

IS ANYONE SAFE? Civil Compulsion under the Draft Mental Health Bill*

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Introduction

The British Government published a draft Mental Health Bill for England and Wales on 26 June 2002.¹ Its publication was preceded by a White Paper in December 2000,² a Green Paper in November 1999,³ and a report prepared by a committee chaired by Professor Genevra Richardson.⁴

The focus of the Bill is on risk management and compulsion in the community. It has been widely condemned by professional bodies, and by carers and patient groups. The nature of the criticism is that the proposals are unprincipled and impractical.

It is important to establish whether this is so. The purpose of this paper is to analyse the Government's case for change and, having done that, to analyse the new civil powers of detention and compulsory treatment.

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1 *Draft Mental Health Bill, Department of Health, Cm 5538-I, June 2002. The Bill's publication was accompanied by the publication of two associated documents: Mental Health Bill Consultation Document, Department of Health, Cm 5538-III, 2002 and the Draft Mental Health Bill Explanatory Notes, Department of Health, Cm 5538-II, June 2002.*

2 *Reforming the Mental Health Act. Part I: The new legal framework (Department of Health/Home Office, December 2000, Cm 5016-I); Part II: High-risk patients (Department of Health/Home Office, December 2000, Cm 5016-II).*

3 *Reform of the Mental Health Act 1983. Proposals for Consultation (Department of Health, 1999, Cm 4480, November 1999).*

4 *Review of the Expert Committee: Review of the Mental Health Act 1983 (Department of Health, November 1999). The committee, which was established by the Department of Health in October 1998, also published its outline proposals: Review of the Mental Health Act 1983, Draft Outline Proposals by Scoping Study Group, April 1999.*

The Government's case

According to the Government, the existing Mental Health Act does not adequately protect people from the significant risk posed by a minority of patients. In particular, it remains based on treatment in hospital, and too often has allowed severely ill people outside hospital to drift out of contact with services.⁵

The Government was therefore concerned that this state of affairs might be true and require a remedy; later concluded that it was true; and invented the hypothesis that existing legislation contributes to this state of affairs. It has now identified a solution, the Mental Health Bill. It believes this is a reasonable solution that does not violate other established principles, and it intends to apply this solution to the facts that constitute the problem.

The Government's proposition may or may not be true.

In order to determine whether it is true, it is necessary to define who within the population is 'mentally disordered', the extent of their violence, what constitutes adequate protection from such violence, and, if people are inadequately protected, whether this is because of our laws. If the Government's proposition is sound, it is still necessary to examine the proposed solution: is it likely to solve the problem, and is it an acceptable solution if its implementation will violate other cherished convictions, such as liberty and justice?

This analytical approach, called pragmatism, seeks to secure a proper regard for the future practical consequences of our actions; to reduce the dangerous influence of subjective egoism; and to encourage the adoption of a reasonable, modest fallibilism with respect to our moral precepts. The best outcome we can legitimately hope for is that we are warranted in asserting a belief upon which we may successfully act, without any presumption of its independent, universal, or timeless truth.⁶

Who is mentally disordered?

It is necessary to define or describe who within a population is mentally disordered before it is possible to estimate the level of violence for which they are collectively responsible.

If persons with anti-social or psychopathic personalities are categorised as mentally disordered, it is necessarily true that other people are relatively more at risk from the mentally disordered than if they are excluded. Furthermore, if our definition of a psychopathic disorder requires abnormally aggressive or seriously irresponsible conduct, as it does under the 1983 Act, it is inevitable that people within the definition will often have been violent. Such a concept is bound to produce such a statistical finding, the whole aim being to detain those who, though not mentally ill, put others at significant risk. Conversely, if such people are excluded, the level of violence committed by what may be called the anti-social element in society will be that much greater, and the contribution of the mentally disordered that much less.

The definition of mental disorder in the 1983 Act includes people categorized as having a psychopathic disorder, but does not include people by reason only of promiscuity, immoral conduct, sexual deviancy or dependence on alcohol or drugs. It is clear from the draft Bill, however, that the Government considers that such persons have a mental disorder. By implication,

5 *Reforming the Mental Health Act. Part I: The new legal framework (Department of Health/Home Office, December 2000, Cm 5016-I), p. xxx. (The 'White Paper').*

6 *See Dewey, J, Logic: The Theory of Inquiry (1938).*

it counts them as part of the group of mentally disordered persons who commit violence, violence from which the public are inadequately protected. It will later be argued that this all-inclusive approach is artificial and unjustified.

The level of violence to others

There are about forty homicides per 100,000 psychiatric admissions.⁷ In statistical terms, the risk that a mentally ill individual will kill themselves is substantially higher than the risk of homicide. According to one study, people suffering from schizophrenia are one hundred times more likely to kill themselves than someone else, and those with a mood disorder are one thousand times more likely.⁸

Research findings do tend to demonstrate a positive relationship between mental illness and violence, although there is some evidence that violence by people with mental disorder is not increasing.⁹ The risk of violent behaviour is modestly increased in people with psychotic illness alone. The greatest risk is associated with personality disorder, substance misuse, and conditions where substance abuse is combined with severe mental illness.

Whether people are adequately protected

Different people have different levels of anxiety. As a result, trying to determine what is an acceptable risk, what constitutes adequate protection, and whether a particular system is 'unsafe', is partly subjective. It is, nevertheless, important to try to establish whether violence associated with mental disorder is increasing, and to make comparisons between different kinds of violence.

The criminal statistics for England and Wales between 1957 and 1995 reveal little fluctuation in the number of mentally ill people who committed criminal homicide during this 38 year period, and a three per cent annual decline in their contribution to the official statistics. The number of homicides committed by them peaked at 130 in 1972, and then fell steadily to 60 in 1995. People are more likely to win the National Lottery jackpot than they are to die at the hand of a stranger with a mental illness.¹⁰

Although there appears to be a positive relationship between mental illness and violence, people with drug misuse or substance dependence disorders present the highest risk. Furthermore, variables such as male sex, young age, and lower socio-economic status proportionately make a much higher contribution to violence in society than the modest amount attributable to mental illness. In a large United States study, 16% of 18–24-year-old men from low socio-economic classes were found to be violent, and they represented a far greater risk than the people with schizophrenia.¹¹

7 Tidmarsh, D, *Psychiatric risk, safety cultures and homicide inquiries*, *The Journal of Forensic Psychiatry* (1997) 8(1): 138–151.

8 Häfner, H., and Böker, W., (1973) (translated by H. Marshall, 1982). *Crimes of Violence by Mentally Abnormal Offenders*. Cambridge: Cambridge University Press.

9 Mullen, PE, et al., *Community care and criminal*

offending in schizophrenia. *Lancet* (2000) 355:614–617.

10 Taylor PJ and Gunn J (1999), 'Homicides by people with mental illness: myth and reality' *British Journal of Psychiatry* 174: 9–14.

11 Swanson JW, et al., (1990). *Violence and psychiatric disorder in the community: Evidence from the Epidemiologic Catchment Area Surveys*. *Hospital and Community Psychiatry*, 41:761–770.

The available evidence suggests therefore that the closure of the old asylums, and the movement to providing care in the community, has not led to an increase in the level of violence committed by the mentally ill. The proportion of violence in society attributable to mental illness remains low, and people are better protected from violence of this kind than from most other kinds. Violence has much more to do with education, upbringing, alcohol, drugs and testosterone than mental illness. That is not to say, of course, that it is appropriate to detain and treat people in these classes under mental health laws.

The facts do not support the Government's proposition.

That this is so leads to a supplementary point, which is the need to encourage people to be realistic about risks and their management. It is impossible for mental health services to be totally safe, and Governments should take account of the natural limits of practice before they introduce legislation:

- Risk cannot be avoided and even a very low risk from time to time becomes an actuality. However careful the assessment, it is inevitable that some patients will later take their own lives or commit a serious offence.
- Any decision to detain an individual, or to compel them to have treatment, involves balancing competing risks, of which the risk that others may suffer physical harm is but one. For example, detention and compulsory treatment risk loss of employment, family contact, self-esteem and dignity; unnecessary or unjustified deprivation of liberty; institutionalisation, and disabling side-effects.
- The purpose of compulsory powers is not to eliminate that element of risk in human life which is a consequence of being free to act, and to make choices and decisions; it is to protect the individual and others from risks that arise when a person's judgement of risk, or their capacity to control behaviour associated with serious risk, is significantly impaired by mental disorder.
- Good practice relies on good morale and a feeling amongst practitioners that they will be supported if they act reasonably; it is unjust to criticise them when decisions properly made have unfortunate, even catastrophic, consequences.
- The occurrence of such tragedies does not per se demonstrate any error of judgement on the part of those who decided that allowing the patient their liberty did not involve unacceptable risks.
- An outcome is often the result of a complex series of events, and the choice of one particular causal factor may be arbitrary.
- Small differences in one key variable can result in vastly different behaviours and outcomes: just as a sudden change in the physical state of water into steam or ice occurs with the rise or fall of temperature beyond a critical level, so the addition of a small additional stress on an individual may have a profound effect on their mental state or behaviour.
- All violence takes place in the present, and the past is a past, and so unreliable, guide to present and future events.
- Understanding the situations in which a person has previously been dangerous, and avoiding their repetition, can give a false sense of security about the future. Although life is understood backwards, it must be lived forwards, and the difference between explanation and prediction

is significant: explanation relies on hindsight, prediction on foresight, and the prediction of future risk involves more than an explanation of the past.

- Unless the individual's propensity for violence has a simple and readily understandable trigger, it is impossible to identify all of the relevant situations; some of them lie in the future, and will not yet have been encountered by the patient.
- Predictions are most often founded not on fact but on 'retrospective predictions' of what occurred in the past ('retrodiction').
- A risk can in theory be measured and is the basis of actuarial prediction – in theory because in practice all of the critical variables never are known. The risk depends on the situation but the situations in which the patient may find themselves in the future can only be speculated upon.
- Because future events can never be predicted, it is important to put in place an adequate system for supervising an individual whose own safety may potentially be at risk or who may pose a threat to the safety of others. However, this approach is not fail-safe: it is based on the assumption that most attacks do not erupt like thunderstorms from clear skies. In reality, as with weather systems, only the pattern of events for the next 24 hours can usually be forecast with some accuracy; and contact with supervisors is less regular.
- All human beings, regardless of their skills, abilities and specialist knowledge, make fallible decisions and commit unsafe acts, and this human propensity for committing errors and violating safety procedures can be moderated but never entirely eliminated.

Whether our laws are at fault

Even if people are inadequately protected from the actions of people who suffer from mental disorder, this may not be a fault of our laws. It may be due to insufficient resources, poor government, poor service management, poor risk management, faulty practice, a faulty understanding of the law, or simply part of the human condition. In other words, a problem or limitation that is to a significant extent replicated across a world full of different mental health laws. Implicit in any discussion about the need for new laws is the assumption that modifying their content modifies outcomes. However, the extent to which this is true is unclear. Legislation is actually a relatively ineffective means of modifying behaviour. Although it can provide a framework for managing violence associated with mental disorder, it cannot significantly reduce these risks. That this is so is clear from recent homicide inquiry reports. Had the professional carers foreseen what was about to happen, they already had power under the present law to intervene. That they did not intervene was due, not to any lack of legal powers, but to the fact that they did not foresee what was about to occur. Yet no amount of new legislation can improve foresight. Nor can it improve insight, for 'he that complies against his will, Is of his own opinion still.'¹²

The key to progress rests with improving government, resources, diagnostic tools, treatments and training, and, most fundamentally of all, with education:

'I believe that education is the fundamental method of social progress and reform. All reforms which rest simply upon the law, or the threatening of certain penalties, or upon changes in mechanical or outward arrangements, are transitory and futile.... But through education society

¹² Butler, *Hudibras* (1663), Part 3, Canto 3.

can formulate its own purposes, can organize its own means and resources, and thus shape itself with definiteness and economy in the direction in which it wishes to move.... Education thus conceived marks the most perfect and intimate union of science and art conceivable in human experience.¹³

The importance of our other convictions

A pragmatic approach to law-making involves considering whether the Government's solution violates other important convictions. Does it show adequate regard for those principles that have been demonstrated to have value? Even if there is benefit in the proposals, what is the cost?

Some of the most important, established, principles concerning the formulation of mental health laws may be restated here:¹⁴

1. It is unsatisfactory to seek to determine principles by reason only, without regard for human experience of the world within which principles are formulated and applied. Our value judgments are judgments about experienced objects.
2. There are many reasons to limit state intervention in people's lives: errors in law spread their negative effects throughout the nation as opposed to individual errors that are limited in scope; the damage of erroneous laws affect citizens more than legislators, who are thus less inclined to repeal them; it takes longer to repair the damage done by legislation than the damage done by individuals by their own private choices; because of the constant watch of critics, politicians are less inclined to publicly admit error and undo the damage done; politicians are more inclined than citizens to make decisions based on political gain and prejudice, rather than principle.¹⁵
3. The British constitution separates powers, the aim being to keep executive powers in check and under proper scrutiny, and so to secure good government. This is necessary because the 'whole art of government consists in the art of being honest',¹⁶ and 'it is not by the consolidation, or concentration of powers, but by their distribution, that good government is effected.'¹⁷
4. Promoting liberty, protecting individuals from harm caused by those at liberty, and those not at liberty from abuse by those who are, alleviating suffering, and restoring to health those whose health has declined, are all legitimate objectives, in that they reflect values embraced by virtually all members of our society.¹⁸
5. We are, however, 'faced with choices between ends equally ultimate, and claims equally absolute, the realisation of some of which must inevitably involve the sacrifice of others.'¹⁹ Whether individuals 'should be allowed certain liberties at all depends on the priority given

13 Dewey, J, *My Pedagogic Creed* (1897), in *The Essential Dewey, Volume 1* (ed. Hickman L and Alexander TM), Indiana University Press, Bloomington & Indianapolis, 1998, p.234.

14 Some of these principles were previously stated in Eldergill, A, *Reforming the Mental Health Act*, *Journal of Forensic Psychiatry*, Vol. 12, No. 2, 379-397.

15 Benjamin Constant: *Political Writings* (trans. and ed. Biancamaria Fontana), Cambridge University Press 1988.

16 Thomas Jefferson: *Rights of British America, 1774. The Writings of Thomas Jefferson, Memorial Edition* (ed., Lipscomb & Bergh), Washington, DC, 1903-04.

17 Thomas Jefferson: *Autobiography, 1821. The Writings of Thomas Jefferson, Memorial Edition* (ed., Lipscomb & Bergh), Washington, DC, 1903-04, 1:122.

18 Eldergill, AC, *Mental Health Review Tribunals - Law and Practice* (Sweet & Maxwell, 1997), p.45.

19 Berlin, Sir I, *Four Essays on Liberty* (Oxford University Press, 1969), p.168.

by society to different values, and the crucial point is the criterion by which it is decided that a particular liberty should or should not be allowed, or that its exercise is in need of restraint.²⁰

6. When enacting mental health legislation, Parliament has generally sought to erect a balanced legal structure that harmonises three things: individual liberty; bringing treatment to bear where treatment is necessary and can be beneficial; the protection of the public.²¹ Those we describe as ‘patients’ are themselves members of the public, so that the law must seek to ensure that members of the public are not unnecessarily detained, and also that they are protected from those who must necessarily be detained.
7. The use of compulsion has been permitted when significant harm is foreseeable if an individual remains at liberty. Its purpose is to protect the individual or others from those risks that arise when a person’s capacity to judge risks, or to control the behaviour giving rise to them, is impaired by mental disorder.
8. Other risks are, constitutionally, matters for citizens to weigh in their own minds. The purpose of compulsion is not to eliminate that element of risk in human life that is simply part of being free to act and to make choices and decisions. A person who obeys our laws is entitled to place a high premium on their liberty, even to value it more highly than their health. Subject to the stated limits, people are entitled to make what others regard as errors of judgement, and to behave in a manner which a doctor regards as not in their best interests, in the sense that it does not best promote health.
9. This desire to determine one’s own interests is common to human beings, and so not to be portrayed as an abuse of liberty. On the one hand stands liberty, a right which Parliament and the law should always favour and guard, on the other licence, a wilful use of liberty to contravene the law, which the law must of necessity always punish.
10. Any power given to one person over another is capable of being abused. No legislative body should be deluded by the integrity of their own purposes, and conclude that unlimited powers will never be abused because they themselves are not disposed to abuse them.²² Mankind soon learns to make interested uses of every right and power which they possess or may assume.²³
11. This risk of abuse is multiplied if the individual is not free to escape abuse, is incapacitated or otherwise vulnerable, or their word is not given the same weight as that of others. Children and adults with mental health problems are particularly at risk, and the law has usually afforded them special protection.
12. This protection involves imposing legal duties on those with power, conferring legal rights on those in their power, and independent scrutiny of how these powers and duties are exercised. The effectiveness of such schemes depends on whether, and to what extent, they are observed.
13. This is a matter of constitutional importance, for the observance of legal rights and the rule of law are the cornerstones of all liberal democracies. The rule of law ‘implies the subordination of all authorities, legislative, executive [and] judicial ... to certain principles

20 *Dias, RWM., Jurisprudence (Butterworths, 5th ed., 1985), p.109.*

21 *Hansard, H.C. Vol. 605, col. 276.*

22 *Thomas Jefferson: Notes on Virginia Q.XIII, 1782. Memorial Edition (supra), 2:164.*

23 *Thomas Jefferson: Notes on Virginia Q.XIII, 1782. Memorial Edition (supra), 2:164.*

which would generally be accepted as characteristic of law, such as the ideas of the fundamental principles of justice, moral principles, fairness and due process. It implies respect for the supreme value and dignity of the individual.²⁴

14. In any legal system, 'it implies limitations on legislative power, safeguards against abuse of executive power, adequate and equal opportunities of access to legal advice and assistance, ... proper protection of the individual and group rights and liberties, and equality before the law ... It means more than that the government maintains and enforces law and order, but that the government is, itself, subject to rules of law and cannot itself disregard the law or remake it to suit itself.'²⁵
15. In framing these principles and laws, Parliament has sought to be just, justice being 'a firm and continuous desire to render to everyone that which is his due.'²⁶
16. If new laws are necessary, they should impose minimum powers, duties and rights; provide mechanisms for enforcing duties and remedies for abuse of powers; be unambiguous, just, in plain English, and as short as possible.
17. Because there is a long record of experimentation in human conduct, cumulative verifications give these principles a well-earned prestige. Lightly to disregard them is the height of foolishness.²⁷

The Government's solution

Having considered the case for change, and some of the principles that should govern the drafting of mental health legislation, it is time to examine the proposed solution.

The draft Bill comprises 180 clauses divided into 11 parts, and nine schedules. Some parts of the Bill are sub-divided into chapters, in order to make the document more readable.

As with the 1983 Act, Part 1 is concerned with introductory matters, such as defining mental disorder, Part 2 with civil compulsion, Part 3 with patients involved in criminal proceedings, and Part 4 with medical treatment. Part 5 then sets out a new statutory scheme for incapacitated patients, while the remainder of the Act deals with matters such as powers of entry and conveyance, patient representation, appeals and statutory offences.

A new compulsory assessment power replaces section 2 of the 1983 Act, and all patients must first be assessed under this 28-day procedure. A person subject to it may be detained in hospital as a resident patient or assessed in the community as a non-resident patient. Further compulsion requires a tribunal order. The professional responsible for the patient's assessment and medical treatment is known as their 'clinical supervisor', and this person replaces the 'responsible medical officer'.

Mental disorder

The Bill's definition of mental disorder, taken from the Richardson Report, is meaningless: 'mental disorder' means 'any ... disorder of mind ... which results in a ... disturbance of mental functioning.' In short, 'mental disorder' means any mental disorder which results in a mental disorder.

24 David M Walker, *The Oxford Companion to Law* (Clarendon Press, Oxford, 1980), p.1093.

25 *Ibid.*

26 Justinian, *Inst.*, 1, 1.

27 Dewey, J, *Human Nature and Conduct* (Allen & Unwin, 1922).

The general purpose of any definition of a class is to state its boundary but here no one is excluded. The definition is not a definition at all.

The constitutional purpose of defining ‘mental disorder,’ and dividing disorders into different classes, is to define, as far as practicable, the group of citizens to whom the statute applies, and the circumstances in which resort may be made to compulsory powers. By the use of such mechanisms Parliament has usually sought to ensure that the liberty of individuals is not unnecessarily, or unjustifiably, infringed.

The comprehensive nature of the definition is significant because the four statutory forms of mental disorder are to be abolished. If an individual comes within this ‘definition’ of mental disorder – and, as drafted, no one is outside it – they may be detained or supervised by other individuals, provided they meet the loose criteria for compulsion in the Bill.

Section 1(3) of the present Act is not reproduced. This provides that no one may be dealt with as mentally disordered by reason solely of promiscuity, immoral conduct, sexual deviancy or dependence on alcohol or drugs. The statutory bar on using mental health laws to detain or compel people who depend on drugs or alcohol, or who sexually offend against children, but whose conduct is not otherwise abnormal or harmful, is therefore abolished.

By removing existing exclusions and limitations, the new scheme renders an extensive new population of people liable to compulsory treatment: people who depend on alcohol or drugs, where their dependence is the only justification for a finding that they are mentally disordered; people whose sexual behaviour is considered to be deviant, where their behaviour is the only justification for a finding that they are mentally disordered; people with a ‘disordered personality’ or a learning disability, even though their conditions are untreatable, and their behaviour is not abnormally aggressive or seriously irresponsible; non-compliant out-patients; conditionally discharged restricted patients; and those now subject to guardianship or after-care under supervision.

Alcohol and drug dependency services will be drawn into implementing mental health laws, and the patient population will change if psychiatric services are used to contain people who exhibit socially deviant behaviour. The public’s fear of the mentally disordered will then increase.²⁸

Persons who may only be treated compulsorily

The Bill goes further, and provides that some people with a mental disorder may *only* be treated under a compulsory order. Urgent treatment aside, in two situations an incapacitated patient may not be treated by their clinical supervisor unless the treatment is authorised under Part 2.

The first situation is where an incapacitated person would resist the proposed treatment. Here, it is to be assumed that a person who has indicated that s/he does not want to receive treatment, or a particular treatment, would resist it. Thus, we arrive at the rather Einstein-looking formula, ‘incapacity + resistance = compulsion.’

The second situation is where there is a substantial risk that an incapacitated patient will commit suicide or cause serious harm to others.

It seems to be assumed that an incapacitated person who resists treatment necessarily meets the statutory conditions for compulsory treatment. Otherwise, the patient cannot be treated by specialist mental health services.

²⁸ Rabkin, JG, ‘Criminal Behaviour of Discharged Mental Patients: A Critical Appraisal of the Research,’ *Psychological Bulletin* (1989, 86, 1–27).

These requirements must be read with the new incapacity scheme set out in Part 5. The effect is that incapacitated patients who resist treatment, or are at substantial risk, may only be treated by their clinical supervisor under Part 2, whilst other incapacitated people may be treated under Part 5, without being 'sectioned', provided they qualify for its safeguards. Broadly speaking, they qualify for this less formal scheme if they are in-patients, and their incapacity and need for in-patient treatment are likely to last more than 28 days.

Because people 'who are not capable of consenting to treatment' must sometimes be 'sectioned' or not treated, it is crucially important to know who these people are. However, the Bill does not include a definition, and is of no assistance.

It might be assumed that the provisions mainly affect people who cannot consent to treatment because they have a learning disability or suffer from a form of dementia. In other words, the test is a cognitive test based on the individual's capacity to understand the nature, purpose and likely effects of the proposed treatment, and also perhaps the alternatives and likely consequences of no treatment.

However, the Richardson Report and the Lord Chancellor's paper on incapacity, *Who Decides?*, adopted the Law Commission's recommendation that an individual who is able to understand and retain information relevant to a treatment decision is still incapacitated if s/he is unable to make a decision based on that information.²⁹

The Law Commission gave an example of what it meant by this, which the Lord Chancellor's paper refers to:

'Some people may be unable to exert their will ... because of delusions or compulsions or [some] other reason connected with their disability. The schizophrenic who cannot believe what his doctors or financial advisors tell him is one example; the manic depressive whose impulses override his understanding is another ... The Law Commission thus recommended that a person should be regarded as unable to make a decision by reason of mental disability if the disability is such that, at the time when the decision needs to be made, the person is:

- unable to understand or retain the information relevant to the decision or
- unable to make a decision based on that information.'³⁰

Many in-patients with diagnoses of chronic schizophrenia or a mood disorder come within this class, and some out-patients. If a 'cognitive + conative' approach of this kind is adopted by Parliament or the courts then many people who have a severe mental illness may only be given treatment on a compulsory basis.

This approach to capacity is grounded in Kant's notion of the autonomous individual, and in his distinction between autonomy and heteronomy of the will. The heteronomous person derives principles of action from outside her or himself, for example by considering the objects or consequences of their choices, or by acting in accordance with the commands of the state or society. The autonomous individual derives principles of action from within, what they will be in accordance with reason. Those incapable of acting in accordance with reason are incapable of autonomy. They are not part of the Enlightenment.

29 'Who Decides? Making Decisions on Behalf of Mentally Incapacitated Adults', Lord Chancellor's

Department, London, December 1997, pp.12-13.

30 *Ibid.*, p.13. See Law Com 231, para. 3.21.

When applied to the making of decisions by, or concerning, people who have a mental disorder, this ‘people are unable to exert their will’ approach results in a perverted concept of capacity. Rather than honestly say, ‘I know you don’t will this but I sincerely believe that it is in your best interests’, it involves the professional saying, ‘You may think you know what you wish but you lack reason and you are unable to exert your will. I actually know what you will, what you wish, better than you. The rational you wishes me to do this, to compel you to have this treatment that you appear to resent.’

It is an approach that brings to mind the warning of Sir Isaiah Berlin:

‘Even though men suffer ... in the process, they are lifted by it to a height to which they could never have risen without my coercive – but creative – violation of their lives. This is the argument used by every dictator, inquisitor, and bully who seeks some moral, and even aesthetic, justification for his conduct. I must do for men (or with them) what they cannot do for themselves, and I cannot ask their permission or consent, because they are in no condition to know what is best for them.’³¹

This is, Berlin suggests, a form of thinking to which the scientist may be especially prone, and he reminds us that Auguste Comte asked, ‘If we do not allow free thinking in chemistry or biology, why should we allow it in morals or politics?’ For if, as Comte believed, scientific method will in due course reveal all truths then what case is there for freedom of opinion or action, at least as an end in itself, and why should any conduct be tolerated that is not authorized by appropriate experts?³²

Such a dehumanising approach is totalitarian in nature, and an awareness of the suffering it has caused, and causes – leading to its emphatic rejection – ought to be the great lesson of the twentieth century.

What each individual wishes, whether ill or not at the time, is at that time their will. They have expressed their preference and, in doing so, the decision they would make if left free to decide. It may be that their choice is founded upon a belief that facts exist which do not exist, or is profoundly affected by an abnormal mood, but what they wish is, nevertheless, still truly what they wish, and a true expression of their mind and the world within which they move.

What each person wills for herself must therefore never be denied or reinvented by those who do not will it for them. The human will is the essence of human dignity, and one must treat people in such a position as capable human beings who refuse their consent. If their wishes are overridden, the justification for compulsion must be the risks associated with their decision, not that they are incapable of making a decision.

It may be contended that this is simply another kind of incapacity, namely incapacity by reason of mental disorder to understand, appreciate or control the significant risks associated with the individual’s decision. Hence, the distinction is academic. There is, however, a difference. Whilst it is always necessary to make a decision for a person who is incapable of making a decision for themselves, the approach advocated here is that most people with a severe mental illness are capable of making their own decision. They must therefore be allowed to decide for themselves unless it can be demonstrated that their decision gives rise to significant risks. To this extent they retain their autonomy.

31 Berlin, *Sir I, supra*.

32 Berlin, *Sir I, supra*, p.151.

It is a risk approach, and one which gives rise to a moral duty on the part of others to provide safe care once significant risks are established. This care must accord with the principle of beneficence, which asserts an obligation to help others further *their own* important and legitimate interests.

Proceeding in this way gives proper recognition to the importance of individual liberty and autonomy in English society. It recognises the sanctity of the individual – the fact that no person is a means to another’s end – and the fact that, though much is taken, much remains.

Whether the human personality is a proper subject for medicine

The Home Office and the Department of Health have for some time now been considering the introduction of new laws aimed at protecting the public from individuals who have a ‘dangerous severe personality disorder’.

In July 1999, the two departments published a consultation document, setting out proposals intended to ensure ‘that DSPD people are kept in detention for as long as they pose a high risk. The approach the Government has developed ... involves the idea of detention based on the serious risk such people present to the public.’³³

The Government was therefore advocating that risk alone, as well as mental disorder and criminal punishment, can justify detention. As a result, consideration was given to detaining such people in ‘third units’, in essence adult secure accommodation of the kind presently provided for some behaviourally-disturbed children.

This is a quarantine argument; one which holds that, subject to problems of identification, the civil detention of dangerous people is justified even if they have not committed any violent offences. The contrary argument is that the civil detention of dangerous non-offenders is never warranted, because it is a fundamental principle that citizens who obey our laws have a right to be at liberty. To imprison a person who has not yet committed the offence one fears is the criminal justice system of Alice’s Wonderland: “No, no!” said the Queen. “Sentence first – verdict afterwards.”

The ‘third-unit’ option seems to have been abandoned, probably because it was thought that indefinitely detaining non-offenders in civilian accommodation risks infringing the European Convention on Human Rights. Article 5(1) permits the detention of convicted persons and those of unsound mind in appropriate facilities (prisons and hospitals, respectively), but does not in clear terms permit the detention of citizens who have not offended merely because there is a risk they will do so in future. Detention in secure non-hospital accommodation rather rules out pleading mental disorder, and a need for treatment, as the justification, and nor can punishment or lawful sentence be pleaded, because the individuals are not serving a term of imprisonment.

Probably for these reasons, therefore, the Government seems to have retreated, at least for the present, to the justification that such people are mentally disordered: they require medical treatment in hospital or medical treatment under supervision in the community.

It is, no doubt, with the anti-social in mind that the criteria for compulsion, and various key statutory terms – such as mental disorder, medical treatment, hospital and clinical supervisor – are defined as they are. Indeed, the proposals for the compulsion of civilians seem designed to deal with people who habitually threaten, harm or alarm others, whatever the cause. It is in effect a ‘well

³³ Home Office/Department of Health, *Managing Dangerous People with Severe Personality Disorder, Proposals for Policy Development, July 1999.*

dodgy' Act, designed to sweep from the streets, or to supervise and control, anyone whose conduct causes the public significant concern, but whose behaviour – in the absence of actual evidence or proof of serious offending – does not allow the police or the courts to place them in custody.

Much of the recent debate has centred on whether or not the NHS and other agencies are resourced to provide such an extensive service. However, this assumes that such people should be dealt with on the basis that their conduct is evidence of a medical condition that requires medical intervention. The arguments for not permitting this are compelling.

Kurt Schneider defined personality as, 'the unique quality of the individual, his feelings and personal goals; the sum of his traits, habits and experiences and the whole system of relatively permanent tendencies, physical and mental, which are distinctive of a given individual.'³⁴ In short, personality is what makes one individual different from another. It is who I am.

This observation immediately gives rise to two important questions: Are people said to have disordered personalities injured, ill or diseased? And, is the human personality a proper subject for medicine?

The evidence suggests that present medical interventions have, like liberal prison regimes, the reformation of the individual as their aim. This is unacceptable because the proper function of medical science and practice is to treat individual suffering attributable to disease or injury, not to alleviate the suffering of society; and, in the field of mental health, to treat those diseases or injuries which interfere with the development or expression of an individual's personality, not to reform her or his personality by reference to some social or political norm.

The mental state and behaviour of an individual said to have a personality disorder is abnormal, in the sense that it deviates from the social norm, but normal in relation to their own individual norm: that is, it is consistent with what is known about their development and functioning over time. Here then, the individual is only abnormal by reference to a social norm, and such a deviation cannot be said to constitute a disease because mere social deviation is not evidence of biological disorder. This requires evidence of injury or deviation from the individual norm. If there is no evidence of either then one is simply confusing individuality with ill-health: treating as biologically abnormal an undiseased, uninjured, creature living its natural life, so that medicines are pesticides.

The motivation for this social control is transparent. People want to live in a cultivated society, and they cultivate society in much the same way they cultivate nature in their gardens. This involves eradicating disease in the garden, but also weeding it and controlling pests, that is containing or destroying organisms which are doing nothing more than expressing their natures. There is nothing unique in this, for the same power is claimed over animals and unborn life, and most other things that interfere with personal survival or fulfilment. But it is why CS Lewis wrote that, 'To be cured against one's will and cured of states which we may not regard as disease is to be put on a level with those who have not yet reached the age of reason or those who never will; to be classed with infants, imbeciles and domestic animals. But to be punished ... because we have deserved it ... is to be treated as a human person made in God's image.'³⁵

³⁴ Schneider, K, *Clinical Psychopathology* (5th ed., trans. Hamilton MW, Grune & Stratton, 1958).

³⁵ Lewis, CS, *The Humanitarian Theory of Punishment*, *University of Melbourne Law Review* (1953) 228.

Although many people would not today understand the issue in religious terms, the argument retains its inner strength: there is more human dignity in punishment than in medicalizing anti-social or violent behaviour.

This is an uncomfortable message for an age that is uncomfortable with the notion of punishment, the more so when the debate involves issues of responsibility and free will, and the extent to which some people's personalities do not enable them to refrain from anti-social behaviour. However, our conscious thinking and deciding are embodied in the workings of our brains, and consequently *our* behaviour is determined by *our* thinking and choosing. While determinism provides an explanation for our choices and actions, it is humans beings, not deterministic rules, that cause events. The fact that an individual's personality, as determined by their genes and previous experiences, dictates the choice s/he makes does not mean that s/he has not chosen between alternatives. Furthermore, whilst not everyone has the same capacity to eschew the wrong, this does not preclude us from judging their actions, because whether an action is harmful is not affected by its antecedents. In short, our conscious decisions and actions are matters of personal choice: each chooses what suits their personality, not that of others, and must be accountable to others for their choice. The counterpart of freedom and autonomy is accountability for acts freely and autonomously done.

The view presented here therefore is that those persons presently categorized as psychopaths are not mentally disordered, and they should be excluded from mental health legislation. We are simply medicalizing 'deviant behaviour'.³⁶ Believing this, there is no inhumanity in holding that they should be imprisoned if their offence and forensic history merits it. If we are satisfied that our prison system is the best that can be devised for the prevention of crime, and the reformation of the criminal, then we may rest satisfied that it is the best treatment for the sort of insanity from which criminals suffer. If, on the other hand, we are not satisfied that prisons are reformatory then why this is so needs to be the principal focus of our attention.³⁷

What cannot be justified are mental health or social protection laws that permit the preventive detention of law-abiding citizens who are free of injury or disease. It would be unjust to detain them for crimes they have not committed and are actuarially unlikely to commit. It would be immoral, because the old maxim that 'you shall not do evil that good may come' is applicable in law as well as in morals. It would be inutile, because any impact on the rates at which serious offences are committed is likely to be marginal. There is little gain in detaining a handful of notionally dangerous civilians each year when guilt in criminal proceedings must be proved beyond all reasonable doubt, because every year we release without penalty thousands of rapists and other violent offenders. Lastly, it would be unwise. For, when the public perceives that they are no safer despite such a reform, rather than realise and learn from their folly, they will demand that basic freedoms be further curtailed and the penalties made more severe.

36 In Conrad's opinion, the conditions for the medicalization of deviance are that: (1) a behaviour or set of behaviours must be defined as deviant and as a problem in need of remedy by some segment of society; (2) previous or traditional forms of social control must be seen as inefficient or unacceptable, e.g. corporal punishment or penal servitude; (3) some medical form of social control must be available; (4) ambiguous organic data as to the source of the problem must exist; and (5)

the medical profession must be willing to accept the deviant behaviour as within their jurisdiction. Conrad, P, *On the Medicalization of Deviance and Social Control*, in *Critical Psychiatry: The Politics of Mental Health* (ed. D. Ingleby, Penguin Books, 1981), pp. 111-118.

37 Maudsley, H, *Responsibility in Mental Disease*, 4th ed, 1885, Kegan Paul, Trench & Co., London, p.27.

Such demands misunderstand the functions of the law and its natural limits. It is not within the power of the law, given the venality of the times, to cleanse the Augean stable. As Montesquieu observed, in 'moderate governments, the love of one's country, shame, and the fear of blame are restraining motives, capable of preventing a multitude of crimes. Here, the greatest punishment of a bad action is conviction ... In those states a good legislator is ... more attentive to inspire good morals than to inflict penalties.'³⁸

Only those who know the cost but not the value of our freedoms would embark upon such a journey. Nothing which has great value is without cost, and the value of anything is what one is prepared to sacrifice for it. The value attached to trial by one's peers is the financial cost of the jury system; the value of justice is demonstrated by a willingness to see the guilty go free rather than risk convicting the innocent; and the value of liberty is demonstrated by stoically bearing the many evils which liberty permits. If the defence of these freedoms was worth the sacrifice of millions during two wars then, unless society has become wholly degraded, it must withstand the death of a few during peacetime. Such a scheme has no utility which can justify its innate immorality and the infliction of such great injustice; and it would be highly imprudent to interfere with public liberties in the name of public safety when the necessity of such a scheme has not been firmly established.³⁹

The relevant conditions for compulsion

The new statutory criteria for compulsion are called 'the relevant conditions', of which there are four. The same criteria are used for compulsory assessment and treatment, and the short-term detention of informal in-patients requires that these conditions appear to be met.

The first two conditions for compulsion

The first two conditions are duplicitous, and read more properly as a single condition; one which requires that 'the patient is suffering from [a] mental disorder ... of such a nature or degree as to warrant the provision of medical treatment ...'

This condition is easily satisfied because the nature or degree of the individual's disorder need no longer be of a severity that warrants detention, compulsion or treatment. If s/he has a mental disorder, all that is required is that it is of a kind that warrants providing medical treatment. The Bill provides that 'medical treatment' means,

'treatment for mental disorder provided under the supervision of an approved clinician; and for this purpose 'treatment' includes

- (a) nursing,
- (b) care,
- (c) habilitation (including education, and training in work, social and independent living skills),
and
- (d) rehabilitation (read in accordance with paragraph (c)).'

38 Montesquieu, *Baron de, The Spirit of the Laws* (Cambridge University Press, 1989).

39 This passage is taken from Eldergill, A, *Psychopathy, the Law and Individual Rights*, Princeton University

Law Journal, Volume III, Issue 2, Spring 1999. Reproduced in Eldergill, A, *A Greater Evil*, *The Guardian*, 20 July 1999.

This definition differs from that in the 1983 Act in two respects.

Firstly, treatments of the kind described constitute medical treatment if they are provided under the supervision of an approved clinician. Who is an approved clinician is left to regulations. However, according to the explanatory notes, it is expected that the term will refer to medical practitioners and psychologists of consultant status. Under the current statute, the listed interventions only count as medical treatments if they are provided under medical supervision.

When regulations are made, the Minister may seek to preserve the breadth of the existing definition, by describing all medical practitioners as approved clinicians. Alternatively, he may adhere to the intention expressed in the explanatory notes, by limiting the term to treatments provided under the supervision of a consultant.

If the Minister includes all doctors within the term, the first condition for compulsion is met by people who require treatment for anxiety or depression from their family doctor.

If the Minister restricts the term to consultants, the first condition is that the person has a mental disorder serious enough to warrant treatment by specialist mental health services. At its most stringent, therefore, people who experience depression or acute anxiety meet the condition if they require an out-patient appointment or a referral to mental health services.

It can be seen that who meets the test for detention in the primary legislation (the Parliamentary Act) depends on the secondary legislation made by the Minister (the regulations). This is unsatisfactory, and may be unlawful. For example, because it enables the conditions for compulsion to be periodically varied by Ministers without going back to Parliament.

The second difference relates to the words in parentheses, which are new: 'including education, and training in work, social and independent living skills'. The use of the word 'including' indicates that the list is not exhaustive, and that the interventions referred to are examples. Other supervised measures appropriate to a person's social habilitation or rehabilitation can constitute medical treatment.

The effect of the revisions is that social interventions which most people would not think of as forms of medical treatment are medical treatments for legal purposes. For example, work training or training in social skills under the supervision of a psychologist is medical treatment, even though no medical practitioner is involved in providing it.

Thus, a person who takes street drugs, and whose behaviour is anti-social and alarming, may be said to have a mental disorder that warrants providing them with medical treatment, in the form of work training, and training in social skills, under psychological supervision. This is social compulsion dressed up as medical compulsion.

The second condition for compulsion

When a person is described as suffering from a psychopathic disorder or mental impairment, the current Act makes it a precondition of long-term detention for treatment that treatment will alleviate their condition or prevent its deterioration.

The equivalent condition of compulsion in the draft Bill is that 'appropriate medical treatment is available in the patient's case'.

'Appropriate' is a very general word, and what is appropriate to a situation depends on the situation and all of the circumstances. The Bill deliberately does not say that treatment is only

appropriate if it alleviates the patient's condition or prevents its deterioration, and this is not a treatability test. By analogy, where a person has an incurable cancer, treatment which alleviates pain may be appropriate, even though it has no curative value.

The previous example helps to make this clear. This involved training in social skills under psychological supervision. These available 'medical treatments' can be described as an appropriate way of treating the individual's anti-social behaviour, in which case it is not formally necessary to determine that the interventions are likely to alleviate or stabilise any underlying disorder.

Likewise, where an individual's violent behaviour places other people at significant risk, supervised social interventions of the kind imposed on restricted patients may be an appropriate way of managing the risks. Indeed, the very fact that the individual's violent propensities are untreatable may make it particularly appropriate to ensure that s/he is subject to habilitation under supervision.

Again, therefore, the wording is designed to permit the compulsion under mental health legislation of people whose behaviour is dangerous, threatening or alarming.

The final condition for compulsion

The final condition consists of alternative criteria, and which of them applies depends on whether other people are at substantial risk of serious harm.

In cases where there is a substantial risk that the patient will cause serious harm to others, the final condition is that 'it is necessary for the protection of those persons that medical treatment be provided to him'. It is not necessary to demonstrate that the treatment cannot be provided without compulsion.

Where no substantial risk of serious harm to others exists, the final condition is that it is necessary for the patient's health or safety, or the protection of others, that 'medical treatment' is provided, and this treatment cannot be provided unless the patient is subject to the provisions of the new Act.

This is a very lax condition, although how lax depends on who the Minister chooses to describe as an approved clinician, which will determine how medical treatment is defined. If treatment of any description suffices, a person meets all four conditions for compulsion if s/he requires but refuses treatment for mental disorder from a general practitioner. If only medical treatment provided under the supervision of a consultant suffices, a person meets the conditions if s/he refuses appropriate treatment from mental health or alcohol and drug dependency services, including measures such as work training and training in social skills.

Breadth of the conditions

It is important to emphasize the comprehensive nature of the conditions for compulsion:

- The definition of mental disorder in the Bill is meaningless, and no one is excluded from it;
- People may be dealt with as mentally disordered by reason solely of promiscuity, immoral conduct, sexual deviancy or dependence on alcohol or drugs;
- Who meets the test for compulsory treatment in the Parliamentary Act depends on the regulations made by the Minister;

- Social interventions not provided under medical supervision, such as work training and training in social skills, are defined as medical treatments;
- A person satisfies the conditions for compulsion if s/he refuses appropriate treatment from mental health or alcohol and drug dependency services, including social measures of the kind just described.

Powers of detention and compulsion

There is not space here to describe every aspect of the new civil powers. Given the Government's intention to introduce the Bill during the current Parliamentary session, the overriding need is to ensure a full and proper debate of its terms, by exposing the most significant ways in which existing powers are increased.

Short-term powers

The 1983 Act contains a number of short-term powers which enable a person to be detained for up to 72 hours. The Bill retains these short-term powers but with some modifications.

Under the Bill, a doctor may authorize the detention for up to 72 hours of an informal in-patient who appears to require compulsory assessment *in the community*. An 'authorised person' may likewise detain such a person for up to six hours. Who is authorized to use this power will be determined by the Minister after Parliament has enacted the legislation. It may be that the power will remain reserved to suitably qualified nurses. However, the Bill does not require this. As a matter of law, the Minister could empower other people, either now or at a later date. For example, approved mental health professionals or the person registered in respect of an independent hospital. The new section 135(1) power adopts the existing statutory grounds. Because the criteria remain unchanged so they remain defective in the same respects. The power is mostly used, and the criteria stretched, in order to enable professionals to remove and assess a person who refuses entry to their home. However, reason to suspect that an individual meets the criteria for admission and detention under the Act is not a ground for issuing the warrant. Whether a person can care for themselves, or is being ill-treated or neglected, is not the same issue as whether the only way in which a statutory assessment can be undertaken is by forced entry and removal.

The most controversial short-term provision is the urgent removal power in Clause 143. This authorises a constable acting on information from an approved mental health professional to force entry to private premises without a warrant. The constable must have reasonable grounds for believing two things: that an occupant believed to suffer from mental disorder is in urgent need of care or control in order to prevent serious harm to themselves or others; and that the urgency of the situation makes their removal under a warrant impracticable.

Necessarily, this power, as with all others, extends to people who are alcohol or drug dependant, or 'sexually deviant'.

Although the clause initially seems to be an emergency section 135(1) power, it is in fact much wider. It may be used if a patient is absent from hospital or their place of residence, or to effect the speedy recall to hospital of a restricted patient. It could also be used when a non-resident patient does not attend hospital for medication, if a constable is advised that the person is thereby in urgent need of care or control. If the patient is removed to hospital (which is a place of safety),

and their non-residency status is revoked within six hours, there will be no need to apply retrospectively to a court for a warrant.

The new 'section 4' emergency admission procedure may be invoked where a registered doctor and an approved mental health professional determine that the relevant conditions for compulsion are met. It provides that the patient shall be admitted to hospital if the doctor – rather than both professionals, as at present – determines that their assessment is an urgent necessity, and that awaiting a second medical examination would involve undesirable delay.

This is unsatisfactory. The fact that the relevant conditions for compulsion exist signifies only that compulsion is warranted, either as a resident or as a non-resident patient. Although the approved professional's opinion is that the conditions are met, it may also be their opinion that admission and detention are inappropriate. If so, the individual's detention is then founded on one medical opinion with which the approved professional disagrees, and that possibly from a general practitioner, or a doctor with no previous acquaintance of the patient. Furthermore, even if the approved professional believes that detention is appropriate, s/he may not agree that detention or assessment is urgently necessary, or that it is undesirable to await the second medical examination, for example from a consultant psychiatrist.

Preliminary examinations

Formal assessments of the need to invoke compulsory powers are currently undertaken by an approved social worker and two doctors. These assessments are referred to as 'preliminary examinations' in the Bill, and they will be conducted by two doctors and 'an approved mental health professional'.

The present intention is that this latter figure may be a trained and accredited social worker or health service professional. The involvement of a social worker will therefore no longer be essential, and the existing separation of powers, which requires that the applicant is independent of the doctors recommending compulsion, is abolished. In future, assessments may be conducted by three health service colleagues, all employees of the same detaining body.

Dealing with requests for a preliminary examination will also be an NHS function, and this is a further indication of the Government's desire to transfer mental health social workers to NHS care trusts.

The terminology emphasises that the statutory purpose of preliminary examinations is simply to determine whether a person meets the Government's conditions for compulsory medical treatment, not to assess their overall situation, including their social circumstances. More particularly, those examining the patient must determine three things:

- 1 Are the relevant conditions for compulsion met?
- 2 If so, is detention in a hospital appropriate?
- 3 If it is not, what requirements should be imposed on a non-resident patient?

Liability to compulsion is automatic if the three examiners agree that the relevant conditions for compulsion are met. None of them is given any discretion to consider matters not included in the Government's test for compulsion, such as the likely effect on the citizen's employment prospects and family life, or on the therapeutic relationship. Not only is the patient being compelled, the professionals are being compelled to use compulsion.

It can be seen that the approved mental health professional's role differs from that of an approved social worker. The latter is not required to determine whether an individual satisfies the medical grounds for compulsion. If two doctors certify that the medical conditions are met, their duty is to consider these recommendations together with any 'other relevant circumstances', and then to decide whether compulsion is necessary and proper, and an application ought to be made. No duty to apply arises if their professional opinion is that compulsion ought not to be used.

This professional discretion is entirely lacking from the new scheme. The approved professional's role is the same as that of the doctors: simply to examine the patient, and to determine and record whether or not the relevant conditions are met, compulsion being automatic if they are. Examiners must also now record determinations that a person does not meet the relevant conditions, together with the reasons for that finding. At present, it is only necessary to complete prescribed statutory forms when compulsory powers are either recommended or used.

A person who meets the conditions for compulsion may be detained in hospital if a nurse or social worker and one doctor consider it 'appropriate', notwithstanding that the other doctor, who may have special expertise in psychiatry, considers it to be inappropriate. Thus, the individual's detention is authorised even though the medical opinion is evenly split, with the expert opinion being against detention.

The test for detention is as subjective as such tests can be. Not 'is the individual's mental disorder sufficiently severe to warrant deprivation of liberty?', or 'is depriving this individual of their liberty justified by the risk of harm?', but 'does a professional person think it is appropriate to detain them while an assessment is carried out?'

This is not a proper constitutional basis on which to deprive a citizen of their liberty. The test ought not to be whether detention is appropriate but whether it is necessary – necessary because of the severity of the disorder and the consequential significant risk to the person's own health or safety or that of others.

It is unlikely that these provisions satisfy Article 5 of the European Convention on Human Rights. According to *Winterwerp*, detention on the grounds of unsoundness of mind must be founded on objective medical evidence, not divided medical evidence based on a statutory test devoid of any proper limitations on the power.⁴⁰

When detention is not appropriate, the requirements that may be imposed on a non-resident patient include that s/he does not engage in specified conduct. Presumably, this condition is directed in particular at those who depend on alcohol or drugs, are 'sexually deviant', or otherwise engage in anti-social behaviour. The fact that the requirements which may be imposed 'include' those specified in the Bill leaves open, and unclear, what other requirements may lawfully be imposed.

According to the Bill, a patient is subject to those requirements specified by all or the majority of the examiners. However, the Bill only requires an examiner to specify requirements if s/he determines that detention is not appropriate. Where the approved professional is the only examiner to determine that detention is inappropriate, the patient will be a non-resident patient but the requirements s/he specifies have not been specified by all or the majority of the examiners.

40 *Winterwerp v. The Netherlands* (1979) 2 EHRR 387.

Consent and treatment issues

The Bill provides that a Part 2 patient's consent is not required for any medication specified in their care plan provided that it is administered in a hospital.

By implication, a patient who has capacity to consent to treatment may consent to it being given at home. Conversely, whenever an incapacitated person is given medicine at home that medication is, by definition, given without their consent.

The drafting raises four key questions: What constitutes capacity? What constitutes consent? What is a hospital? What rights do patients have to a binding, independent, second-opinion?

The first question has already been considered, and it was noted that many mentally ill patients may be incapacitated according to one common interpretation.

The fact that home treatment teams have no statutory authority to treat incapacitated patients at home may tempt professionals to invoke the common law in an attempt to plug this gap. When challenged, it will be argued that it is a common-law duty to treat an incapacitated patient whenever treatment is necessary to preserve their life, health or well-being, and treatment is in their best interests.⁴¹ Attempting to justify under common law the administration of medicines authorised under statute is, however, artificial.

An alternative position may be to argue that any oral medication authorised under the statute is being self-administered, even though it has been dispensed by a home treatment nurse *in situ*, and the nurse is standing over the patient. The Government needs to clarify its intention in precise, unambiguous, terms.

On the answer to the second question – what constitutes consent? – hangs the practical consequence of how many patients with capacity may end up being given medication at home.

In practice, consultants or tribunals will no doubt impose a requirement or condition that the patient takes prescribed medication, in addition to a requirement that s/he attends hospital as required. It will be pointed out that there will be no need to require the patient to attend hospital, or to convey them there, if an injection can be given at home. The patient has this option.

It may be objected that any medicines given in such circumstances are not given with consent, for if the person truly consented to their administration a compulsory treatment order would be unnecessary. Against this, the procedures for patients liable to compulsory treatment under the 1983 Act provide for medicines being given with or without consent. The current statutory position is therefore that a patient may give a valid consent to medication notwithstanding that a refusal may result in administration by force.

If this is the case, home treatment and assertive outreach teams will be giving medication within the home to people who would refuse it if free to decide. It is then only a matter of time before a patient dies at home following the administration of medication, with such incidents eventually leading to public concern for patients, in place of concern for their own safety. And so, in the absence of balanced legislation, the laws shift periodically from one pole to the other, ending with the future re-establishment of a Mental Health Commission to monitor the use of these powers.

The answer to the third question – what is a hospital? – will determine the range of places within which medication may be given by force, and to which patients may be conveyed for that purpose.

⁴¹ *Re F* [1990] 2 AC 1.

When the Government says that medication may only be administered without consent in a hospital, this assurance must be understood in the context of how it has chosen to define a hospital. Medication may be given without consent in any NHS clinic or out-patient department, and in small 'mental nursing homes' that are willing to provide the service. Furthermore, non-resident patients may be required to reside at these small homes, in which case they may be treated on the premises without their consent.

The definition of a hospital also leaves open the possibility of 'third units' being developed 'through the back door'. Any private establishment that provides treatment for people who are liable to detention under the Mental Health Act is a hospital. Similarly, a private establishment is a hospital if its main purpose is to provide medical treatment for mental disorder. Because people with personality disorders, substance abuse problems or sexual deviancy now have a mental disorder, and social interventions under psychological supervision constitute medical treatment, an establishment which offers such a service is a 'hospital'. Provided it is suitably registered, it may where 'appropriate' detain people who meet the conditions for compulsion. Establishments which do not register to receive detained patients may still accept non-resident patients, who can be required to reside there and be given medication on the premises without consent. These people are being contained, not detained.

Defining anti-social people as mentally disordered, supervised social interventions as medical treatments, and establishments which detain such people or provide social services as hospitals, therefore enables adult secure accommodation to be dressed up for Convention purposes as hospital treatment for persons of unsound mind.

The final question concerns the right to a second-opinion. Fairness and commonsense dictate that decisions to prescribe treatments that can be administered by force should be subject to safeguards. However, the new Mental Health Tribunal will not perform the functions performed by Mental Health Act Commission second-opinion doctors. Whenever the tribunal decides that a person meets the relevant conditions for compulsion, its order must state either that the care plan submitted to it is approved for the medical treatment of the patient or that it is approved with such modifications as are agreed with the clinical supervisor. In other words, the care plan must be approved if the patient meets the criteria for compulsion and the patient's consultant is unwilling to modify it. It may only be modified with her or his consent. The practical effect is that patients subject to compulsion will no longer have a right to an independent, binding, second-opinion concerning the necessity or appropriateness of the medication they are forced to take.

Likewise, people subject to compulsion will no longer have a right to an independent adjudication of the need to administer ECT. Under the Bill, the clinical supervisor must apply to the tribunal for it to authorize ECT, and the attached care plan must specify that ECT is to be administered. However, provided that the patient meets the conditions for compulsion, here too the tribunal must approve this plan unless the patient's consultant is willing to modify it. All that Clause 38(4) adds is that the tribunal's 'order must state that that treatment [ECT] is authorised'. Tribunals must therefore authorize treatments which the patient's consultant insists upon.

Enforcement provisions

The Bill provides that the consultant of a non-resident patient may sign a pink statutory form, upon the completion of which the patient is liable to detention. Although a warrant is required if the patient refuses entry to their home, for the purpose of removing them to hospital, the balance of power and personal convenience is shifted. If the patient refuses to comply with their consultant's requirements, and a warrant is then obtained, s/he faces detention during the remainder of the assessment or treatment period, which may be weeks or months. Non-compliance leads not to the particular requirement being enforced on a single occasion, but to termination of the individual's right to be at home and to move about in their community.

The consultant therefore has a considerable stick to wield if the patient fails to comply with conditions or requirements, even allowing for the fact that hospital beds are in short supply. The patient will be told that admission will be the result of any failure to take medication at home, to attend hospital for injections, or to comply with requirements. The patient will know that their detention lies wholly in the consultant's hands, because it does not depend on a fresh preliminary examination, or on obtaining the consent of an approved mental health professional to admission.

Although the Bill's usual safeguards require that an appropriate mental health professional agrees that detention is appropriate, here detention is founded on one medical opinion, an opinion which conflicts with, and overturns, the decision of three examiners or the tribunal as to its inappropriateness.

Mental Health Tribunals

The existing Mental Health Review Tribunals are to be abolished, and the functions of the new Mental Health Tribunal are significantly different. It is not only the body that reviews the need for compulsion; it is also the body that authorizes compulsion beyond the initial 28-day period.

The powers of the new tribunal are limited. In particular, it has no discretion to discharge a person who meets the relevant conditions for compulsion. Here too, practitioners are prohibited from taking into account matters not referred to in the Government's test. As a result, more patients will be subject to perennial compulsion, because some people with chronic illnesses never satisfy the statutory test for discharge. That is not to say that they ought not to be discharged once they are functioning at their optimum level, provided that neither they nor anyone else is at significant risk.

Under the Bill, hospitals will no longer have to prove that the legal grounds for compulsion are met. The drafting is very clever or too clever: 'A tribunal must discharge the patient if it determines that not all of the conditions for compulsion are met' is uncomfortably close to the old, unlawful, test: 'A tribunal must discharge the patient if it is satisfied that not all of the conditions for compulsion are met.'

Reliability is the cornerstone. The Convention test is whether it can be 'reliably shown' that the person suffers from a mental disorder sufficiently serious to warrant detention. It is, of course, always possible to make a decision one way or the other if legislation forces one to do so. However, if the evidence is finely balanced, has it been reliably shown that the conditions for compulsion exist? It may be that the Convention requires a burden of proof.

Whether a patient who meets the conditions for compulsion is released from detention is left entirely to the tribunal's discretion, there being no grounds which qualify when detention is justified.

Furthermore, when a person who has been detained for up to 28 days asks the tribunal to review the grounds for the detention, it can extend the period of compulsion by up to six months. Necessarily, many patients will be wary of challenging their detention, given the purpose and possible consequences of independent review. This wariness is likely to be reinforced by the fact that their perception of tribunals will change. Instead of being the independent body that can order their release, it will be seen as the authority that imposes long-term compulsion. It must still be doubtful that these provisions satisfy Article 5.

A notable feature of the new scheme is that people who have not committed an offence may be placed under restrictions on discharge, transfer and leave of the kind now imposed by the Crown Court on offenders who pose a risk of serious harm to the public. The effect is that some resident Part 2 patients will be subject to restrictions but with control being exercised by the tribunal rather than the Home Office. It is no doubt hoped that these provisions will in particular be used for 'sexual deviants' and persons said to have 'dangerous severe personality disorders'.

Safeguards

The White Paper stated that, 'removing an individual's liberty against their will is a very serious step ... so the White Paper outlines how safeguards will be improved.'⁴² It is, however, commonsense to look at what is done, and not to what is said, and to judge intentions by acts.

The detail is different, and many important safeguards against the poor or inappropriate use of compulsion are swept away. In addition to those already mentioned, the Bill takes away the powers of a patient's nearest relative; abolishes the statutory duty to provide after-care; provides that the guidance in the Code of Practice may be qualified; revokes the discharge powers of NHS bodies and local authorities; and makes no provision for a Mental Health Commission.

No nearest relative

A person's nearest relative has several important powers under the present Act, two of which protect patients against the inappropriate use of compulsory powers.

At the end of the assessment period, the patient's nearest relative may veto further compulsory treatment unless a judge rules that their objections are unreasonable. In addition, unless the patient is likely to be dangerous, a patient's nearest relative may discharge them from hospital and compulsory treatment. Provided that their objections to compulsion are not unreasonable, and no one is in danger, a patient's spouse, partner or child therefore has a right to insist on caring for them at home.

These powers recognise the importance of the family in people's lives, and the need to limit the circumstances in which the state may interfere with individual and family life. A balance is achieved between the state's claim to provide protective compulsory care and the right claimed by families to care for their loved ones, and to cope with and manage behaviour that mostly affects only them. As Mill once beautifully put it, to individuality should belong the part of life in which it is chiefly the individual that is interested; to society, the part which chiefly interests society.

The Bill abolishes the nearest relative as a legal entity, and with it the family's right to these protective powers. The proposals weaken, indeed largely illegitimize, the role of the family.

⁴² *Reforming the Mental Health Act. Part I: The new legal framework (Department of Health/Home Office, December 2000, Cm 5016-1).*

A new 'nominated person' replaces the nearest relative. This person, who is usually chosen by the patient, has a right to be consulted about most decisions concerning treatment or compulsion. S/he must then say what the patient's ascertainable wishes and feelings are. However, a right to be consulted, and a duty to help express the patient's wishes, confers no power. The nominated person has but one power, which is to apply to the tribunal for the patient's discharge.

Patients and nominated persons have a right to help under the Bill's new advocacy provisions. 'Mental health advocates' must, where practicable, be independent of the hospital that is responsible for the patient's treatment. They must help patients and their nominated persons to obtain, and understand, information about the patient's treatment; why it is being provided and under what legal authority; what statutory requirements apply to the patient; and the patient's statutory rights. The White Paper indicates that they will be unqualified, and act as independent facilitators to handle patient and family concerns. Their role has as much to do with explaining the consultant's treatment, and why the patient must comply with it, as it does with protecting the person's legal rights.

Carers who provide regular and substantial care must also be consulted about some decisions. These rights are, by definition, carers' rights, and their advice may be that the patient should remain subject to detention or compulsion.

No duty to provide after-care

The Government indicated in the White Paper that patients would not be charged for services they must comply with, but the Bill makes no such provision. It removes the existing statutory duty on the NHS and local authorities to provide after-care to people who have been detained for treatment.

Qualified Code of Practice

The new Code of Practice must set out general principles to which a professional must have regard whenever coming to a decision under the Act. However, the code may now provide that one or more general principles shall not apply in circumstances in which its application would be 'inappropriate', or in relation to specified decisions or persons.

The code must also give further guidance concerning the discharge of statutory functions, but likewise it may provide that the guidance is not to apply to specified persons.

Powers of NHS bodies and local authorities

Hospital managers, Health Authorities, NHS trusts, and local authorities will all lose their powers to discharge individuals from compulsion. Only the patient's clinical supervisor or the tribunal may discharge a patient.

No Mental Health Commission

When vulnerable people are subject to detention in psychiatric facilities, the law has usually sought to protect them by requiring an independent legal body to visit them, in order to ensure that the powers are not being abused. The Mental Health Act Commission presently performs this essential function.

The history of the Commission is that it has experienced the same difficulties as other health service bodies: tight political control of what ought to be a process of independent scrutiny; fear that constructive, sensible, criticism which is evidence-based will lead to non-reappointment; a non-professional management board directing the activities of expert members; significant under-funding; low rates of pay; a failure to recruit or engage leading experts; casualisation of labour in order to increase output, resulting in diminished professional standing; failure to adhere to statutory remit; and bureaucratic processes devised for health service bodies, a class to which the Commission belongs in name only.

Although the Department of Health is mostly to blame for the Commission's well-known shortcomings, it is the Commission which is being abolished.

The future arrangements for monitoring the use of mental health powers are described in the consultation document that accompanied the Bill's publication. A specially established division within the Government's 'new health care inspectorate' will scrutinize the way in which powers are applied. This refers to the Government's intention to establish a new Commission for Healthcare Audit and Inspection (CHAI).

The new 'super-commission' will take over the work of the Commission for Health Improvement, the Audit Commission's work on value for money, and the National Care Standards Commission's remit to inspect private hospitals. It will be responsible for inspecting NHS hospitals, the Government's star rating system, the imposition of special measures for failing organisations, the licensing of private hospitals, the conduct of NHS value for money audits, the scrutiny of patient complaints, and the way in which Mental Health Act powers are used.

Ensuring that compulsory treatment powers are not abused thus forms a relatively small part of an extensive remit, the remainder of which is concerned with ensuring that trusts implement the Government's NHS Plan and modernisation agenda. Here, it may be observed that the attention of public bodies which monitor standards focuses on one of two things:

- Quality standards (setting, monitoring and enforcing quality standards; patient safety; implementing service reforms designed to improve quality).
- Legal standards (including the maintenance of ethical standards that may not be legally enforceable).

Almost all of the public bodies that the Department of Health has created, and for which it is responsible, exist in order to ensure or improve the quality of care. They have been created, not to ensure compliance with constitutional rights, but to drive forward the Government's NHS agenda. In 1999/2000, its 64 non-departmental and non-provider public bodies employed 14,780 staff and received £715m in public funding. The Mental Health Act Commission employed 32 of the 14,780 staff, and received just over £3m (or 0.4%) of this £715m.

The Government's justification for what amounts to a take-over of the MHAC by the Commission for Health Improvement is that it has 'been considering generally the number of external bodies that subject the NHS, and front line staff in particular, to scrutiny, and the way in which these functions are exercised'.

It is, of course, true that the creation of too many quality-assurance commissions and public bodies has disadvantages: too much top-down guidance, too many codes of practice, confusion on the ground about what to prioritise, a feeling amongst staff that they are drowning in paper, the impossibility of meeting all targets, leading to demoralisation, and so on.

It is, however, this very Government that has created these quangos, and which is responsible for the problem. Rather than abolish some quangos it has established to implement the NHS programme, the Government now proposes getting rid of the small, semi-independent, Mental Health Act Commission established in 1983.

This will do enormous harm, and no good. The fact that quangos are merged so that they exercise their functions as divisions of one super-quango does not reduce bureaucratic regulation. This requires reducing the range of functions performed. Furthermore, one can only successfully join institutions that perform similar functions. Merging the Mental Health Act Commission and CHI, simply because they both monitor the health service, is like merging Boots and Currys, simply because they both retail goods on the High Street. You still have two separate businesses: enforcing the Government's NHS agenda/protecting individuals' constitutional rights; selling toiletries/selling electrical equipment. Merging them does not change that, and the Government's proposals are little more than the ill-considered expression of an in-cliché about 'joined-up working'. Why should patients – that is members of the public – want their constitutional rights, their liberty and the use of force against them 'joined up' with the Government's NHS modernisation and 'quality assurance' agenda?

This is the most poisonous of all the proposals in the Bill. What will happen is what has always happened. As one small division within a super-Commission dedicated to monitoring compliance with the NHS programme, the constitutional imperative will be consumed by the larger political imperatives. When CHAI budgets are set, 'mental health legal money' will compete with Ministerial performance-targets, and be diverted to the inspection of acute care – in the same way that funds announced for mental health initiatives are now diverted by Health Authorities to reducing waiting list times, or whatever the current political agenda dictates.

A separate Commission is therefore essential, given the number and range of people who will be liable to compulsion; the fact that compulsion will now take place in the community; the position of incapacitated people; and the overall reduction in safeguards for those subject to compulsion.

The functions performed by this Commission should meet common international standards. These are the minimum standards agreed by nations as being the baseline for countries that wish to be considered civilised in this respect.

The observance of standards agreed by the United Nations – that is by all nations meeting in general assembly – requires that every mental health facility is inspected by a competent and independent authority prescribed by domestic law. Such inspections must be sufficiently frequent to ensure that the conditions, treatment and care of patients comply with international principles.⁴³

Observance of draft recommendations agreed by the Committee of Ministers will (unless amended) require the existence of an independent and adequately funded authority with responsibility for the implementation of mental health legislation. The functions of this authority should include setting and monitoring standards in relation to the implementation of the legislation; visiting and inspecting premises used to care for people suffering from mental disorder;

43 *Principles for the protection of persons with mental illness and the improvement of mental health care, Adopted by General Assembly resolution 46/119 of 17 December 1991; Declaration on the Rights of Mentally Retarded Persons, Proclaimed by General Assembly*

resolution 2856 (XXVI) of 20 December 1971; Declaration on the Rights of Disabled Persons, Proclaimed by General Assembly resolution 3447 (XXX) of 9 December 1975.

to establish their suitability; meeting privately with patients subject to mental health legislation; having access to their medical and clinical files; receiving complaints and ensuring that they are dealt with appropriately; reviewing any restrictions on rights of communication; ensuring that relevant professional obligations and standards are met; ensuring that statistics on the use of the legislation are collected systematically; providing an annual report to the relevant Minister; advising her/him on the conditions and facilities appropriate for such care; ensuring that the Minister and those responsible for patients respond to reports and questions raised during visits; ensuring that follow-up action is taken. The authority should be notified of the deaths of persons subject to involuntary placement or treatment, and have power to undertake or order their independent investigation.⁴⁴

This last function is an important one because the present requirement to hold independent homicide inquiries is being abolished by stealth, notwithstanding the recent decision of the European Court of Human Rights in *Edwards*. In that case, the court held that the standard procedures used to conduct independent homicide inquiries under NHS guidelines do not satisfy the requirements of the Convention. The inquiry panel had no power to compel witnesses; sat in private during its hearing of evidence; the deceased's family were not represented, and were unable to put any questions to witnesses; and they had to wait until the report's publication to discover the substance of the evidence about what occurred. Accordingly, the procedures did not comply with the requirements of Article 2 to hold an effective investigation into the individual's death.⁴⁵

The Department of Health's decision to replacing the existing independent homicide inquiries with short internal reviews not only does not address the requirements set down in the *Edwards* judgment, it significantly reduces the existing requirements which were held not to comply with the Convention. That may be why the new procedures are being introduced by e-mail to chief executives, rather than by publicly withdrawing the existing guidelines.

To summarise, the Government's intention is that there will no longer be a separate Commission the sole function of which is to monitor the use of compulsory powers.

In 1982, Parliament amended the last Mental Health Bill by strengthening the role of what was to be the new Mental Health Act Commission. It must be hoped that it will again perform a similar valuable service. If it does, there is much to be said for placing the new Mental Health Commission on the same footing as the Health Service Commissioner: that is, accountable to and funded by Parliament, not the Department of Health. There is now ample evidence that the Department of Health does not attach sufficient value to these important legal functions.

44 *European Union Charter of Fundamental Rights; Draft Recommendation of the Committee of Ministers to member States to ensure the protection of the human rights and dignity of people with mental disorder, especially those placed as involuntary patients in a psychiatric establishment.*

45 *Edwards and Another v United Kingdom, Application No 46477/99, European Court of Human Rights, 14 March 2002.*

Summary and concluding remarks

The maintenance of legal standards, and in particular observance of the rule of law, is a matter of great importance for many people.

Patients are themselves members of the public, so the law must ensure that members of the public are not unnecessarily detained, and also that they are protected from those who must necessarily be detained.

The rule of law implies the subordination of all authorities to certain principles which would generally be accepted as characteristic of law, such as ideas of the fundamental principles of justice, moral principles, fairness and due process. It implies respect for the supreme value and dignity of the individual.

The Government is concerned that existing legislation remains based on treatment in hospital, and too often has allowed severely ill people outside hospital to drift out of contact with services. It does not adequately protect people from the significant risk posed by a minority of patients.

This proposition may or may not be true, and in fact the existing evidence does not support the Government's proposition. The closure of the asylums has not led to an increase in the level of violence committed by the mentally ill, and people are rather better protected from violence associated with mental illness than they are from other forms of violence.

The problem of violence in society is one that has much more to do with education, upbringing, alcohol, drugs and testosterone than mental illness. That is not to say that it is appropriate to detain and medically treat people in these classes under mental health laws.

Legislation is, in any case, a relatively ineffective means of modifying behaviour. Although it can provide a framework for managing violence associated with mental disorder, it cannot significantly reduce these risks.

The draft legislation seems designed to sweep from the streets, or to supervise and control, anyone whose behaviour causes the public significant concern, but whose behaviour does not allow the police or the courts to place them in custody in the absence of any evidence or proof of serious offending. In many respects, it does not comply with the European Convention on Human Rights, or with the minimum international standards agreed by nations as being the baseline for countries that wish to be considered civilised in this respect.

No rational, humane, person can support such a set of proposals. A moral case can be made for allowing some people in the community who have a severe mental illness to be treated without their consent, for example where they would otherwise be detained and treated without consent in hospital. Any statutory scheme of this kind must, however, be carefully defined, and subject to rigorous restrictions and safeguards. Patently, the Government has chosen not to argue this case, and its proposals are immoral and, without professional support, by definition impractical.

Given the universal opposition, the problem for the Department of Health now is how it can regain the confidence of professional, patient and carers' organisations. Doing that must necessitate moving those persons responsible for the proposals, and then seeking to achieve a reasonable and fair consensus of opinion.

Not all democracies are liberal democracies. Should the Government choose to push on regardless, it will soon enough learn the limits of force and the benefits of compromise, and the truth of Abraham Lincoln's observation that nothing is settled finally unless it is settled justly.