changes, and which would make the application of involuntary treatment feasible in general hospitals. Thought might be given to a less than 'three-person' tribunal to authorise an order (but retained for appeals).

We also note the comments of Atkinson and Patrick who draw attention to the often neglected position of patients with learning disabilities. We fear that these patients are sometimes incorrectly regarded as having capacity in order to avoid the uncertainties around the use of force that would be necessary in providing medical or surgical interventions.

In conclusion, we see the ML as a beginning. We aimed to show that practical expression could be given to the concept of a single statute governing the treatment of all persons who lack decision-making capacity, wherever they are treated or cared for. Whilst many details remain to be resolved, we believe we have succeeded in our aim.

14 The proposed amendments are presented in an Addendum at the end of the Model Law

The Model Law

Outline of the model law

Part I Principles

1. Principles of the Act

The following principles apply for the purposes of the Act:

(1) A person must be assumed to have capacity unless lack of capacity is established.

(2) A person is not to be treated as unable to make a decision unless all practicable steps to help the person to do so have been taken without success.

(3) A person is not to be treated as unable to make a decision merely because the person makes an unwise decision.

(4) An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests, except as otherwise specified.

(5) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

(6) All powers shall be exercised, and all services provided without any direct or indirect discrimination on the grounds of disability, age, gender, sexual orientation, race, colour, language, religion or national, ethnic or social origin and any differences on these grounds should be respected.

(7) Any compulsory detention or treatment of a person under the Act should be matched by a reciprocal duty to provide treatment and support that is likely to provide a health benefit to that person.

(8) Family members, friends or partners, who provide care to patients on an informal basis, should receive respect for their role and experience and have their views and needs taken into account.

Part II General provisions

2. Scope of the Act

Except as otherwise provided the Act applies to persons who because of an impairment or disturbance in the functioning of the mind lack the capacity at the material time to make a decision relating to their care or treatment.

3. Definition of capacity

(1) For the purposes of the Act a person ("P") is unable to make a decision and lacks capacity if unable:

(a) to understand the information relevant to the decision

(b) to retain that information

(c) to use, weigh or appreciate that information as part of the process of making the decision, or

(d) to communicate the decision (whether by talking, using sign language or any other means).

(2) The fact that P is able to retain the relevant information for a short period only does not prevent P from being regarded as able to make the decision.

4. Definition of best interests

(1) In determining what is in the best interests of a person ("P"), the decision-maker must consider all the relevant circumstances including whether it is likely that P will at some time have capacity in relation to the matter, and if so when that is likely to be.

(2) He or she must, so far as reasonably practicable, permit and encourage P to participate, or to improve P's ability to participate, as fully as possible in any act done, and any decision made, affecting P.

(3) The decision-maker must consider, so far as is reasonably ascertainable:

(a) P's past and present wishes and feelings (and, in particular, any relevant written statement made by P with capacity)

(b) the beliefs and values that would be likely to influence P's decision if he or she had capacity, and

(c) the other factors that P would be likely to consider if able to do so.

(4) The decision-maker must take into account, if it is practicable and appropriate to consult them, the views of:

(a) anyone named by P as someone to be consulted on the matter in question or on matters of that kind

(b) anyone engaged in caring for P or interested in P's welfare

(c) any substitute decision maker appointed by the person or appointed for the person by the Tribunal

as to what would be in P's best interests.

(5) Notwithstanding (4) above, if a clause of this Act requires the agreement of any person that provision shall apply.

(6) The principle of best interests applies to all decisions and to those participating as carers (or advocates) in decisions made on behalf of P, unless otherwise specified.

(7) For the purpose of this Act a substitute decision maker is a person who has been appointed by the person ("P") or by the Tribunal to act on behalf of P for the purposes of making decisions in relation to the care or treatment of P.

(8) If all the other factors above are met, a decision may be in P's best interests although it is not in accordance with P's present expression of wishes and feelings, and although P objects to the treatment.

(9) In determining best interests an advance refusal of treatment made by P in accordance with clause 53 shall be binding upon a decision maker in accordance with the provisions of clause 54.

(10) Where:

(a) under the Act, P's treatment is authorised only when it is in his or her best interests, and

(b) during the course of such treatment P poses a serious threat of harm to another person,

P may be provided with such treatment as is immediately necessary to prevent such harm occurring and is proportionate to the likely seriousness of that harm.

5. Further definitions: care and treatment and primary carer

(1) "Care or treatment" that may be provided under the Act includes actions in relation to medical treatment, nursing, psychological or care needs, habilitation and rehabilitation and specific welfare arrangements, and includes the use of restraint or seclusion in accordance with guidelines established by Regulations.

(2) "A decision in relation to care or treatment" of the person ("P") includes a decision to admit the person to a hospital or care home for the purposes of care or treatment.

(3) The "primary carer" is the person who has the closest day to day care of P or, in the absence of such a person, a person who has an ongoing concern for the well-being of P.

(4) The primary carer shall act in the role of substitute decision maker until another person is appointed unless:

(a) P objects to the primary carer being appointed

(b) the primary carer is unable to act or is otherwise unsuitable.

(5) If subclause (4)(a) or (b) applies the appropriate authority shall appoint an advocate to act in the role until the substitute decision maker is appointed.

(6) The advocate may at any time make an application to a single member Tribunal for a substitute decision maker to be appointed.

6. General authority

(1) Subject to the other provisions of the Act, a person is authorised to do an act with respect to the welfare, care or treatment of a person who lacks capacity ("P") if that act is in the best interests of P.

(2) Nothing in this clause excludes a person's civil or criminal liability resulting from negligence in doing the act.

(3) If that act involves the restraint of P the act must be a proportionate response to the likelihood of harm to P and the seriousness of that harm if the act is not done.

(4) A person restrains P if he or she:

(a) uses or threatens to use force to secure the doing of an act which P resists, or

(b) restricts P's liberty of movement, whether or not P resists, or authorises another person to do any of those things.

(5) This clause does not authorise the use of force on P to administer medication unless it is immediately necessary to prevent serious harm to P.

(6) This clause does not authorise the provision of serious medical treatment, unless the requirements of Part III are met.

(7) Except as provided by (3) above, this clause does not authorise the deprivation of P's liberty.

(8) This clause does not authorise a person to do an act that is contrary to:

(a) a decision made by P in a valid advance directive, as provided by clauses 53 and 54

(b) the decision of a substitute decision maker acting within the scope of his or her authority.

7. Application of the Parts of the Act[1]

The following Parts of the Act apply to certain decisions or acts:

(1) Part III applies if the decision or act involves serious medical treatment.

(2) Part IV applies if P does not object to the care or treatment but:

(a) is likely to require care or treatment in a hospital or care home for at least 28 days, or

(b) needs to be deprived of liberty in his or her best interests in a hospital or care home.

(3) Part V applies if a person ("P") objects to a decision or act that involves the provision of care or treatment to P, unless that decision or act is authorised by clause 6.

Part III Serious medical treatment

8. Application of this Part

Except as otherwise provided, this Part applies to every person receiving care or treatment under this Act or receiving treatment authorised by a substitute decision maker or the Tribunal under clause 49 or 50.

9. Requirements before serious medical treatment can be provided

(1) If a health or social care provider is proposing to provide, or secure the provision of, serious medical treatment for a person ("P") who lacks capacity to consent to the treatment, the following provisions apply:

(a) The clinician in charge of P's care or treatment (the responsible clinician) shall consult:

(i) P, unless inappropriate or impracticable

(ii) the substitute decision maker for P

(iii) P's primary carer.

1 *A possible amendment to Clause 7 following review of the commentaries (see our Response to Commentaries) is presented in the Addendum at the end of the Model Law.*

(b) Where no substitute decision maker has been appointed the responsible clinician shall apply to the Tribunal for the appointment of a suitable person to act.

(c) If the appointment of such a person is impracticable the primary carer of P shall be appointed to act in that role in accordance with clause 5(4).

(2) Before serious medical treatment is provided to P the approved clinician must prepare a written care plan.

(3) "Serious medical treatment" means treatment that is defined in Regulations.

10. Approved doctor to provide second opinion on serious medical treatment where there is a disagreement as to P's best interests

(1) In the event of a disagreement between the responsible clinician and the substitute decision maker, or person acting in that role under clause 5(4), that the treatment is in the best interests of a person ("P"), an approved doctor must examine P and give a second opinion.

(2) In any case where it is proposed to provide serious medical treatment to P a request for an approved doctor to examine P and give a second opinion may also be made by:

(a) the substitute decision maker

(b) an advocate

(c) P's primary carer.

(3) If agreement on whether the proposed treatment is in P's best interests still cannot be reached following the second opinion, the case will be referred to the Tribunal for a determination.

11. Treatment urgently required

(1) If serious medical treatment needs to be provided to a person who lacks capacity as a matter of urgency in order to save life or serious and imminent deterioration in health, it may be provided on the basis of the opinion of one medical practitioner despite the absence of a second opinion or a care plan.

(2) This clause does not authorise a person to provide treatment that is contrary to:

(a) a decision made by P in a valid advance directive, as provided by clauses 53 and 54

(b) the decision of a substitute decision maker acting within the scope of his or her authority.

12. Serious medical treatment requiring approval by a second medical opinion or the Tribunal

(1) If a healthcare provider is proposing to provide, or secure the provision of:

(a) electroconvulsive therapy

(b) medication for mental disorder beyond the period of 3 months from the date of the first treatment provided under this Act

(c) other treatments prescribed in Regulations

for a person ("P"), who lacks capacity to consent to the treatment, the agreement of an approved doctor qualified to give a second opinion on the treatment shall be obtained before the treatment proceeds.

(2) The agreement to the proposed treatment of the approved doctor who gives the second opinion shall be recorded on an approved form.

(3) Regulations shall provide for the period of time for which the approved form is in force.

(4) In respect of treatment provided under clause (1)(b) above, the maximum period for which the approved form shall be in force is 6 months.

(5) If a healthcare provider is proposing:

(a) to withhold or withdraw artificial nutrition or hydration from a person in a permanent vegetative state or a minimally conscious state

(b) organ or bone marrow donation by a person who lacks capacity to consent

(c) non-therapeutic sterilisation of a person who lacks capacity to consent

(d) other treatment prescribed by Regulations

an application shall be made to the Tribunal for a determination on the matter.

Part IV Informal Patients lacking capacity and needing care and treatment[2]

13. Application of this Part

(1) This Part applies to a person ("P") who because of an impairment or disturbance in the functioning of the mind is reasonably believed to lack the capacity to make a decision relating to his or her care or treatment (including accommodation for care and treatment) and:

(a) P is likely to require care and treatment in hospital or a care home for at least 28 days, or

(b) it is a reasonably believed that P needs to be deprived of liberty in his or her best interests in a hospital or care home.

14. Protections for informal patients in residential care

(1) If a person ("P") to whom this Part applies is receiving care or treatment in a hospital or care home, or it is necessary for him or her to enter hospital or a care home for care or treatment, and:

(a) treatment can lawfully be provided without P being subject to the provisions of Part V

(d) it is likely that P will continue to lack capacity and to require care or treatment in hospital or a care home for at least 28 days

an approved clinician shall examine P.

(2) If the approved clinician is satisfied that:

(a) P lacks capacity in relation to care or treatment in the hospital or care home

(b) care or treatment in the hospital or care home for at least 28 days is in P's best interests

P may be admitted to that hospital or care home and the hospital or care home shall register P with the appropriate authority.

2 *We propose a number of simplifying amendments to Part IV in the light of the commentaries (see our Response to Commentaries) – A simplified Part IV, now dealing only with 'Deprivation of Liberty' can be found in the Addendum at the end of the Model Law.*

(3) The appropriate authority shall appoint a person as the responsible clinician in charge of the care or treatment of P.

15. Requirements for informal patients lacking capacity and requiring residential care for a significant period

(1) The responsible clinician shall prepare a written care plan.

(2) Before preparing the care plan the responsible clinician shall consult the substitute decision maker for P or, in the absence of such a person, the primary carer.

(3) A copy of the care plan should be provided to P, the substitute decision maker, the carer and an advocate of P.

16. Review of care plan

The care plan shall be reviewed by the approved clinician at regular intervals, as specified by Regulations.

17. Requirements for informal patients lacking capacity and needing to be deprived of liberty in their best interests

(1) In the following situation, clause 18 applies:

(a) a person ("P") to whom this Part applies:

(i) is receiving care or treatment in a hospital or care home, or

(ii) it is necessary for P to enter a hospital or care home for care or treatment

(b) treatment can be lawfully be provided without P being subject to the provisions of Part V

(c) it is reasonably believed that P needs to be deprived of liberty in his or her best interests.

18. Conditions for deprivation of liberty

(1) When the conditions specified in clause 17 apply, a registered medical practitioner and an approved health or social care professional must each examine P and decide whether the following conditions are met:

(a) P lacks capacity in relation to whether he or she should be accommodated in the relevant hospital or care home for care or treatment

(b) P has an impairment or dysfunction of the mind

(c) it is in P's best interests to be a detained resident

(d) deprivation of liberty is a proportionate response to the likelihood of P suffering harm, and the likely seriousness of that harm.

(2) P is to be considered to be deprived of liberty within this Part if:

(a) he or she would not be permitted to leave the hospital or care home upon expressing a wish to do so or attempting to do so, or

(b) effective control is exercised over P's care and his or her freedom of movement is so confined as to amount to a deprivation of liberty.

(3) Before a person may be deprived of liberty under this clause the period of deprivation of liberty shall be agreed by the registered medical practitioner and the health or social care professional.

(4) This period shall not exceed 12 months.

(5) If it is an emergency P may be deprived of liberty on the basis of one assessment provided that the second assessment occurs within 72 hours.

(6) Where the examiners are agreed that conditions of this clause are met, P may be deprived of liberty in the manner authorised.

19. Formal procedures for deprivation of liberty

(1) If the registered medical practitioner and the approved health or social care professional agree that the conditions in clause 18(1) are met, the hospital or care home shall register P with the appropriate authority.

(2) The appropriate authority shall appoint a person as the responsible clinician in charge of the care or treatment of P.

(3) The responsible clinician shall prepare a written care plan.

(4) Before preparing the care plan the responsible clinician shall consult the substitute decision maker for P or, in the absence of such a person, the primary carer.

(5) A copy of the care plan shall be provided to P, the substitute decision maker, the carer and an advocate of P.

(6) If there is no substitute decision maker the responsible clinician shall apply to the Tribunal to appoint one.

20. Applications to the Mental Capacity Tribunal

P, P's primary carer, or P's substitute decision maker may apply to the Tribunal for a review of a decision to admit P to a hospital or care home or to deprive P of liberty under this Part.

Part V Compulsory Provision of Care and Treatment[3]

21. Application of this Part

(a) This Part applies to a person ("P") if the following conditions are met:

(1) P has an impairment or dysfunction of the mind.

(2) P lacks capacity to make a decision about his or her care or treatment.

(3) P needs care or treatment in his or her best interests.

(4) P objects to the decision or act that is proposed in relation to his or her care or treatment and that decision or act is not authorised by clause 6.

(5) The proposed objective cannot be achieved in an alternative less restrictive fashion.

(6) Treatment is available that is likely to alleviate or prevent a deterioration in P's condition.

3 *We propose a number of amendments to Part V that simplify the compulsory treatment process as a result of the commentaries (see our Response to the Commentaries). The amendments include a change to Clause 27 (3) and revised Clauses 28–33. They are presented in the Addendum at the end of the Model Law.*

(7) The exercise of compulsory powers is a necessary and proportionate response to the risk of harm posed to P or any other person, and to the seriousness of that harm, if the care or treatment is not provided.

(b) If any of these conditions are no longer met P shall be discharged from compulsory powers.

22. Preliminary examination

(1) If the appropriate authority receives a reasonable request for a health assessment of a person ("P") from any person with a legitimate interest in P's welfare, and if the conditions in clause 21 appear to be met in P's case, it must, as soon as practicable after receiving the request, arrange for P to be examined by a registered medical practitioner.

(2) After examining P, if the registered medical practitioner considers it likely that all the conditions in clause 21 are met in P's case and that compulsory assessment is necessary, the registered medical practitioner may apply to the authority for the compulsory assessment and registration of P.

(3) The appropriate authority shall:

(a) appoint a responsible clinician to be in charge of the assessment, care or treatment of P

(b) ensure P is advised, as far as practicable, of the availability of advocates

(c) register P as a compulsory patient

(d) provide P with a copy of the certificate of registration and appropriate information.

(4) P may be detained in hospital for assessment and treatment under this clause for up to 24 hours from the time of admission to hospital, or the responsible clinician may direct that P be assessed in the community if that would be safe and viable, provided no treatment is provided to P that is contrary to clause 28 below.

(5) The substitute decision maker for P or the primary carer shall be consulted concerning P's assessment if practicable.

23. Powers of entry and inspection

An approved health or social care professional as provided in Regulations may at all reasonable times enter and inspect any premises (not being a hospital) in which a person who lacks mental capacity is living, if he or she has reasonable cause to believe that the person is not under proper care.

24. Power to take a person to a place of safety

(1) If it appears to a justice of the peace on information on oath by an approved health or social care professional that there is reasonable cause to suspect that a person ("P") appears to lack capacity to make decisions about his or her care or treatment and:

(a) has been, or is being, ill treated or neglected in any place, or kept otherwise than under proper control, or

(b) being unable to care for himself or herself is living alone and is in need of care and attention

the justice may issue a warrant authorising a police officer to enter the premises, by force if necessary, and if thought fit to remove P to a place of safety with a view to making proper arrangements for P's care.

(2) If a police officer finds in a place to which the public have access a person ("P") who appears to be unable to make decisions about care or treatment, and who appears to be in immediate need of care or control, the constable may, if he or she thinks necessary to do so in the best interests of that person or for the protection of others, remove that person to a place of safety.

(3) P may be detained under this clause for a period not exceeding 24 hours for the purpose of being examined by a registered medical practitioner under clause 22.

25. Conveyance to hospital

(1) A person:

(a) for whom an application for compulsory assessment has been made by a registered medical practitioner

(b) who has been registered as a compulsory patient under clause 22(3)

(c) who is lawfully recalled to hospital by the responsible clinician

may be taken by an authorised person and conveyed to a hospital, or to another designated place of assessment, at any time within the following 72 hours.

(2) The range of persons who may be authorised to exercise this power shall be designated by Regulations.

26. Application in respect of patient already in hospital

If, in the case of a person ("P") who is receiving treatment in a hospital, it appears to a nurse of the prescribed class:

(a) that P is suffering from an impairment or dysfunction of the mind of such a degree that it is necessary for P's health or safety or for the protection of others for P to be immediately restrained from leaving the hospital; and

(b) that it is not practicable to secure the immediate attendance of a practitioner for the purpose of furnishing a report under clause 22

the nurse may record that fact in writing, and in that event P may be detained in the hospital until a medical practitioner has arrived and examined P, provided that the maximum period for which P may be detained under this clause is 6 hours.

27. Initial assessment

(1) At the end of 24 hours after the person ("P") is registered as a compulsory patient, he or she must be discharged from compulsory care, unless a health or social care professional as provided in Regulations has examined P and made a report to the appropriate authority that the conditions in clause 21 are likely to be met in P's case and that it is appropriate for P to be subject to initial assessment under this Part.

(2) The report under the above clause shall not be provided by the registered medical practitioner who provided the initial report under clause 22.

(3) If both examiners agree that the conditions appear to be met, P may be detained and given care or treatment for a further 7 days, or the responsible clinician may direct that P be assessed in the community as provided below, but no treatment may given to P contrary to clause 28 below.

(4) Each examiner must give an opinion as to whether it is appropriate for P:

(a) to be detained in a hospital while the assessment is carried out, or

(b) to be assessed in the community.

(5) In considering whether it is appropriate for the assessment to take place in the community they shall each consider:

(a) P's views on being assessed in the community

(b) whether P can be safely and effectively assessed in the community

(c) whether care or treatment for P can be provided safely and effectively in the community.

(6) If, during the period of assessment, the responsible clinician considers:

(a) a person under community assessment requires care or treatment in hospital

(b) a person in hospital could be adequately assessed in the community

the responsible clinician may direct such a change in the place of assessment.

(7) If at any time during the period of initial assessment the responsible clinician considers there are no longer reasonable grounds to believe that P meets the conditions in clause 21, the responsible clinician shall immediately discharge P from compulsory assessment.

28. Treatment within the period of preliminary examination and initial assessment

(1) During the period of preliminary examination and initial assessment the person ("P") may not be provided with medical treatment to which he or she objects unless:

(a) it is covered by the general authority established by clause 6

(b) it is necessary to save life or prevent serious and immediate deterioration in P's health or to protect another person from harm

(c) where serious medical treatment is to be provided that is covered by clause 12, the requirements of that clause are satisfied.

(2) Any treatment provided under (1)(a) or (b) shall not be given in the community but P shall be conveyed to hospital for the purposes of treatment.

29. The end of the initial assessment period

(1) Before the end of the 7 day period of initial assessment the responsible clinician may apply to the Tribunal for:

(a) an Assessment Order for up to 28 days

(b) a Compulsory Treatment Order.

(2) If no application is made to the Tribunal the authority for the compulsory assessment of P shall lapse at the end of 7 days.

(3) An Assessment Order may be made, following an initial hearing, by a single member Tribunal.

(4) A Compulsory Treatment Order may be made, following a full hearing, by a three member Tribunal.

(5) An application may not be made for a Compulsory Treatment Order under (1)(b), without an initial Assessment Order having first been made, unless:

(a) a substitute decision maker has been appointed for P and he or she does not object

(b) P has on a previous occasion been admitted to hospital lacking capacity and needing treatment in his or her best interests and was, immediately prior to registration under this Part, being treated as a voluntary patient in the same health service.

30. Preliminary care plan

(1) Prior to the hearing before the Tribunal concerning the Assessment Order, the responsible clinician shall prepare a preliminary care plan, setting out the medical treatment which the person ("P") is to receive under compulsory powers.

(2) This plan shall be included in P's records.

(3) A copy of the plan shall be provided to P and to his or her SDM.

(4) If it is appropriate for the person ("P") to be subject to assessment under the Assessment Order in the community, the plan must specify the conditions to be imposed on P:

(a) to ensure that the assessment may be properly carried out

(b) to protect the health or safety of P or any other person.

(5) The conditions may include a condition that P:

(a) attends at a specified place at specified times

(b) makes himself or herself available for assessment during specified periods.

(6) Before making a determination that it is appropriate for P to be assessed in the community or specifying any conditions under (2) the examiner must consult:

(a) P, unless inappropriate or impracticable

(b) the substitute decision maker

(c) any person who will have the care of P in the community.

31. General consultation requirements under the preliminary care plan

(1) Before finalising the preliminary care plan the responsible clinician shall consult the substitute decision maker, or, if no substitute decision maker has been appointed, the person who provides care for P (the primary carer).

(2) If the substitute decision maker does not agree with any element of the plan this shall be recorded in the plan and the matter shall be decided by the Tribunal.

32. Initial hearing before the Mental Capacity Tribunal

(1) An application for an Assessment Order shall be heard before a Tribunal consisting of a single legal member.

(2) The Tribunal shall discharge the patient if the conditions in Clause 21 are not met.

(3) If the Tribunal decides that the conditions in Clause 21 are met and it is appropriate to do so it shall make an Assessment Order.

(4) At any time prior to the making of the Assessment Order, on application by the primary carer, an advocate acting on behalf of P, or the responsible clinician, the Tribunal shall have the power to appoint a substitute decision maker.

(5) When making an order under (3) the Tribunal may set a date within 28 days for a full hearing concerning a Compulsory Treatment Order.

33. Assessment Orders

(1) The Assessment Order shall:

(a) specify the length of the assessment period, which shall not exceed 28 days

(b) authorise the provision of compulsory treatment under a preliminary care plan, provided no treatment is authorised contrary to Part III of the Act

(c) appoint a substitute decision maker if none has been appointed.

(2) If the Assessment Order expires before a Compulsory Treatment Order is made P shall be immediately discharged from compulsory assessment.

34. Compulsory Treatment Orders

(1) The responsible clinician may apply to the Full Tribunal during the compulsory assessment period for a Compulsory Treatment Order.

(2) The full Tribunal shall consist of a legal member, a medical member and a lay member

(3) The legal member of the Tribunal shall be the presiding officer.

(4) The application shall be based on:

(a) the written recommendation of a registered medical practitioner and another health or social care professional that the conditions in clause 21 are met

(b) a draft care plan.

(5) if the Tribunal finds that the conditions in clause 21 are met it may make an order considered appropriate in the circumstances.

(6) The Tribunal may specify the kinds of conditions that can be imposed by the responsible clinician on the person ("P") within the community. These conditions may include:

(a) where P may reside

(b) where and when P shall attend for treatment

(c) restrictions or limits that can be imposed on P's conduct or freedom of movement, provided that any such restrictions must be proportionate to the harm that is likely to occur if they are not imposed.

(7) The Tribunal shall authorise the care plan, subject to any amendments it requires, although amendments to the treatment provisions may only be made with the agreement of the Responsible Clinician and the medical member of the Tribunal.

(8) Once it has been authorised by the Tribunal, the care plan provides sufficient authority for authorised persons to provide the care or treatment described in the plan, including the authority to detain P in hospital, and to return P to hospital if he or she is absent without permission, when hospital treatment is included in the plan.

(9) The duration of the order shall be specified by the Tribunal but shall not exceed 6 months.

(10) P or P's substitute decision maker may make one application to the tribunal for review of the terms of, or discharge from, the Compulsory Treatment Order, at any time while the order is in force.

(11) Notwithstanding (10), P or P's substitute decision maker may apply to the Tribunal for review of, or discharge from, the Compulsory Treatment Order if P is returned from community treatment to detention in hospital for treatment for more than 72 hours.

35. The care plan

(1) The care plan to be approved by the Tribunal must include:

(a) a description of the medical treatment to be provided to the person ("P") while the plan is in force, provided no treatment may be authorised contrary to Part III

(b) such other information relating to the care of P as may be prescribed in Regulations.

(2) In preparing a plan for P, the responsible clinician must consult the following persons about the treatment proposed:

(a) P, unless inappropriate or impracticable

(b) P's substitute decision maker

(c) the primary carer of P.

(3) The responsible clinician must send a copy of the plan to:

(a) P

(b) P's substitute decision maker

(c) the primary carer of P

as soon as practicable after the plan is in force.

(4) The responsible clinician may amend the care plan with the agreement of the substitute decision maker at any time while it is in force.

(5) If there is disagreement between the responsible clinician and the substitute decision maker as to:

(a) a change to the treatment

(b) a condition of a community treatment order

(c) a change in the location of treatment from community to hospital or from hospital to community

and it cannot be resolved between them, an opinion shall be sought from a approved doctor qualified to give a second opinion and the change shall not be instituted without his or her agreement.

36. Renewal and termination of Compulsory Treatment Orders

(1) If at any time during the life of a Compulsory Treatment Order the responsible clinician considers the conditions in clause 21 are no longer met, the responsible clinician shall discharge P from the Order.

(2) The responsible clinician may, before the Compulsory Treatment Order has expired, apply to the Tribunal for a new order under Clause 34.

(3) If no new order has been made, the order shall lapse at its conclusion and P shall be immediately released from compulsory treatment.

37. Community treatment

(1) Before deciding whether the person ("P") may reside in the community under a Compulsory Treatment Order the responsible clinician shall be satisfied that:

(a) compulsory care in the community is compatible with safe and effective care

(b) appropriate services are available in the community

(c) P has been consulted as far as practicable, and P's views carefully considered, as to whether community treatment should proceed

(d) any carers have been consulted and their views considered

(e) the SDM has been consulted and his or her view considered.

(2) If the conditions in (1)(a) or 1(b) cease to apply P shall be recalled by the responsible clinician to hospital or discharged from compulsory care.

38. Power to recall to hospital

(1) The responsible clinician may recall to hospital a person ('P") under compulsory treatment in the community, if the responsible clinician considers:

(a) P requires medical treatment in hospital; and

(b) there would be a risk of harm to the health or safety of P or to other persons if P were not recalled to hospital for that purpose.

(2) The responsible clinician may also recall P to hospital if P fails to comply with a condition specified under clause 34(6) above.

(3) The lawful recall of P to hospital shall be sufficient authority for an authorised person to take and convey P to hospital and for P to be detained there in accordance with the provisions of the Act.

39. Treatment without consent under Assessment Order or Compulsory Treatment Order

The consent of a person ("P"), who is the subject of an Assessment Order or a Compulsory Treatment Order, shall not be required for the provision to P of any treatment, given by or under the direction of P's responsible clinician:

(a) that is covered by the general authority established by clause 6

(b) that is included in the care plan approved by the Tribunal, or in a lawfully amended care plan

(c) that needs to be provided as a matter of urgency in order to save P's life or serious and imminent deterioration in P's health.

Part VI Forensic provisions

40. Remand on bail or to hospital for a report on mental condition

(1) An accused person (P) charged with a criminal offence may be remanded by the court on bail or, if it would be impractical for P to be assessed on bail, to hospital for up to 28 days for a report to be prepared on his or her mental condition, where:

(a) the court is satisfied on the evidence of a medical practitioner that there is reason to suspect that P has an impairment or dysfunction of mind, and

(b) P consents to the exercise by the court of this power, or

(c) if P lacks capacity to consent, the court is satisfied on the evidence of a medical practitioner that an assessment is in P's best interests.

(2) P and P's substitute decision maker may request a second medical opinion as to whether the conditions in (1) are met.

(3) P may appeal to the Tribunal against the order, and if the Tribunal is satisfied that any of the conditions in (1) are not met, it shall discharge P from assessment.

41. Remand to hospital for treatment

(1) An accused person (P) charged with a criminal offence may be remanded by the court on bail or, if it would be impractical for P to be treated on bail, to detention in hospital for treatment for his or her mental condition, provided that:

(a) the court is satisfied on the evidence of a medical practitioner and an approved health or social care professional that P has an impairment or dysfunction of the mind

(b) P needs care or treatment for his or her health or safety or the safety of another person

(c) where P has capacity he or she consents to the exercise by the court of this power, or where P lacks capacity the court is satisfied on the evidence of a medical practitioner that treatment is in P's best interests

(d) treatment is available which is likely to alleviate or prevent a deterioration in P's condition.

(2) P and P's substitute decision maker may request a second medical opinion as to whether the conditions in (1) are met.

(3) The duration of the order shall not exceed 6 months.

42. Due process and treatment during remand under clause 40 or 41

(1) The accused person ("P") must be represented by a lawyer when a court makes a remand order under clause 40 or 41.

(2) P may apply to the Tribunal for discharge from a remand order, and if the Tribunal is satisfied that any of the conditions in clause 40(1) or 41(1) are not met, as required, P shall be discharged from the order and returned to the court.

(3) P and P's substitute decision maker may request a second medical opinion, to be placed before the court or Tribunal, as to whether the conditions in clause 40(1) or 41(1) are met.

(4) During a remand for assessment or treatment under clause 40 or 41, P may not be provided with medical treatment to which he or she objects, unless:

(a) it is covered by the general authority established by clause 6, or

(b) there are reasonable grounds to believe P lacks the capacity to consent to treatment, and

(i) the treatment is necessary to save life or prevent serious and immediate deterioration in P's health, or to protect another person from harm

(ii) where serious medical treatment covered by clause 12 is to be provided, the requirements of that clause are satisfied.

(5) That a person has been remanded for assessment or treatment does not prevent an application being made for that person's compulsory assessment or treatment under Part V.

43. A hospital order with a concurrent sentence

(1) If a person is convicted of a criminal offence punishable by imprisonment the court may, after determining the sentence for the offence, make an order that the person ("P") be detained in hospital, if the court is satisfied on the evidence of a medical practitioner and a social or health professional that the following conditions are met:

(a) P has an impairment or dysfunction of the mind

(b) P needs care or treatment in his or her best interests or to protect the safety of another person

(c) treatment is available that is likely to alleviate or prevent deterioration in P's condition

(d) if P has capacity he or she is willing to accept treatment for the disorder, or if P lacks capacity treatment is in his or her best interests.

(2) P may be treated under this order despite his or her objection so long as P lacks capacity to consent to treatment, provided that where serious medical treatment covered by clause 12 is to be provided, the requirements of that clause must be satisfied.

(3) While P is under treatment in a hospital under this provision P's sentence will continue to run.

(4) If any of the conditions in (1) are no longer met P shall be admitted to prison to complete the sentence or, if the sentence is in the community, to the terms of the sentence.

(5) P may apply to the Tribunal for discharge from a treatment order made under this clause, and if any of the conditions in (1) are no longer met the Tribunal shall discharge P from the order, and P shall then be admitted to prison to complete his or her sentence or, if the sentence is in the community, the terms of the sentence.

(6) Where at the end of P's sentence the conditions in (1) continue to apply:

(a) if P lacks capacity to consent to treatment P shall be deemed to be subject to a compulsory treatment order made under clause 34

(b) if P has capacity and is willing to consent to treatment he or she shall be treated as a voluntary patient.

44. Treatment order without a concurrent sentence

(1) Where a person ("P") is convicted of an offence punishable by imprisonment the court may make a treatment order without sentencing P if:

(a) P has an impairment or dysfunction of the mind

(b) P lacks capacity to make a decision about his or her care or treatment

(c) P needs care or treatment in his or her best interests

(d) treatment is available that is likely to alleviate or prevent deterioration in P's condition

(e) the care or treatment cannot safely be provided in a less restrictive manner

(f) the court is of the opinion, having regard to all the circumstances of the case, including the nature of the offence and the character and antecedents of the offender and other methods of dealing with P, that an order under this clause is the most suitable method of disposing of the case.

(2) A treatment order made under this clause deems P to be subject to a compulsory treatment order made under clause 34 and the associated provisions of the Act shall apply.

45. Treatment order for a person found not guilty by reason of insanity or unfit to plead

(1) If a person ("P") accused of an offence punishable by imprisonment is found not guilty by reason of insanity or unfit to plead for the offence, the court may:

(a) if it considers it necessary in the interests of P or to protect the safety of another person, order P's detention in hospital for treatment under this clause

(b) make a Compulsory Treatment Order for P under clause 34, if the conditions for such an order are met

(c) make no order, if P is subject to a sentence imposed on another charge

(d) if it would be safe to do so, direct P's immediate release.

(2) Where the court orders P's detention in a hospital under clause (1)(a) the consent of P shall not be required for the provision of treatment to P by or under the direction of his or her responsible clinician, for the duration of the order, where the following conditions are met:

(a) where serious medical treatment covered by clause 12 is to be provided, the requirements of that clause are satisfied

(b) where P lacks the capacity to consent, the treatment is in P's best interests or necessary to protect the safety of others

(c) where P has the capacity to consent, the responsible clinician is satisfied that:

(i) P needs treatment in his or her own interests or for the protection of another person from harm

(ii) P is suffering from an impairment or dysfunction of the mind that contributed significantly to the acts or omissions that constituted the offence

(iii) treatment is available that is likely to alleviate or prevent a deterioration in P's condition and is likely to reduce the risk of the recurrence of those acts or omissions.

(3) P may apply to the Tribunal for discharge from an order under clause (1)(a) at intervals specified by Regulations.

(4) Where, on such an application, the Tribunal is satisfied that the order is no longer necessary in the interests of P or for the protection of others, or that continuation of the order would be disproportionate to the seriousness of the offence with which P was charged, the Tribunal shall:

(a) exercise the power under clause 34 to make a Compulsory Treatment Order for P, if the conditions for such an order are met;

(b) direct P's discharge from the order.

46. Transfer from prison to hospital

(1) A person ("P") serving a custodial sentence may be transferred from prison to hospital if one medical practitioner and one health or social care professional certify that the following conditions are met:

(a) P has an impairment or dysfunction of the mind

(b) P needs care or treatment in hospital

(c) treatment is available which is likely to alleviate or prevent a deterioration in P's condition

(d) if P retains capacity he or she is willing to accept treatment

(e) if P lacks capacity, treatment is in his or her best interests.

(2) If any of the conditions in (1) are no longer met P shall be admitted to prison to complete the sentence.

(3) P may apply to the Tribunal for discharge from treatment in hospital under this clause, and if any of the conditions in (1) are no longer met the Tribunal shall discharge P and direct that P be admitted to prison to complete his or her sentence.

47. Care plans for patients detained under Part VI

(1) A preliminary care plan shall be prepared for a person remanded to hospital for assessment under clause 40 as if that person was subject to an Assessment Order under clause 33.

(2) A care plan shall be prepared for a person ordered to undergo treatment in hospital under clauses 41, 43, 44, 45 and 46, as if that person was subject to a Compulsory Treatment Order under Part V.

Part VII The Mental Capacity Tribunal

48. The Mental Capacity Tribunal

(1) There shall be a Mental Capacity Tribunal that shall consist of two divisions:

(a) the Primary Division

(b) the Appeal Division.

(2) The Primary Division shall hear all cases in the original jurisdiction except matters reserved to the Appeal Division.

(3) Hearings before the Primary Division may, as provided in the Act, be conducted by a single legal member of the Tribunal.

(4) In all other cases the Primary Division shall comprise three members, a legal member, a medical member and a lay member.

(5) The legal member of the Tribunal shall preside.

(6) The Appeal Division shall have the powers of a court and shall be presided over by a judge.

(7) The Appeal Division shall have jurisdiction over:

(a) appeals from the Primary Division

(b) any other specified matters.

Part VIII Patient safeguards

49. Appointment of person to act as substitute decision maker

(1) P may appoint a substitute decision maker to have authority to make decisions about P's care or treatment in the event that P has lost the capacity to make the decisions.

(2) P must have reached 18 and have capacity to make the gift of power.

(3) The gift of power must be in writing and be witnessed.

(4) Subject to (5) the authority includes the power to consent to or to refuse treatment by a person providing care (subject to an advance refusal by P).

(5) The power conferred on a substitute decision maker shall not authorise:

(a) giving or refusing consent to life sustaining treatment unless the power expressly so provides

(b) the provision of treatment contrary to Parts III, IV or V of the Act

(c) the provision of treatment to which the patient objects unless that treatment is authorised by clause 6.

50. Powers of the Tribunal to make decisions and appoint substitute decision makers

(1) If a person ("P") lacks capacity in relation to any matter concerning his or her care or treatment the Tribunal may:

(a) by making an order, make the necessary decision or decisions on P's behalf, or

(b) appoint a person (the "substitute decision maker") to make decisions on P's behalf in relation to a specified matter or matters.

(2) The Tribunal shall not authorise the provision of treatment contrary to Parts III, IV or V of the Act.

51. The appointment of advocates

(1) The appropriate authority must make reasonable arrangements to enable persons ("independent mental capacity advocates") to be available to represent and support persons for whom acts or decisions are proposed under the Act.

(2) For the purpose of carrying out his or her functions, an independent mental capacity advocate:

(a) may interview in private the person whom he or she has been instructed to represent

(b) may, at all reasonable times, examine and take copies of any health record or a record in connection with a social services function, which in his or her opinion may be relevant to the independent mental capacity advocate's investigation.

(3) The appropriate authority must inform P of the availability of advocates whenever P becomes subject to any Part of this Act.

52. Functions of advocates

(1) The functions of independent mental capacity advocates include:

(a) providing support to the person whom the advocate has been instructed to represent ("P") so that P may participate as fully as possible in any relevant decision

(b) obtaining and evaluating relevant information

(c) ascertaining P's likely wishes and feelings, and the beliefs and values that would be likely to influence P, if he or she had capacity

(d) ascertaining what alternative courses of action are available in relation to P

(e) obtaining a further medical opinion where treatment is proposed and the advocate thinks that one should be obtained

(f) challenging, or providing assistance for the purpose of challenging, any relevant decision.

53. Advance decisions to refuse treatment

(1) "Advance decision" means a decision made with capacity by a person ("P") aged 18 years or over:

(a) that if at a later time and in such circumstances as P may specify a particular treatment is proposed to be carried out or continued by a person providing health care for P, and

(b) at that time P lacks capacity to consent to the carrying out or continuation of that treatment

the specified treatment is not to be carried out or continued.

(2) P may withdraw or alter an advance decision at any time when P has capacity.

(3) A withdrawal (including a partial withdrawal) need not be in writing.

(4) An advance decision is not valid if P has, after the advance decision was made, conferred authority on a substitute decision maker to give or refuse consent to the treatment to which the advance decision relates, or has done anything else clearly inconsistent with the advance decision remaining P's fixed decision.

(5) An advance decision is not applicable to the treatment in question if any circumstances specified in the advance decision are absent, or there are reasonable grounds for believing that circumstances exist which P did not anticipate at the time of the advance decision and which would have affected P's decision.

(6) An advance decision is not applicable to life-sustaining treatment unless the decision is verified by a statement by P to the effect that it is to apply to that treatment even if life is at risk.

(7) To be effective:

(a) an advance decision must be in writing and signed by P or by another person in P's presence and by P's direction

(b) P's signature on the advance directive must be made or acknowledged by P in the presence of a witness who also signs the document in P's presence.

54. Effect of advance decisions

(1) If P has made an advance decision which is valid, and applicable to a treatment, the decision has effect as if he or she had made it, and had had capacity to make it, at the time when the question arises whether the treatment should be carried out or continued.

(2) Nothing in an apparent advance decision stops a person:

(a) providing life-sustaining treatment, or

(b) doing any act he reasonably believes to be necessary to prevent a serious deterioration in P's condition,

while a decision on any relevant issue is sought from the Tribunal.

(3) Where a substitute decision maker is appointed for P that person shall not have authority over those treatments that are covered by a valid advance decision made by P unless P has subsequently conferred express authority on the substitute decision maker to make decisions of that kind.

Addendum

Possible amendments to Parts IV and V following review of the commentaries:

As a result of a consideration of the commentaries on the Model Law we propose a number of possible amendments to Parts IV and V that take account of some of the points raised (see our response to the commentaries). We here reproduce the complete clauses as amended.

Clause 7 needs to be amended to allow for the changes in Part IV

7. Application of the Parts of the Act

The following Parts of the Act apply to certain decisions or acts:

(1) Part III applies if the decision or act involves serious medical treatment.

(2) Part IV applies if P does not object to the care or treatment but is likely, at some time within the next 28 days, to require care or treatment in a hospital or care home in circumstances that amount to deprivation of liberty.

(3) Part V applies if a person ("P") objects to a decision or act that involves the provision of care or treatment to P, unless that decision or act is authorised by clause 6.

Part IV Persons lacking capacity who need to be deprived of their liberty

Part IV now deals only with provisions for the deprivation of liberty and comprises just three clauses. The original **Clauses 16 – 20** are eliminated.

13. Application of this Part

(1) This Part applies to a person ("P") when the following conditions are met:

(a) P, because of an impairment or disturbance in the functioning of the mind, lacks the capacity to make a decision relating to his or her care or treatment (including accommodation for care and treatment)

(b) P is likely, at some time within the next 28 days, to require care or treatment in a hospital or care home in circumstances that amount to deprivation of liberty

(c) P does not object to receiving care or treatment in circumstances that amount to deprivation of liberty

(d) P needs to be deprived of liberty in his or her best interests

(e) deprivation of liberty is a proportionate response to the likelihood of P suffering harm, and the likely seriousness of that harm.

(2) P shall be considered to be deprived of liberty within this Part if:

(a) he or she would not be permitted to leave the hospital or care home upon expressing a wish to do so or attempting to do so, or

(b) effective control is exercised over P's care and his or her freedom of movement is so confined as to amount to a deprivation of liberty.

14. Deprivation of liberty

(1) P may be deprived of liberty under this Part for up to 28 days when a registered medical practitioner has examined P and certified in writing to the hospital or care home in which P is already accommodated or which has agreed to admit P that the conditions in clause 13 are met.

(2) The hospital or care home shall then register P with the appropriate authority.

(3) The appropriate authority shall appoint a person as the responsible clinician in charge of the care or treatment of P.

(4) Registration provides the authority for the conveyance of P to the hospital or care home.

(5) The responsible clinician shall prepare a written care plan for P.

(6) Before preparing the care plan the responsible clinician shall consult the substitute decision maker for P or, in the absence of such a person, the primary carer.

(7) A copy of the care plan shall be provided to P, the substitute decision maker, the primary carer and any advocate of P.

(8) If there is no substitute decision maker the responsible clinician shall apply to the Tribunal to appoint one.

(9) If the conditions are no longer met within the period of 28 days specified in subclause (1) above the responsible clinician shall certify that fact in writing to the hospital or care home and P shall be released from these provisions

(10) A deprivation of liberty may only extend beyond 28 days if another health or social care professional, who is independent of the care or treatment team, has also examined P and certified that the conditions in clause 13 are met, whereupon deprivation of liberty under this Part is authorised for up to 12 months.

(11) The period of deprivation of liberty shall not exceed 12 months, unless the responsible clinician and another health or social care professional, who is independent of the treatment team, each examine the patient and certify that the conditions in clause 13 continue to be met, in which case the deprivation of liberty may extend for another agreed period up to 12 months.

15. Applications to the Mental Capacity Tribunal

P, P's primary carer, or P's substitute decision maker may apply to the Tribunal for a review of a decision to deprive P of liberty under this Part

Part V. The Compulsory Treatment Order could be amended to provide for a simplified assessment process by amending **Clause 27(3)** and by replacing **Clauses 28–33** as follows:

27 *(3)* Requires a small change so that treatment for a further 7 days cannot be given contrary to Clause 31 below (not Clause 28 in the original)

28 Certificate of Further Assessment

(1) During the period of initial assessment the responsible clinician may complete a Certificate of Further Assessment stating in writing his or her view that:

(a) the conditions in clause 21 are met; and

(b) a further period of assessment is required.

(2) The completion of that Certificate authorises further compulsory assessment of P for up to 21 further days.

29. Application for Compulsory Treatment Order

(1) Before the end of the 21 day period of further assessment the responsible clinician may apply to the Tribunal for a Compulsory Treatment Order.

(2) If no such application is made the authority for the compulsory assessment of P shall lapse at the end of the period of further assessment.

(3) A Compulsory Treatment Order may be made, following a full hearing, by a three member Tribunal.

30. Urgent application for a hearing before Tribunal

(1) At any time during the period of P's initial or further assessment, P, P's SDM, P's primary carer, or any other person with a legitimate interest in P's welfare, may apply to the Tribunal for an urgent hearing concerning P's need for compulsory assessment.

(2) That application will be heard by a single member Tribunal within 7 days.

(3) Following that hearing, the Tribunal shall order P's immediate release from compulsory assessment unless it finds that the conditions in clause 21 are met.

(4) This hearing does not prejudice P's right to a full hearing before the Tribunal concerning any application for a Compulsory Treatment Order.

31. Treatment within the period of preliminary examination and assessment

(1) During the period of preliminary examination and assessment P may not be provided with medical treatment to which he or she objects unless:

(a) it is covered by the general authority established by clause 6

(b) it is necessary to prevent serious harm to P's health or safety or to protect another person from harm

(c) where serious medical treatment is to be provided that is covered by clause 12, the requirements of that clause are satisfied.

(2) Any treatment provided under (1)(b) or (c) shall not be given in the community but P shall be conveyed to hospital for the purposes of treatment.

32. Draft care plan

(1) Prior to the hearing before the Tribunal concerning the Compulsory Treatment Order, the responsible clinician shall prepare a draft care plan, setting out the medical treatment which the person ("P") is to receive under compulsory powers.

(2) This plan shall be included in P's records.

(3) A copy of the plan shall be provided to P and to his or her SDM.

(4) If it is appropriate for the person ("P") to be subject to treatment in the community, the plan must specify the conditions to be imposed on P:

(a) to ensure that the treatment may be properly carried out

(b) to protect the health or safety of P or any other person.

(5) The conditions may include a condition that P:

(a) shall attend at a specified place at specified times

(b) shall be available for treatment during specified periods.

33. General consultation requirements concerning draft care plan

(1) Before finalising the draft care plan the responsible clinician shall consult:

(a) P, unless inappropriate or impracticable

(b) P's substitute decision maker, if one has been appointed

(c) if no substitute decision maker has been appointed, the person who usually provides care for P (the primary carer)

(d) any other person who will have the care of P in the community.

(2) If the substitute decision maker does not agree with any element of the plan this shall be recorded in the plan and the matter shall be decided by the Tribunal.

An Overview

The role of capacity in mental health laws – recent reviews and legislation

Kris Gledhill[1]

The context in which the Szmukler et al proposal is put forward is the several reviews in the different jurisdictions in the United Kingdom and in Ireland, which have led to capacity becoming a central feature in relation to civil detention in Scotland and in Ireland, and which may well lead to it becoming a central feature in Northern Ireland, though efforts to achieve the same in England and Wales were rejected.

For forensic patients, however, capacity is not prominent, and the proposal made goes further than recent legislative amendments and debates have contemplated. These are set out in the order in which they occurred: the Richardson Committee review of the English statute, then the amendments in Scotland, followed by those in Ireland (which pre-dated those in Scotland but came into effect later); next was the action that was eventually taken in relation to the English statute, and finally there are the proposals as to what to do in Northern Ireland. The latter is the only one that comes close to the proposals of Szmukler and others, which they acknowledge in their paper.

(i) The Richardson Committee

The first review was that by the Expert Committee appointed to advise the Secretary of State for Health on the *Mental Health Act 1983* for England and Wales (also known as the Richardson Committee), which reported in November 1999[2]. It suggested, in a chapter on underlying principles[3], that treatment for mental ill-health should be governed by principles similar to those relevant to physical ill-health, where patients with capacity decide whether or not to accept treatment: providing similar respect for autonomy in the mental health field was necessary to avoid discrimination on the basis of mental disorder. The logic of this would be that only those without capacity could be compelled to accept treatment. However, a consultation exercise carried out by the Committee revealed that only a small minority of respondents suggested that capacity to make decisions should be the only test: the larger body of opinion favoured overriding decisions to refuse treatment by those with capacity when to do so was necessary for public

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2 *Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009576 (last accessed 29 August 2009)*

3 *Chapter 2*

safety. The Committee supported this approach[4], and so suggested that the criteria for an order for compulsory treatment[5] be phrased so that it could be met in alternative circumstances: either when the patient was without capacity and compulsory care and treatment was necessary for his or her health or safety, or to protect the patient from serious exploitation, or to protect others from serious harm; or, if the patient had capacity, when there was a substantial risk of serious harm to other persons , or possibly to the health or safety of the patient or to the safety of other persons if the patient was untreated[6].

In relation to patients involved in the criminal justice system, the Committee noted[7] that it had made little progress in deciding the extent to which principles applicable to civil patients should be adjusted when carried across to those in the criminal justice system. This was largely for pragmatic reasons: the complexity of the panoply of existing regimes, and the lack of internal coherence; the uncertainty of government policy in relation to those with severe personality disorders[8]; and the lack of time available to it to consider the issues involved or to discuss them with the government department most involved, the Home Office[9]. The Committee did, nevertheless, make several recommendations, including that offenders who lacked capacity and met the criteria for a compulsory order should be dealt with primarily according to their health needs[10], that transfers be used when offenders met the civil criteria[11], and that the criminal courts should be able to make a health order if the offender met the criteria for a civil order and lacked capacity[12]. The Committee did not conclude that those who retained capacity should be excluded from treatment, noting that "to leave in prison offenders who could benefit from treatment would not be productive of public safety"[13]; however, there was the contrary point that hospitals and health professionals "should not be required to detain offenders who are persistently unwilling to engage in treatment or who are untreatable"[14]. The belief the Committee expressed was that mentally disordered offenders who retained capacity would probably be personality disordered and subject to a mental health order only if there was the possibility of benefit to the patient: since this would invariably depend on

4 *Para 2.7. The Committee noted that there was a "more intractable dilemma", namely what to do when the harm involved is not to others but to the patient; the consultation process did not produce any consensus on this. Arguments as to whether to intervene to prevent self-harm or to respect autonomous choices to self-harm "reflect a difference in fundamental philosophy which can only be resolved by according preference to one approach over the other. We have set out the alternative views as best we can and invite politicians to make the moral choice between them" (para 2.11).*

5 *This was in the civil setting; it would be a judicial order, made by a Tribunal.*

6 *Paras 5.94 and 5.95. There were other criteria for the compulsory order: the presence of a mental disorder of such seriousness as to require care and treatment under specialist services; the proposed care and treatment be the least restrictive alternative and be in the patient's best interests; treatment be available that was likely to prevent a deterioration or secure an improvement.*

7 *Chapter 15*

8 *A consultation paper, 'Managing Dangerous People with Severe Personality Disorder', was issued by the Department of Health and the Home Office, in July 1999 (just days after the Richardson Committee report was delivered to the Department of Health); available at http://www.homeoffice.gov.uk/documents/cons-1999-personality-disorder (last accessed 29 August 2009)*

9 *This was before the reorganisation of central government that saw the creation of the Ministry of Justice, which took some of the Home Office's functions in relation to mental health matters.*

10 *Para 15.9. They also suggested at para 15.15 that those with a learning disability should be placed under the framework for those with long-term capacity problems that was being developed (and became the Mental Capacity Act 2005); courts should be able to make an appropriate order under the incapacity framework instead of imposing a criminal sentence.*

11 *Para 15.16: the Committee noted that offenders could not be denied appropriate healthcare without discrimination; in Ch 16, the Committee recommended that, since the poor quality of mental health services in prisons meant that compulsory treatment in prison was inappropriate, arrangements should be in place whereby prisoners could be transferred to hospital for an assessment of their needs and whether there should be a formal transfer to hospital.*

12 *Para 15.13.*

13 *Para 15.14.*

14 *Para 15.11.*

cooperation, it could be tested by the greater use of interim orders[15]. The Committee supported the retention of the Restriction Order regime[16], which was described as "an essential safeguard" in the identification of "high risk cases": however, it should rest on a special risk assessment so that those dealing with the offender subsequently could know the basis for its imposition[17].

It was some time before new legislation was forthcoming for England and Wales: it did not incorporate capacity principles and is discussed below: a more speedy process was followed in Scotland, which did put capacity as a central feature, but only on relation to civil detention.

(ii) The MacLean Committee and the Millan Committee

The Scottish Executive also established a review of its legislation, the *Mental Health (Scotland) Act 1984*, by the Millan Committee, which was appointed in February 1999 and reported in January 2001[18]. There was also the MacLean Committee, more officially the Committee on Serious Violent and Sexual Offenders, which reported in June 2000[19]; its recommendations were subject to comment by the Millan Committee. The MacLean Committee had concluded that the range of sentences available to the criminal courts in Scotland was suitable except in relation to a small number of offenders who posed a high and continuing risk to the public, for whom there should be a new sentence, the Order for Lifelong Restriction[20]. It felt that a small number of such offenders might have a mental disorder[21] as well, most likely a complex combination of forms of disorder, and suggested that such offenders should receive an OLR together with a hospital direction: this would mean that they would be detained in the high secure setting of the State Hospital and could be transferred to prison if treatment was no longer appropriate[22].

The Millan Committee believed that capacity should be a central component of the process for authorising civil detention on the ground of mental disorder: its formulation was to require that the judgment of the patient be significantly impaired as a result of mental disorder[23]. It also gave

15 *Para 15.14. Naturally, a penal sentence could be imposed in the event of non-cooperation.*

16 *Para 15.17.*

17 *The Committee also suggested that the role of the Secretary of State be replaced by an extended role for the Tribunal to approve leave and transfer decisions, since it was more appropriate that such important decisions be taken by a judicial body rather than by central government as they were essential precursors to release and so relevant to the human rights standard that release should be governed by a judicial body: paras 15.19ff. The Secretary of State would be a party to the Tribunal. The Committee also recommended that the conditional discharge regime be continued, though this would be to provide for recall to hospital since the Committee recommended that the effect of a detention order would be to allow in-patient or out-patient treatment and so there would be no need for a conditional discharge for that purpose: paras 15.24ff.*

18 *New Directions, SE/2001/56.*

19 *SE/2000/68*

20 *Chapters 5 and 6; this would be available if the offender had committed a violent or sexual offence or another offense showing a propensity to such offending, and there were reasonable grounds for believing that there was a substantial and continuing risk to the public (which would require a formal risk assessment) such as to require such an order.*

21 *Defined in the Mental Health (Scotland) Act 1984 as amended by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 as 'mental illness (including personality disorder) or mental handicap however caused or manifested'. The replacement for the 1984 Act, the Mental Health (Care and Treatment) (Scotland) Act 2003, maintained a similar definition: s328 provides that "(1) … "mental disorder" means any – (a) mental illness; (b) personality disorder; or (c) learning disability, however caused or manifested …" This followed the recommendations if the Millan Committee, see ch 4 of New Directions.*

22 *Chapter 7*

23 *Chapter 5, paras 40ff. At para 41, it noted "We propose that it should not be possible for a compulsory intervention to be made under mental health law unless there is evidence that the person's judgment is significantly impaired, as a result of mental disorder, so as to justify the intervention. This expresses a broadly similar concept to incapacity, but is felt to be a less legalistic formulation, and one which may be easier to apply in practice. It may also be a term which is easier for service users to accept than the term 'incapable'."*

consideration to the question of the approach to be taken in relation to offenders with mental disorder[24], concluded that protecting the public from risk was a proper legislative object and identified the need for a framework that provided for "the range of legislative needs, including … protection of the public from those who may pose a risk to others"[25], but it recommended that the criteria for detention through the criminal process should be the same as for civil detention[26].

In relation to high risk offenders, the Millan Committee agreed with the MacLean Committee that some such offenders would have complex disorders, but also set out its view that others might have an untreated mental illness and would not pose a high risk after appropriate treatment, and so could be dealt with by way of the existing hospital order regime without any need for anything such as an OLR[27]. As had been the view of the Richardson Committee, the Millan Committee was content for the Restriction Order regime to continue[28]. It was also able to give brief consideration[29] to those who were unfit to stand trial because of their mental disorder – 'insanity in bar of trial'[30] – and found to have committed the actus reus of the charge[31]; and also those found fit to stand trial but to have been insane at the time of the offence and so not guilty by reason of insanity[32]. Such findings allowed the court to impose an appropriate order for either hospital or community care. The Committee noted that various practical problems had arisen, namely a lack of fit between the legal questions posed and the clinical understanding of these constructs, and delays in dealing with the cases in court because of difficulties in arranging the necessary medical evidence in a timely fashion. Their main conclusion was that the whole area, and the question of diminished responsibility as a partial defence to murder, should be subject to a full review by the Scottish Law Commission[33].

24 *The statutory regime then in place in Scotland had the power to impose mental health disposals in one statute (the Criminal Procedure (Scotland) Act 1995, whereas the effects of the disposals were set out in the Mental Health (Scotland) Act 1984. The Committee noted that some people saw advantages to this, both from the point of view of having a comprehensive code for the criminal justice system, which might also encourage an integrated response to mentally disordered offenders from the system which tends to have to deal with them, namely the criminal justice system. However, their view was that it was better to have all provisions relating to mental disorder in one statute: ch 24.*

25 *Chapter 2, para 22.*

26 *Chapter 26, para 15. The Committee had been concerned about facilities in prisons and had concluded that compulsory treatment in a prison setting would not be right: ch 26, paras 59ff. This led it to reject the idea of having the conditions of a community treatment order relating to treatment continuing to have effect in prison. The Committee did also note that the more important question in the criminal context might well be ensuring access to treatment: at para 1 of ch 26, the Committee noted that there were some problems in relation to the availability of facilities, particularly for young people and female offenders with self-harming behaviour.*

27 *Chapter 27, para 9.*

28 *Chapter 27, paras 15ff discuss the Restriction Order: there is no suggestion that they be abolished. The Committee suggested that the discharge of such patients – who at that time could appeal to the Sheriff (s63 of the 1984 Act) or be discharged by the Scottish Ministers – become a matter for the Parole Board (sitting as the Restricted Patients Review Board): ch 27, paras 41ff; though it also suggested that the Mental Health Tribunal it proposed in relation to civil patients should also have jurisdiction over restricted patients: ch 27, para 49.*

29 *Chapter 29*

30 *The test – set out in MH Advocate v Wilson 1942 JC 75 – involves a mental disorder preventing the giving of instructions or following the evidence; English law has a similar test, in R v Pritchard (1836) 7 C&P 303.*

31 *This process is carried out pursuant to the Criminal Procedure (Scotland) Act 1995; there is a similar process in England and Wales, introduced by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991.*

32 *The test in Scotland is whether mental disorder prevented a defendant from controlling his conduct: HM Advocate v Kidd 1960 JC 61. This is wider than the M'Naghten Rules (based on M'Naghten's Case (1843) 10 Cl&F 200) applicable in England and Wales, which require that the defendant's delusions cause him not to know the nature or quality of the act or that it was unlawful.*

33 *This was done: the Scottish Law Commission issued a Discussion Paper in January 2003 and its Report in July 2004 (SE/2004/92), which proposed that there be a defence of lack of criminal responsibility if mental disorder means that the person cannot appreciate the nature or wrongfulness of conduct (but excluding from this a personality disorder characterised by abnormally aggressive or seriously irresponsible conduct); and that a person be unfit for trial if a mental or physical disorder means that effective participation is not possible.*

One additional feature of the regime, which had recently proved controversial, had to be considered, the need to be satisfied as to the "treatability" of patients with personality disorders[34]. An order for discharge in a highly-publicised case where there was felt to be an ongoing risk to the public but the treatability requirement was not met[35] led to the *Mental Health (Public Safety and Appeals) (Scotland) Act 1999*, which required the detention of a restricted patient who did not meet the treatability test if detention was necessary to protect the public from serious harm[36]. The Millan Committee suggested that this test be removed, since the hospital system should be used only for those who could be treated: this approach allows the hospital system to be used where protecting the public coincides with the treatment of mental disorder, but protecting the public in other situations is a matter for the criminal justice system[37].

(iii) *The Mental Health (Care and Treatment) (Scotland) Act 2003*

The Scottish Parliament, which had been the first UK legislature to put in place a comprehensive framework in relation to adults without capacity – the *Adults with Incapacity (Scotland) Act 2000* – soon enacted legislation based to a significant extent on the recommendations of the Millan Committee. The *Mental Health (Care and Treatment) (Scotland) Act 2003* – the main provisions of which were brought into effect in October 2005[38] – made long term compulsion in the civil setting dependent on the making of a Compulsory Treatment Order by the new Mental Health Tribunal[39]: the test for this order, which can be on an in-patient or out-patient basis, is set out in s64 and requires various findings, including that the patient's mental disorder leads to a significant impairment in the making of decisions about treatment and that treatment is necessary to avoid a significant risk to the patient or other others[40]. In other words, the Scottish Parliament has engaged with the principles that (i) capacity should be central, which means that those who retain the ability to make true decisions cannot be compelled, at least not in the civil setting; a decision is not a true one under the statutory test if there is a significant impairment to decision-making caused by the disorder; and (ii) danger posed to others is also a basis for intervention in the civil setting, but not as an alternative to the impaired capacity test, which has to be met in any event.

In the criminal justice setting, however, the changes introduced were less radical and did not go as far as the Millan Committee had recommended. Parts 8 and following of the 2003 Act provide for orders that can be made by the criminal courts, by adding sections to the Criminal Procedure (Scotland) Act 1995[41].

34 *Section 17 of the 1984 Act; there was an equivalent requirement in ss3 and 37 of the English Act of 1983.*

35 *See Ruddle v Secretary of State for Scotland [1999] Mental Health Law Reports 159. This led to an inquiry for the Scottish Parliament conducted by the Mental Welfare Commission for Scotland: see Report of the Inquiry into the Care and Treatment of Noel Ruddle, available at http://www.scottish.parliament.uk/business/bills/billsPassed/rudr-01.htm (last accessed 29 August 2009)*

36 *This was upheld, subsequently to the Millan Report, in a challenge in the European Court of Human Rights: Reid v UK [2003] Mental Health Law Reports 226, the Court rejecting a suggestion that detention was only possible if the disorder was treatable.*

37 *Chapter 28, para 18ff:*

38 *See Scottish Statutory Instrument 2005 No 161, The Mental Health (Care and Treatment) (Scotland) Act 2003 (Commencement No 4) Order 2005*

39 *Sections 57ff; only the new Mental Health Tribunal can make the order.*

40 *A short-term detention certificate may be made under s44 if an approved medical practitioner (s22 – a medical practitioner having suitable expertise) certifies the likelihood of, inter alia, mental disorder (ie mental illness, personality disorder or learning disability: s328), significant impairment of ability to make decisions as to medical treatment and significant risk to the health, safety or welfare of the patient or to the safety of others in the absence of treatment.*

41 *The Millan Committee's recommendation that the criteria for the making of criminal orders be part of the same legislation as the civil regime was not followed.*

The main order that can be made after conviction, the Compulsion Order, differs from a civil order in that there is no requirement that the defendant have any impaired capacity: what is needed [42] is that there is mental disorder, that treatment for the disorder is available, that the absence of treatment would result in a significant risk to the health, safety or welfare of the offender or the safety of another, and that the order is necessary. Of course, in determining whether an order is "necessary", a relevant factor might be whether or not the defendant has the capacity to make treatment decisions, since its absence might be a factor in favour of making the order. The Millan Committee's view that the criteria for a hospital order should be the same as those for a civil order, noted above, was rejected by the Scottish Executive, which stated in the Policy Memorandum accompanying the Bill that became the 2003 Act[43]:

> "191. The civil criteria are designed to ensure that a patient is only placed under compulsion and deprived of their liberty when there are grounds for over-ruling the patient's autonomy. The forensic criteria are directed at ensuring that a court disposal and any continuing compulsion are appropriate, given all the circumstances of the offender's mental disorder and offence. We believe this difference is justified in the context of criminal disposals, where the alternative to a mental health order may be prison. The aim is to place the emphasis on the patient's need for appropriate care and treatment rather than on a person's willingness to accept the care and treatment. The intention is also that the criteria should not preclude voluntary transfer of prisoners to hospital under the Bill, when that is the most appropriate course of action.

The proposal to remove the effect of the *Mental Health (Public Safety and Appeals) (Scotland) Act 1999* was also rejected: the legislation had by then been upheld by the Privy Council (and subsequently was upheld by the European Court of Human Rights)[44].

(iv) *The Mental Health Act 2001 and Criminal Law (Insanity) Act 2006 – Ireland*[45]

In response to an admissibility decision in the European Court of Human Rights challenging the absence of an effective court review of detention[46], the Oireachtas in Ireland passed the *Mental Health Act 2001*, which came into effect in 2006[47]. The Act's definition of "mental disorder"[48], which is the key to the use of compulsion, requires "mental illness, severe dementia or significant intellectual disability" which (a) causes " … a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons", or (b) is of a degree such that "the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that

42 *Section 133 of the 2003 Act, inserting s57A into the 1995 Act. The order can be renewed by a Tribunal after 6 months if the criteria still apply, and then for 12 months at a time: see s139ff of the 2003 Act.*

43 *Mental Health (Scotland) Bill (SP Bill 64), 16 September 2002, Policy Memorandum, available at http://www.scottish.parliament.uk/business/bills/billsnotInProgress/index.htm#64 (last accessed 29 August 2009)*

44 *See Policy Memorandum paras 181ff; the case law is Anderson, Docherty and Reid v Scottish Ministers [2001] Mental Health Law Reports 192 and Reid v UK [2003] Mental Health Law Reports 226.*

45 *For a more comprehensive account of the Irish legislation, see Prof Anselm Eldergill's two-part article, 'The Best is the Enemy of the Good: The Mental Health Act 2001', Journal of Mental Health Law, May 2008, pp21–37, and Spring 2009, pp7–18.*

46 *Croke v Ireland [1999] Mental Health Law Reports 118; the friendly settlement of the case, on 21 December 2000, involved its withdrawal on the basis that what was then the Mental Health Bill 1999 would pass into law. There had been previous proposed Bills, but they had not progressed.*

47 *The Mental Health Act 2001 (Commencement) Order 2006, SI No 411 of 2006 brought the act into force from 1 November 2006.*

48 *Section 3 of the Act.*

could be given only by such admission", and admission would be beneficial[49]. Again, the legislature involved has placed lack of capacity as a central feature in the justification for detention, whilst also making harm to others an important matter. The 2001 Act does not have any provisions relating to orders made by the criminal courts in relation to mentally disordered offenders, though it does provide that a Tribunal must authorise the transfer of a civil patient to the secure Central Hospital (s21(2)).

Further legislation was passed to deal with the criminal justice sector, the *Criminal Law (Insanity) Act 2006*. This statute deals with fitness to stand trial, findings of not guilty by reason of insanity and also transfers of prisoners to hospital. Section 4, which sets the test for fitness to stand trial, allows an order for treatment in a designated centre[50], but this requires a finding of "mental disorder" as defined in the 2001 Act; s5, relating to findings of insanity, is similar[51]. In relation to the transfer of prisoners – sentenced or remand prisoners[52] – the provisions are, however, somewhat different[53]: the first relevant question is whether the prisoner has a "mental disorder for which he or she cannot be afforded appropriate care or treatment within the prison"; transfer is then possible if the prisoner "voluntarily consents" or if two or more doctors certify that the transfer should occur because the treatment cannot be provided. That allows the transfer to be effectuated "notwithstanding that the prisoner is unwilling or unable to voluntarily consent to the transfer". In summary, a patient found unfit to stand trial or not guilty by reason of insanity is treated as though he or she were a civil patient, with impaired judgment being a basis for detention; but a serving prisoner requires either agreement to transfer or two medical opinions in the absence of capacity or agreement if the prisoner has capacity.

(v) *The Mental Health Act 2007*

By the time, then, that the Westminster Parliament came to decide on the reform to the *Mental Health Act 1983* for England and Wales, it had an expert committee recommendation on making capacity central, and further expert reports and models of legislation from other parts of the UK and from Ireland that suggested the importance in modern legislation of capacity. In addition, the Westminster Parliament had also put in place a framework to regulate the approach to adults with limited or no capacity, the *Mental Capacity Act 2005*, though not in relation to those placed under the Mental Health Act 1983[54]. There was a significant time period between the Richardson Committee's recommendations and the *Mental Health Act 2007*, which was marked by a number of false starts towards legislation[55], but a

49 *In MR v Sligo Mental Health Services [2007] IEHC 73, 2 March 2007, O'Neill J commented that the language of the statute provides two bases for detention, but that "they are not alternative to each other" and that they are likely to overlap. It is difficult to know precisely what His Honour means, namely whether or not both of the two bases have to be met on the facts.*

50 *This includes the Central Mental Hospital; other "psychiatric centres" may be designated (s3 of the Act), and s13 indicates that they might well be prisons.*

51 *It requires "mental disorder", but does not tie it to mental disorder for the purposes of the 2001 Act; s1 of 2006 act provides that ""mental disorder" includes mental illness, mental disability, dementia or any disease of the mind but does not include intoxication"; the mental disorder has to be "such that the accused person ought not to be held responsible for the act alleged by reason of the fact that he or she – (i) did not know the nature and quality of the act, or (ii) did not know that what he or she was doing was wrong, or (iii) was unable to refrain from committing the act". However, the disposal on such a finding may involve compulsory treatment if there is a finding of mental disorder as defined in the 2001 Act.*

52 *Defined in s1 of the Act*

53 *See s15 of the Act.*

54 *Section 28 of the 2005 Act effectively gives priority to the provisions in the 1983 Act relating to treatment.*

55 *There was a Green Paper (Cmnd 4480, November 1999), a White Paper Cm 5016-I, December 2000), a Draft Bill 2002 (Cm 5538-I) and a further Draft Bill of 2004 (Cm 6305-I), which was subject to pre-legislative scrutiny by the Joint Committee on the Mental Health Bill (Session 2004–5, HL Paper 79-I, HC 95-I), to which the government responded (Cm 6624, July 2005); eventually, the Mental Health Bill 2006 was introduced to the House of Lords in November 2006 (HL Bill 1, Session 2006–7).*

consistent line from the Government was that capacity would not be made part of the test for detention and efforts to make it part of the test were rebuffed. Rather, the emphasis was on public safety or preventing self-harm. A few extracts from the lengthy process leading to reform give a flavour of the approach adopted.

The Green Paper of November 1999 that was published along with the Richardson Committee report called for views to be expressed on the recommendation that capacity be made central to the test for detention: but the Green Paper indicated[56] that

> "The principal concern about this approach is that it introduces a notion of capacity, which, in practice, may not be relevant to the final decision on whether a patient should be made subject to a compulsory order. It is the *degree of risk* that patients with mental disorder pose, to themselves or others, that is crucial to this decision. In the presence of such risk, questions of capacity – while still relevant to the plan of care and treatment – may be largely irrelevant to the question of whether or not a compulsory order should be made."

When the Draft Bill of 2004 was subject to pre-legislative scrutiny, the Joint Committee of both Houses of Parliament recommended the adoption of the Scottish Parliament's approach of including impaired capacity as a precondition for detention[57]. The Government position had been set out to the Joint Committee, the reasons for objecting to capacity as a central component being[58]:

– it would not prevent harm to patients and others;

– professionals would have a very flexible approach to the test in order to ensure that people were treated;

– people with fluctuating capacity would receive inconsistent treatment and have periods of relapse and recovery;

– it would be impossible to treat under compulsion many people with personality disorders.

However, the Joint Committee felt that these difficulties could be overcome in practice and did not justify the position adopted by the Government[59]: put shortly

> – it was a necessary addition to ensure that the legislation covered only psychiatric conditions, in light of the very broad definition of mental disorder[60], namely "an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain"; since this could cover many physical and neurological disorders[61]; the use of an impaired capacity test would answer concerns about the breadth of the proposed new regime;

56 *Page 32, ch 5, para 6*

57 *Para 71 of its report; it heard submissions and evidence, printed as HL Paper 79-II and HC 95-II for Session 2004–5.*

58 *Paragraph 152.*

59 *Paragraphs 153–156.*

60 *Clause 2.5 of the Draft Bill, a definition that was supported by the Joint Committee but on the basis that it would be accompanied by a set of exclusions – as to substance misuse, sexual orientation and cultural and political beliefs and behaviours – that the Government was not proposing should be included. See paragraphs 87–114.*

61 *At para 88, the Joint Committee noted of the extended definition of mental disorder that "Many experts told the Committee that the proposed definition would result in people suffering from a wide range of physical conditions not covered by the current Act being brought within the ambit of the new Bill. It was suggested that those with epilepsy, people who have suffered traumatic brain damage, and those suffering from neurological disorders such as multiple sclerosis, Parkinson's disease or metabolic disorders would be covered by the new definition because of the psychological and behavioural symptoms of their conditions.*

– it would approximate the test for best interests in what became the Mental Capacity Act 2005, and reduce the emphasis on risk (since the test for capacity takes into account the consequences of the decision) whilst allowing intervention without a discriminatory regime that makes a special case of mentally-ill people;

– it was inconsistent to ignore capacity and autonomy in relation to the criteria for detention but make it central in relation to other areas, such as ECT[62] or psychosurgery[63].

The Government issued a formal response to the Joint Committee's Report[64], and rejected most of its recommendations, including those in relation to the impaired capacity test, noting "it is not safe to assume that there is a link between the severity of a condition – and therefore the need for treatment – and the person's ability to make decisions"[65].

When a Bill was finally introduced into Parliament in 2006, the House of Lords did add a clause making it a precondition for civil detention (either for assessment under s2 or treatment under s3 of the 1983 Act) that "because of his mental disorder, his ability to make decisions about the provision of medical treatment is significantly impaired"[66]. The central arguments in favour that featured in the debate were: (i) decision-making capacity was central in relation to other forms of medical treatment, and should be central in relation to mental health because there was no great contrast in terms of ability to participate[67]; it was part of good professional practice in any event, including in mental health work, was part of the test as to detention in Scotland (where it did not seem to be causing a problem), and in the English legislation was already relevant in relation to decisions about medication beyond three months and ECT[68] and psychosurgery[69]; (ii) allowing people to retain some decision-making capacity about their treatment would make them more likely to present themselves; and for those placed in the mental health system, there would be more compliance because the loss of the ability to make decisions was a source of frustration and could lead to non-compliance and a position of opposition to the clinicians who were viewed as having an "upper hand" in a relationship and not taking the views of patients seriously; in other words, it would promote confidence in the system by users[70], which would raise the prospects of it being successful; (iii) assessment of capacity was to become a matter required on a daily basis with the introduction of the *Mental Capacity Act 2005*, and making it a necessary focus for mental health clinicians would enable them to identify patients who did not recognise their own illness, who might present the most serious risk.

62 *Clause 179 of the Draft Bill indicated that ECT would require the consent of an adult patient with capacity. This became law: see s27 Mental Health Act 2007, adding s58A Mental Health Act 1983.*

63 *See s57 Mental Health Act 1983.*

64 *July 2005, Department of Health, Cm 6624*

65 *Page 16.*

66 *Moved and adopted at the Committee Stage: HL Hansard, 10 January 2007, Vol 688, col 228ff. Specifically referred to in the debate was a study conducted by Prof Szmuckler that indicated that 85% of those assessed just after admission under compulsory powers at The Maudsley Hospital in London did not have capacity, and so a higher proportion would meet the lower test of impaired decision-making: col 235.*

67 *Baroness Barker, who moved the relevant amendment stated at col 230 "In mental health, as in all other aspects of healthcare, there is a growing recognition that the involvement and compliance of patients in their treatment, and in maintaining their treatment regimes, rests on their ability to be part of the decision-making about it."*

68 *Section 58 of the 1983 Act required consent from a patient with capacity or the authority of a second opinion doctor.*

69 *Section 57 of the 1983 Act required consent from a patient with capacity and the authority of a second opinion doctor.*

70 *Baroness Murphy, who made some points in favour of this proposition noted that this might in particular be of assistance to populations that were statistically overrepresented in the system, in particular black communities: see col 236.*

The only opposition to this amendment in the debate came from the Government minister in charge of taking the Bill through the House of Lords, Lord Hunt[71], who commented that "[t]he primary purpose of the legislation is to protect people from the harm that may be caused by mental disorder" and as such was to be contrasted with the Mental Capacity Act 2005, which was designed "to provide a way of intervening where people cannot make their own decisions". The question of compulsion turned on "the needs of patients and the risk that their disorder poses to themselves and to others, not their decision-making ability" and an impaired decision-making test "could result in some patients going untreated and thereby harming themselves or others"[72]; this – leaving people to harm themselves or commit a crime they would not otherwise commit – was not something that promoted autonomy, whereas treating people so that they could recover from serious mental disorder would allow them better to operate autonomously. He restated the previously-indicated position that medical professionals would misreport impaired capacity in order to ensure treatment, and that the test would cause the premature discharge of patients who regained their capacity before their treatment was complete and who would then have to be discharged to deteriorate again. Moreover, he did not accept that reluctant patients would be more likely to comply if the pre-conditions for compulsion included an impaired decision-making clause. The Government majority in the House of Commons reversed the impaired capacity clause inserted by the House of Lords: this was done at the Committee stage of the Bill. Though the issue took up one and a half of the 12 sittings of the Committee, the arguments were along the same lines as those presented in the Lords, with one side emphasising risk and the other emphasising autonomy and the need to avoid discrimination as between physical and mental illness. The vote was along party lines[73].

Accordingly, the question of capacity is not relevant to the test for detention under the civil provisions for England and Wales, except in an indirect fashion: the White Paper of December 2000, for example, noted that the question of whether the nature and degree of the disorder required detention would include consideration of the question of the patient's capacity to make relevant decisions[74]. With no apparent realisation as to the juxtaposition, capacity was however central in another element of the new regime. Consent to treatment for a 16–18 year old could be given by his or her parents. The White Paper suggested that, in part because of "the increasing recognition of the capacity of a developing young person to take decisions", it should be made clear that the absence of consent from that group would require the use of compulsory powers rather than any reliance on parental powers to consent[75]: this became law under the 2007 Act[76]. In other words, questions of capacity are of vital importance in determining who could give consent for an informal admission, but in a non-consensual admission capacity was only of tangential relevance in light of its potential to affect the assessment of the nature or degree of the disorder.

At no stage in the process of reform did capacity on the part of those in the criminal justice system become a central feature. There were, rather, a number of reasons given as to why those who entered the mental health system via the criminal courts should be subject to differential treatment involving less stringent conditions. For example, when the Joint Committee was considering the Draft Bill of 2004, it recommended that the criteria for detention include a requirement that the disorder be of a nature or

71 *Starting at col 243.*

72 *He acknowledged the research of Prof Szmuckler, but noted that as some people would escape compulsion, this would be an "unacceptable gap".*

73 *See the Third and Fourth sittings of the Public Bill Committee, 26 April 2007, cols 79–120. Available at http://www.publications.parliament.uk//pa/cm200607/cmpublic/cmpbment.htm (last accessed 25 August 2009)*

74 *Paragraph 3.24.*

75 *Paragraphs 3.70ff.*

76 *Section 43 of the 2007 Act, amending s131 of the 1983 statute.*

degree to make treatment appropriate irrespective of whether the defendant would consent to treatment[77]. The Government position was that the civil criterion that voluntary treatment was not possible had to be omitted because otherwise a patient willing to attend hospital voluntarily would have to be subject to a prison sentence[78]. Also missing was any requirement that treatment be necessary to protect the patient or others from harm: the Government position was that this pre-condition was justified in relation to a civil patient as the basis for depriving the patient of his or her liberty, whereas in the criminal setting the justification arose from the fact that a court order was made; and the danger of including a criterion reflecting the need to protect someone from themselves was that this could be met by a prison sentence[79].

(vi) The Bamford Review – Northern Ireland

Reporting in August 2007, the Bamford Review of Mental Health and Learning Disability[80] provided a suggested framework to replace the *Mental Health (Northern Ireland) Order 1986*. Article 3 of the 1986 Order defines mental disorder as "mental illness, mental handicap and any other disorder or disability of mind" but expressly excludes those whose only diagnosis is of a "personality disorder". The criteria for detention for treatment, as set in Art 12, require an opinion that the absence of detention involves "a substantial likelihood of serious physical harm to himself or to other persons". In relation to detention ordered by the criminal courts, Art 44(2) allows a hospital order if there is "mental illness or severe mental impairment of a nature or degree which warrants his detention in hospital for medical treatment" and the order is the more suitable disposal.

The message of the Bamford Review was that the 1986 Order had significant gaps, and it suggested that the opportunity be taken to provide a comprehensive legislative framework based on a number of central principles. The Committee set out four over-arching principles that provided a "sound ethical basis for legislation" and "recognise and support the dignity of the person", namely[81]:

> "i. – Autonomy – respecting the person's capacity to decide and act on his own and his right not to be subject to restraint by others.
>
> ii. – Justice – applying the law fairly and equally.
>
> iii. – Benefit – promoting the health, welfare and safety of the person, while having regard to the safety of others.
>
> iv. – Least Harm – acting in a way that minimises the likelihood of harm to the person."

The Committee's preference was for one legal framework that dealt with all issues arising in relation to capacity and mental health which "should apply in a non-discriminatory way to both physical and mental health decisions, as well as to welfare and financial needs"[82]. In other words, the separate area of law relating to mental health law should become a sub-set of the law relating to what happens when someone has a loss of capacity to act autonomously. Capacity law should develop and incorporate mental health

77 *Paragraphs 272–3.*

78 *Paragraphs 267–268. This was a position similar to that adopted by the Scottish Executive (and Parliament, given that the 2003 Act passed as it did) in relation to why impaired judgment should not be part of the test for a detention order in the criminal setting: see infra.*

79 *Paragraphs 267 and 269. The Joint Committee also rejected this viewpoint in its recommendations.*

80 *Its extensive collection of papers can be found at http://www.rmhldni.gov.uk/index.htm (last accessed 29 August 2009). References here are to the report entitled 'A Comprehensive Legislative Framework'.*

81 *See para 1.8; the consequences of the principles were expanded upon in chapter 5 of the report.*

82 *Para 5.3.*

law "whilst ensuring appropriate protections"[83]; practical arrangements would be put in place for the assessment of capacity. However, the Committee noted that it would then be necessary to consider how this intersected with legislation relating to children and also "the consequence of adopting such an approach for forensic patients and the interface with the Criminal Justice System"[84]. Its starting point in relation to the latter was that the principles-based approach it adopted meant that those who had capacity and made decisions to commit crime would have to be dealt with through the criminal justice system[85]. Of course, it would be possible to have an intervention that was based both on the need to protect the patient and to protect others if the patient's autonomy was compromised so as to prevent a decision with respect to the particular risks in issue.

The Northern Ireland Government has been broadly supportive of the suggestions of the Bamford Review. Its initial response was entitled "Delivering the Bamford Vision"[86]: after discussions between interested departments within the Northern Ireland Government, it was accepted that there was a need for a new framework for mental health and capacity law, but it was proposed[87] that there should be two pieces of legislation, the first amending the 1986 Order because of the "urgent need" for that – though the timescale was given as it being enacted only in 2011 – and then new mental capacity legislation was to follow. The suggestion made was that putting both together in a single statute "would lead to a very complex piece of legislation which may be difficult to implement"; unfortunately, no reason is given for this assertion[88]. The Government response is also far from clear as to what would be the interface with the criminal justice system: the chapter dealing with forensic matters[89] notes the need for service provision, including for people with personality disorders and those detained in prison, but does not give any details on what is proposed in this area.

After the consultation on this initial position, the Northern Ireland Government has produced an updated proposal, entitled "Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland"[90], which retains the idea that there will be separate legislation on mental health and questions of capacity but proposes that the two relevant bills should be introduced at the same time. It is also noted that the legislation relating to mental health matters, which may be in the form of an amendment to the 1986 Order or be a new statute, will be harmonised with the mental capacity legislation "to form a coherent framework"[91]. The timeframe envisages new legislation by April 2011. The mental health law will adopt the Scottish approach: so, it is noted that the proposed criteria for detention for assessment or treatment will include as a pre-requisite that the patient is found to have a "significantly impaired decision-making ability in relation to treatment" because of mental disorder[92]. How this applies to people in the criminal justice system is not clarified.

83 *So at paras 5.57ff the Committee comments on the need to ensure public protection when a person with impaired capacity poses a threat to others (which it notes is not a frequent occurrence).*

84 *Paras 5.5. and 5.6. The Committee noted at para 5.55 that there was a need to ensure that the law relating to criminal responsibility and matters such as unfitness to stand trial, and also the law relating to matters such as transfers from prison to hospital, was amended to comply with the principles-based approach. The "equivalence" requirement means that those in the criminal justice system have the equivalent access to services: para 5.56.*

85 *Para 5.53.*

86 *Available at http://www.dhsspsni.gov.uk/showconsultations?txtid=30219 (last accessed 19 October 2009).*

87 *Ibid pp 25ff*

88 *The Northern Ireland Executive's proposals were put out for consultation, and the responses were collated in 'Summary of Key Points Arising from Consultation', March 2009, available at the same website. One of the points made – on page 7 of the document – was that there was "strong opposition to the proposal for two pieces of legislation".*

89 *Ibid pp 68ff*

90 *Available at www.dhsspsni.gov.uk/legislative-framework-for-mental-capacity.pdf (last accessed 19 October 2009)*

91 *Paragraph 6.1.*

92 *Paragraphs 8.5 and 8.6.*