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# Journal of Mental Health Law

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The Editor encourages the submission of articles, case reviews and comments on topics of interest in the area of Mental Health Law. When submitting manuscripts for publication, it would be helpful if authors could observe the following suggestions:

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Contributions should be typed with double spacing throughout on one side of uniform size paper (preferably A4 size) with at least a one inch margin on all sides. Manuscripts should be submitted in triplicate and pages should be numbered consecutively. Submissions on disc will be accepted where they are of Word 6 format. In such cases a hard copy should also be submitted. Articles should be a maximum of 5,000 words. Longer articles will be considered at the Editor's discretion. A cover page should be included, detailing the title, the number of words, the author's name and address and a short biographical statement about the author.

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# Foreword

This special issue of the Journal of Mental Health Law has been prompted by the recent publication of the Government's Green Paper *Review of the Mental Health Act 1983: Proposals for Reform*. The Green Paper aims to "modernise the legal framework within which mental health care is delivered" by proposing a number of reforms to the current regime established under the Mental Health Act 1983.

We have aimed in this edition to highlight some of the key issues arising from both the Green Paper and the Report submitted to the Department of Health by the Scoping Study Review Team, in July 1999.

In light of the pressing need to publish relevant material within the Green Paper's consultation period and to debate some of the more important issues surrounding the proposals for reform, we have not adopted the Journal's usual format of case and book reviews on this occasion. Reports of some of the more important cases of 1999 and early 2000 will appear in the next issue together with reviews of recently published mental health law texts.

My sincere thanks go to the contributors who have worked over Christmas and the New Year period to ensure that this edition materialised within the 4-month consultation period.

*Charlotte Emmett*

Editor, Journal of Mental Health Law

# Reform of the Mental Health Act 1983: Squandering an Opportunity?

*Jill Peay**

**This article compares and contrasts two recently published documents. First, the Report of the Expert Committee (chaired by Professor Genevra Richardson) entitled 'Review of the Mental Health Act 1983'. I shall refer to it throughout as the Richardson Report ('RR').[1] Second, 'Reform of the Mental Health Act 1983 - Proposals for Consultation', which is referred to here as the Green Paper ('GP').[2]**

Whilst both documents were published in November 1999 under the remit of the Department of Health ('DoH'), the Richardson Report preceded the Green Paper. It was delivered in July 1999 to the Parliamentary Under Secretary of State for Health, John Hutton. The Richardson Committee had been established in September 1998 by the DoH in order to provide them with expert advice. The Committee was serviced by the DoH. Accordingly, the contents of the final report would have come as no surprise to them, since they had themselves been fully exposed to the developing reasoning of Richardson. In publishing their own Green Paper some four months later, the DoH had had an opportunity to reflect upon the final Richardson Report. Nonetheless, some might argue that, given the time-scale involved in the production of other similar documents in the field, this rush to a Green Paper was unseemly and unwise. Moreover, since it departs markedly from the recommendations of Richardson, one might argue that the pressure to produce has been, and will prove, counter-productive.

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[1] *Copies of the Richardson Report may be obtained free from Will Niblett, Department of Health, Wellington House, 135-155 Waterloo Road, London SE1 8UG. It is also available on the DoH website at: www.doh.gov.uk/mentalhealth.htm*

[2] *Copies of the Green Paper are available from the same address, price £10.50, or on the same website.*

## Disclosure and disclaimer

Whilst I was a member of the Richardson Committee, I had no explicit involvement in the production of the Green Paper.[3] Indeed, I had no sight of it until the morning of its publication. All that follows should accordingly be read in the peculiar light of someone who is inevitably biased in favour of Richardson (the Report was unanimously approved by its 12 members) and wary (a consequence perhaps of social exclusion) of the Green Paper. *Caveat emptor*.

In examining the two documents together my objective is not to promote the Richardson Report by casting the Green Paper into a less than glowing light. Richardson is not a perfect prescription for mental health law, nor even a complete one. Indeed, the Report recognised the complexity of both the issues and the context in which the government proposed to legislate; we argued vociferously for the need for further extensive consultation.[4] In publishing the Green Paper, the government *is* engaging in further consultation. However, I am concerned that this exercise will not properly address the issues Richardson had identified. This is partly because the Green Paper is itself a confusing morass of consultation points and recommendations without the required reasoning or justification, combined with elements plundered from the Richardson Report but taken out of their proper context, all set alongside other related policy initiatives; namely, with respect to dangerous severe personality disorder, incapacity and the national service framework.[5] It is also because the time-frame for further consultation is short (with final responses needing to be made by 31st March 2000) and because it is hard to imagine how those consulted for a third time (Richardson consulted twice), but about markedly different proposals, will have the energy to address the issues afresh. Indeed, for those issues where Richardson argued that further consultation was critical two will serve as examples; first, charging for services for those subject to or discharged from compulsion, and second, the implications for those with long term incapacity. These two issues are respectively subject, under the Green Paper, merely to the vague assurances that government 'will develop proposals'[6] or will 'consult closely with interested parties'.[7] Thus, whilst this article might be regarded as sour grapes from the scorned academic, it is intended to assist those reading and commenting on the Green Paper to understand its antecedents and prognosis.

## Context and content

Before turning to the detail of the two documents, some further cautionary observations are necessary. First, the aims and objectives of the two differ. The Richardson Committee was set up with a fairly clear brief. It was not our task to formulate policy, rather to enable the legislative framework to reflect government policy. Whilst reform of the Act and not its abolition was the objective set, we *were* asked to undertake a 'root and branch review' and to adopt 'a fresh approach and find innovative solutions'.[8] However, one policy objective was stated with remarkable clarity, and presented as a central tenet critical to the whole programme of reform. That objective was the need for the Committee to address the issue of compulsory treatment in the community.

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[3] *Whilst the usual disclaimer applies, namely that the particular expression of the views in this article are mine, its content was circulated to the chair and other members of the Richardson Committee, who have not demurred.*

[4] *RR at pp 15-17*

[5] *See 'Managing dangerous people with severe personality disorder - proposals for policy development' Home Office/Department of Health (1999); 'Making Decisions' Lord Chancellor's Department (1999) Cm 4465; 'Mental Health National Service Framework' Department of Health (1999). For the government's background strategy to improve services to those with mental disorder see 'Modernising Mental Health Services' Department of Health (1998)*

[6] *GP at p 43*

[7] *GP at p 74*

[8] *Speech by Paul Boateng, then Parliamentary Under Secretary of State for the Health Department, delivered at the first plenary meeting of the Richardson Committee. Reproduced in RR at pp 140-145*

As Paul Boateng put it

'.. if there is a responsibility on statutory authorities to ensure the delivery of quality services to patients through the application of agreed individual care plans, so there is also, increasingly, a responsibility on individual patients to comply with their programmes of care. Non compliance can no longer be an option when appropriate care in appropriate settings is in place. I have made it clear to the field that this is not negotiable'.[9]

Thus, 'non compliance is not an option' was to apply both to patients and to clinicians.

The foreword to the Green Paper sets out its objectives, namely 'to modernise the legal framework within which mental health care is delivered'. The emphasis is on the need for services that are 'genuinely safe, sound and supportive'. Again there is an emphasis on the demands posed by the shift to community care: hence, 'people with mental health problems often need more active and intensive support'. But, where Richardson was urged to be radical (albeit there was a clear bottom line in the need to produce proposals for some compulsion *in* the community), the Green Paper's conception of modernising mental health services entails a controlling and cautionary emphasis. In short, it is reactionary. This is perhaps most explicit in its discussion of the need for compulsory care and treatment in the community

'..too often, patients treated in hospital - both formally and informally - fail to follow their treatment plans on discharge and need to be re-admitted to hospital because their condition deteriorates following loss of contact with care services. It is totally unacceptable that a group of patients who are known to pose a risk either to themselves or to others when they fail to comply with treatment, should so easily drop out of care in this way - sometimes with tragic results'.[10]

Second, the genesis of the two documents bears comparison. The Richardson Report sets out its methodology,[11] authorship,[12] sources[13] and time-scale, with the Committee holding various meetings and making site visits, and issuing both a 'Key Themes' document[14] and a draft report for further consultation, over a period of some 10 months. In total, over 600 submissions from individuals and organisations were received. The Green Paper, albeit typical of such documents, fails to set out is own methodology in any meaningful fashion. Whilst the Green Paper has a forward written by Alan Milburn, the Secretary of State for Health and Alan Michael, the First Secretary, National Assembly of Wales, it would be surprising if either of these had had a hand in the production of the Green Paper. Indeed, Alan Milburn had only just been appointed following Frank Dobson's 'mayoral' resignation. Since civil servants do not put their names to such published policy documents it is impossible to know for certain who, or how many, were involved in its drafting. The provenance of the Green Paper is thus largely unclear.

However, what the Green Paper does disclose about its own background is curious. First, it asserts that

'The work undertaken by the Committee has been a very valuable first phase of the review of the Act. Although not all of their recommendations are accepted.....the overall framework for new legislation described in the Committee's report has been adopted as the framework for the proposals in this consultation paper'.[15]

The thrust of this article casts some doubt on that proposition. The Green Paper further asserts that its proposals have 'been informed by discussion with researchers who are currently engaged in an extensive programme of projects that we commissioned to look into the way that the 1983 Mental Health Act operates'.[16]

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[9] *RR at p 142*

[10] *GP at p 37*

[11] *RR at pp 129-132*

[12] *RR at pp v-vi*

[13] *RR at pp 133-139, 150-170*

[14] *RR at pp 146-149*

[15] *GP at p 7*

[16] *GP at p 7*

Again, as one of those researchers it suffices at this stage for me to observe that even the Green Paper accepts that the bulk of this research was only completed *after* the publication of the Green Paper.[17] Both of these assertions are accordingly economical by comparison with Richardson's 32 pages detailing its methodology, meetings, expert reports commissioned and responses received. In short, Richardson has laid bare its roots; the Green Paper is clothed, if not cloaked, in the terminology of 'Yes, Minister'.

The length of the substance of the two documents is also telling. The Richardson Report covers 126 pages; the Green Paper 70 pages. Pedants engaged in a visual inspection of the Green Paper would argue that much of it reproduces (in the blue background boxes) Richardson's text. Moreover, the Green Paper acknowledges that it does not set out in detail everything that a new Act would include, which, it asserts, will be done in its formal proposals to be published later this year (presumably in a White Paper).[18] However, the Green Paper is markedly short on explanation. Proponents of its approach might argue that these are to be found in the concurrently published Richardson Report; devotees of Richardson would respond by arguing that Richardson's philosophical underpinnings support its framework, not that actually set out in the Green Paper.[19]

Finally, and lest it be thought that the Green Paper is wholly without merit, two features are noteworthy at this stage. First, the Green Paper recommends that all patients subject to compulsory care and treatment beyond 28 days should have their case *automatically* considered by an independent mental disorder tribunal. Secondly, the 'burden of proof' will shift from those subject to compulsion (under the current Act) to the care team (under the new Act); henceforth it would be for the care team to demonstrate that the criteria for making a compulsory order were met.[20] Taken together, these recommendations should significantly enhance the position of those already under a disability and disadvantage by reason of their mental state.

## The differences detailed

The contrast between the Richardson Report and the Green Paper is stark. The latter has been described as taking parts of the skeleton of Richardson, but abandoning its ethical heart[21]; to this one might add, and its principled musculature. The tone of the two documents is also markedly different, with Richardson's emphasis on non-discrimination, patient autonomy and capacity and the Green Paper focusing on risk as being a, if not the, key factor on which compulsion should turn. Moreover, whilst Richardson provides a reasoned justification for its approach, the Green Paper assumes risk to be an aproblematic notion and one that requires no justification beyond recitation of the Government's desire for services that are 'genuinely safe, sound and supportive'. Finally, whilst the Green Paper urges that the provisions of a new Act should be 'fairly and consistently implemented',[22] 'clear',[23] and that people with mental illnesses 'should be treated in the same way as people with any other illnesses'[24] it then goes on to advocate criteria for compulsion that are so broadly drawn that it is almost impossible to conceive of an individual who is suffering, or has suffered, from mental disorder who would *not* fall within the proposed criteria.[25] The criteria have the *potential* to make compulsion the rule for the treatment of

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[17] *GP at p 7*

[18] *GP at p 6*

[19] *Equally, whilst the GP cites the National Service Framework as being another element of the strategy to improve mental health services, the NSF is itself at odds with the GP. Detailing the departures of the GP from the NSF could form the basis of another article; however, p.4 of the NSF (DoH:1999), which stresses non-discrimination, service user involvement, rights for carers etc will suffice here.*

[20] *GP at p 75*

[21] *N. Eastman (1999: personal communication)*

[22] *GP at p 10*

[23] *GP at p 11*

[24] *GP at p 9*

[25] *GP at pp 32-33*

mental disorder. Since they clearly can be discriminatory against those with mental disorder, it is perhaps understandable that the Green Paper has also abandoned Richardson's recommendation that the principle of non-discrimination should be a central tenet of any new Act.

In promoting an alternative model to Richardson's capacity based model, the Green Paper tacitly if not overtly rejects a major plank in the Richardson scheme. The rejection of capacity with the concomitant stark difference in the entry criteria proposed by Richardson and the Green Paper is perhaps the most significant divergence between the two documents, at least in terms of their practical impact. I shall return to the differing nature of the criteria in more detail below.[26]

In asserting that people with mental illness should be treated in the same way as people with any other illness, the Green Paper reflects both the approach of Richardson and (unknowingly) anticipates the recent major report by the US Surgeon General on mental health.[27] Indeed, the latter report, in its 'Vision for the Future', acknowledges that the *majority* of those who need mental health treatment do not seek it, and further asserts that its key recommendation, of *encouraging* people to seek help, will only be achieved if society dismantles the 'sizable and significant' barriers, including stigma, which impede the treatment of those with mental illness.[28] Richardson similarly emphasised the need for non-discrimination to be a central principle in the provision of treatment and care. Indeed, it recommended that 'wherever possible the principles governing mental health care should be the same as those which govern physical health'.[29] Moreover, Richardson was cautious about the counter-productive impact of law, and sought to achieve a balance which would not result in an overall increase in the use of compulsion. In contrast, the Green Paper is content to see non-discrimination (together with other of the Richardson principles, namely patient autonomy, consensual care, reciprocity, respect for diversity, equality, respect for carers, effective communication and provision of information, and evidence based practice) consigned to a Code of Practice. Relegating these principles, together with the rejection of capacity and the adoption of extremely broad entry criteria, based on a status test, will do little to put the treatment of mental and physical disorders on an equal footing. Indeed, even the very existence such broadly drawn criteria are likely to impact on the genuineness with which people with mental disorder *consent* to informal care. Thus, one might ask whether the government's commitment to the principle of parity of care is aspirational rather than one to be embodied in legislation with a practical impact. Or expressed in language not behoven to civil servants, they are being downright deceitful.

## i) Principles and perspective

Richardson adopted the view, reflecting many of the submissions it had received, that future legislation should be underpinned by a series of principles which should be both articulated and central to the devising and implementation of a statutory framework. In addition to the paramount principles of non-discrimination and patient autonomy, ten further principles were spelt out and subsequently threaded through the Report. The Green Paper would adopt only two of these in a new Mental Health Act (informal care and service user participation) whilst creating a new 'principle' of safety of the patient and of the public, and bastardising Richardson's principle of 'least restrictive alternative', which stressed the need to provide care *both* in the least invasive manner and in the least restrictive manner, into one which stressed only locating treatment in the least restrictive setting. Thus, whilst in the Green

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[26] *See also the article by Professor M Gunn on capacity in this edition of the Journal at page 39*

[27] *US Public Health Service (1999/2000) Mental Health: A Report of the Surgeon General. Available at www.surgeongeneral.gov/library/mentalhealth/home.html*

[28] *Surgeon General's Report at pp 453-454*

[29] *RR at p 21*

Paper the adoption of principles are presented as a key reform,[30] in fact, the Green Paper dismantles if not decimates Richardson's principles.

Consistent with this shift away from patient oriented principles, the Green Paper generally focuses on the views and interests of others rather than on the service user, so that Richardson's preference for a patient based 'best interests' test becomes in the Green Paper 'best interests should be determined by members of the multi-disciplinary care team, and based on their professional opinion';[31] similarly, whilst Richardson wanted treatment to take account of the safety of 'other patients, carers and staff' the Green Paper puts the emphasis on the patient's 'safety *and the safety of the public*'. Richardson also stressed the need for evidence based practice to take account not only of research evidence, but also of the views of service users; the Green Paper dismisses evidence based practice as already being part of clinical governance. Finally, Richardson stressed the need for advance agreements about care to be considered routinely,[32] the Green Paper does not endorse this view. Thus, Richardson's approach has a primary focus on the patient and attempts to facilitate and encourage patients into treatment; the Green Paper has a much greater emphasis on the interests of the public, consistent with its overarching theme of managing risk, and thus emphasises the need for widely drawn powers of compulsion.

### ii) Entitlements

The Richardson Committee was greatly concerned about how to protect the principle of reciprocity, namely that where society imposes a duty on people with mental disorders to comply with treatment there should be a parallel duty on health and social care authorities to provide an appropriate standard of care and treatment, without distorting the pattern of care away from informal care to compulsory care.[33] In addition to wrestling with this problem, Richardson also made a series of recommendations about rights which should properly flow from the use of compulsion[34] and additional rights concerning access to services, including the right of a user to an assessment of their mental health needs and the right of prisoners to a similar mental health assessment. Finally, Richardson made further recommendations concerning the safeguarding of an in-patient's remaining rights. All of this receives either short shrift in the Green Paper, or, worse still, no mention at all.

### iii) Entry criteria

The Green Paper presents both the Richardson criteria (with a crucial omission) and its own, as alternatives for consultation. Since the Green Paper comments following the Richardson criteria

'The principal concern about this approach is that it introduces a notion of capacity, which, in practice, may not be relevant to the final decision on whether a patient should be made subject to a compulsory order. It is the *degree of risk* that patients with mental disorder pose, to themselves or others, that is crucial to this decision'[35]

it may reasonably be assumed that capacity has not found favour with the DoH, despite there being widespread practitioner and service user support for it.

However, it is worth briefly reviewing Richardson's criteria, since the Green Paper has managed in its presentation to misrepresent them by omission (see below). Richardson adopts *some* criteria that would

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*30 GP at p 75*

*31 GP at p 34*

*32 RR at p 106*

*33 RR at pp 27-28*

*34 RR at pp 28-31*

*35 GP at p 32*

be common to all compulsory orders (namely, the presence of mental disorder of such seriousness that the patient requires care and treatment under the supervision of specialist mental health services; and that the care and treatment proposed for and consequent upon, the mental disorder is the least restrictive and invasive consistent with safe and effective care; and that the proposed care and treatment is in the patient's best interests[36]). Thereafter, a capacity test applies. For those who lack capacity the compulsory order must be 'necessary for the health or safety of the patient or for the protection of others from serious harm or for the protection of the patient from serious exploitation that s/he be subject to such care and treatment, and that such care and treatment cannot be implemented unless s/he is compelled under this section'.[37] For those who retain the capacity to consent Richardson proposes two alternative approaches, which are described respectively as the consistent and the pragmatic approach to autonomy. For the consistent approach there would need to be 'a substantial risk of serious harm to the safety of other persons if s/he remains untreated'. For the pragmatic approach the criteria would be wider with 'a substantial risk of serious harm to the health or safety of the patient or to the safety of other persons' etc . Richardson recognises that the choice between these two approaches is essentially a moral one, and one for politicians to take.[38] The Green Paper ducks this issue, by eliding the two approaches[39] and then effectively dismisses the moral dilemma they pose by proposing, as an alternative, a model without a capacity test. Finally, Richardson proposes a treatability criterion (that is, going beyond that in the current Act) for all patients who retain capacity; namely, that there should be 'positive clinical measures included within the proposed care and treatment which are likely to prevent deterioration or secure an improvement in the patient's mental condition'.[40]

The dilemma which Richardson highlights with its dual (and mutually exclusive approaches) is that of 'risk to whom?' Where the risk is only to the capacitous patient then, on one analysis, it ought to be tolerated (as it would be for the physically ill). On the alternative analysis, risk to the patient's own health or safety ought to provide a basis for compulsory intervention even in the lives of capacitous patients.

In contrast, the Green Paper confuses the degree of risk with the question of risk to whom. Its preferred criteria are extremely wide.[41] It adopts Richardson's preliminary criteria, whilst omitting those relating to 'least invasive manner' and 'patient's best interests', but then goes on to require the following criteria to be met; namely, that the care and treatment be 'necessary for the health or safety of the patient and/or for the protection of others from serious harm and/or for the protection of the patient from serious exploitation'. Moreover, the patient's health or safety is explicitly to *include* issues relating to welfare and to self-harm. Since the Green Paper also seemingly envisages a compulsory community order being made without a patient first being admitted to hospital,[42] there will not be the 'restraint of beds' which Richardson envisaged on the initial use of the order. Thus, under the Green Paper proposals the use of compulsion (and its concomitant costs including those associated with automatic legal review) is likely to increase exponentially.

## iv) Structure

The Green Paper is schematic and lacking in detail. There is no explanation of the process of formal assessment in community. There is no detail of the criteria that would apply before a patient could enter assessment beyond 'The application must be based on medical evidence, usually from two clinicians, and should take account of the patient's wishes and social circumstances including social care needs'.[43] The

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[36] *RR at p 70*

[37] *RR at p 70*

[38] *RR at p 20*

[39] *GP at p 31*

[40] *RR at pp 70-71*

[41] *See GP at pp 32-33*

[42] *See the case of Mrs O at p 39*

[43] *GP at p 22*

Green Paper does consult on its proposal to abolish the role of the approved social worker in the initial application process. But, this is a proposal which Richardson had floated in its Draft Report and then abandoned in its final report. Whilst the Green Paper adopts much of Richardson's proposed scheme for a new multi-disciplinary tribunal,[44] there is clear disagreement about Richardson's proposal for independent review at day 7 of compulsion. The Green Paper advocates independent review at day 28. Which of the options one prefers is to some extent dependent on the premium one places on the need for consistent, fair and lawful application of the law, and on the desirability of achieving clinical effectiveness. However, combining review only at 28 days with the ability to treat patients on a compulsory basis prior to this, may run the risk of the government finding itself challenged before the ECHR. Making legislation ECHR compliant was something to which the Richardson Committee remained alive. Perhaps though, of most practical importance is the Green Paper's seeming failure to recognise that its proposal for a broad compulsory order in the community will entail a consequent hike in the numbers of tribunal hearings (with the concomitant problems and costs) for patients on the orders in the community.

Curiously, the Green Paper also floats the new idea of the tribunal either regulating the discharge of compulsory orders by permitting the tribunal to reserve the exclusive power to discharge to itself in civil cases or permitting the tribunal to decide at the point where the compulsory order is imposed to reserve to itself the right to review the discharge plan before the patient is released.[45] Those eligible for this 'extra safeguard' of tribunal only endorsed discharge might be those 'known to have a history of non-compliance with treatment, or to pose a serious risk to other people'.[46] Whilst the Green Paper promotes this approach on the grounds that it would ensure that the tribunal were satisfied that patients would receive appropriate care at the end of the period of compulsion (thus underlining the tribunal's responsibility for the process as a whole) what it would also permit (but is not spelt out) is further compulsion where the tribunal takes a different view to the care team about the continuing existence of risk. Thus, where the care team felt that no further compulsory treatment was necessary or justifiable, the tribunal might nonetheless leave an unwilling patient in their unwilling care until such time as the tribunal also shared that view. Given the well documented problems with countering probabilistic notions of risk, such a period might be considerable, thereby increasing the numbers of those subject to compulsory orders at any given time. In short, it would perpetuate the 'doctor as unwilling gaoler' situation, already resented by clinicians with respect to offender-patients who enter the mental health system on restriction orders.

### v) Treatment

The Richardson Committee deliberated at length as to whether the link between loss of liberty and the use of compulsory treatment was inextricable. Ultimately, we concluded that it was not. This led logically to two propositions. First, that someone did not need to lose their liberty in order for compulsory treatment to be given, thus paving the way for some form of compulsion in the community. Second, having lost one's liberty, the imposition of invasive treatment on an unwilling but capacitous patient constituted a further infringement, which required separate justification. Amongst other options, we canvassed opinion in our Draft Report on the issue of 'detention with and without forced

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[44] *For further details see the article by Mark Mullins in this edition of the Journal at page 28*

[45] *GP at p 41*

[46] *GP at p 41*

treatment'. Whilst detention without treatment for those who pose a risk to the health and safety of others is a legal option for those suffering from infectious physical diseases,[47] such thinking is seemingly not to be applied to those with mental disorders. Having explicitly posed the possibility (with all of its drawbacks) in the Richardson Report as a moral judgment for politicians to take,[48] the Green Paper makes no mention of it.

Consistent with this notion that compulsory treatment constituted a further invasion of a patient's integrity, Richardson generally proposed a more restrictive and cautious approach to the use of compulsory treatment than has the Green Paper. In particular, Richardson argued that it could not recommend the compulsory (forcible) administration of medication in any location other than a hospital unit.[49] Whilst Ministerial statements are unequivocally clear; thus, 'We are not talking about forcibly administering treatment over the individual's kitchen table'[50] the Green Paper is worrying vague on the detail of how this would be constrained, referring merely to compulsory treatment 'in a community setting'.[51] Is a reliance on good practice and the need to reflect the views of the Minister to suffice?

Finally, the Green Paper is less than enthusiastic about Richardson's recommendations on ect and rejects its suggestion that depot medication should be subject to special safeguards. There is no mention of Richardson's recommendation that s.63 be abandoned.

## vi) Criminal Justice

In dealing with matters relating to offender-patients, the Richardson Report attempted to assess the extent to which its principles, as developed for civil patients, could logically and properly be applied to those individuals whose mental health problems are disclosed in the context of offending. Whilst it came as no surprise that our recommendation that the Home Secretary should give up his exclusive power to authorise transfer and leave in restricted cases was rejected, the Green Paper barely acknowledges at all Richardson's other proposals in the criminal justice context. Given that Richardson had canvassed the views of all of the major criminal justice players, some might regard it as unacceptable that its recommendations barely receive a mention.

As controversially, but without seemingly recognising that such an approach is controversial, the Green Paper's recommendations assume that doctors can address offending behaviour through medical intervention and that compulsion will continue based primarily on the level of risk.[52] Since untreatability is not to be an impediment to continued compulsion, this recommendation again potentially casts health care professionals into the role of gaolers. However, it is consistent with the Green Paper's approach above in respect of civil orders.

Finally, it is worth observing that should the Green Paper be adopted in its present form, whatever resolution there is of the current debate over dangerous severe personality disorder (DSPD) will be redundant. For under the Green Paper's proposals, where there is no treatability criterion, there will be no impediment to admitting those with personality disorder and detaining them indefinitely on the grounds of risk.

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[47] *See ss 37-38 of the Public Health (Control of Disease) Act 1984. Equally of note, s.35 of the same Act permits court ordered medical examination and testing of those with notifiable diseases, but not their treatment.*

[48] *RR at p 95*

[49] *RR at 75*

[50] *Paul Boateng to the Richardson Committee: see RR at p 142*

[51] *GP at p 39*

[52] *GP at p 46*

## vii) Other omissions

It would be possible for me to detail at much greater length the varied and various ways in which the Green Paper differs from the Richardson Report, fails to address critical matters in detail, or makes proposals which will clearly have wholly unworkable implications, particularly by extending the boundaries and use of compulsion. But space does not permit me to be so ungenerous. Instead, I should just like to touch on the flavour of some other omissions and departures.

First, in respect of safeguards, the Green Paper is lukewarm on issues of advocacy and advance agreements (with its rejection of a capacity based approach, this is perhaps inevitable). Second, it makes no commitment to introduce the essential statutory framework to resolve the *Bournewood* problem, namely, that arising where patients with long term incapacity with mental disorder, and who are currently treated informally, may or may not be unwilling to receive treatment. Whilst Richardson made no pretence that it had 'solved' the *Bournewood* problem, it did address the issue and make some recommendations for an appropriate framework. Third, the Green Paper, whilst recognising the Government's need to implement a programme of research so that it might better understand how the current Act is being applied, does not adopt Richardson's recommendation for monitoring use of and compliance with any new legislation, including the Code of Practice; rather, it merely 'welcomes comments on the list of functions proposed by the Committee' for the Mental Health Act Commission.[53] Thus, the government again risks finding itself in the position it did when it came to undertake its current review of the Act; namely, not knowing, and having no means of finding out within the necessary time-scale, whether and how the current Act was working. Fourth, in an attempt to meet some of the problems relating to race discrimination in the use of the current Act, Richardson recommended both the monitoring of its principles and the introduction of a requirement that there be 'objective' evidence on which to order compulsory assessment. Neither of these proposals is mentioned in the Green Paper. Finally, in rejecting a capacity based test for compulsion and a treatability test, but adopting a broad definition of mental disorder which does not exclude learning disability or personality disorder, the Green Paper, whilst seemingly desirous to promote patients' 'ability to consent to treatment and involve them in decisions on their own care'[54] is unclear as to how this might be achieved. This problem is made more acute since the Green Paper omits all of Richardson's supporting mechanisms for a capacity based test. Thus, the Green Paper is content to leave to 'good practice' and a (non-statutory) Code of Practice all of the problems that will arise where patients with learning disability or personality disorder retain their capacity to make treatment decisions. While clinicians may know best, they do not always know best and nor do patients necessarily share their views. In practice, however, the Green Paper will leave such patients with few options successfully to challenge those views.

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[53] *GP at p 64*

[54] *GP at p 33*

## Conclusion

The Richardson Report was very clear in its recommendation that its proposals represented a coherent whole, capable of delivering the government's objectives in a way that would be acceptable to those whose co-operation would be vital to its success. Whilst we believed that our final report did reflect the values and ethics of those exposed to mental health services on the ground, we also argued the report 'must be taken as a whole, few elements of it could survive on their own'.[55] For this reason we urged that it not be cherry picked. Regrettably, the Green Paper has not just cherry picked, but it has sought to justify its own controversial proposals (for example, for a broad compulsory order in the community) by reference to Richardson's proposals (which were for a highly constrained community order). As the Green Paper states seemingly without irony 'We accept the Committee's proposals for extending the powers of compulsory care and treatment beyond hospital'.[56] This is little short of tendentious.

However, it is also dangerous. Whilst at the beginning of this article it was argued that one aspect of merit in the Green Paper was its advocacy of an automatic tribunal with a reversed burden of proof, it should now be clear that even this safeguard is an empty shell. For, given the extremely broad criteria that the Green Paper advocates, no care team will be inconvenienced (let alone challenged) by the need to satisfy the tribunal that the criteria are met. Richardson's approach, with initially broad criteria which become progressively more detailed as clinicians seek to impose treatment on those who retain capacity, would have had a legally constraining impact, giving the tribunal something on which to bite. Challenging the Green Paper's criteria would be like getting to grips with a blancmange.

It remains a mystery as to whether the Green Paper misrepresents the Richardson Report, fails to understand it or is rejecting of it in the politest of civil service fashions. But, despite the laudatory language, reject it it most certainly has.

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[55] *RR at p 14*

[56] *GP at p 39*

# Mental Health and Compulsion

*Margaret Pedler**

**This article looks at the role of compulsion in mental health law as it applies to civil patients. It starts by setting out the existing position and the Government's proposals for reform as set out in the current Green Paper "Reform of the Mental Health Act 1983"[1]. It goes on to consider principles which might be relevant to this area of law and the application of these to the Government proposals. Finally, it looks at the relevance of the European Convention on Human Rights.**

## The existing position

Compulsion lies at the heart of the Mental Health Act 1983 which provides both for compulsory detention and compulsory treatment. Key powers under existing law are:

1. A non-renewable power (under section 2) to detain a person in hospital for assessment for up to 28 days on the grounds that they are suffering from a mental disorder which warrants such detention in the interests of their own health or safety or with a view to the protection of other persons.
2. A renewable power (under section 3) to detain a person in hospital for treatment for up to 6 months initially on the grounds that they are suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment which warrants such detention in the interests of their own health or safety or the protection of other persons and treatment (which in the case of psychopathic disorder or mental impairment is likely to alleviate or prevent a deterioration of his condition) cannot be provided unless they are so detained.
3. A power (under sections 7 and 8) to admit a person to guardianship on the grounds that they suffer from mental illness, severe mental impairment, psychopathic disorder or mental impairment which warrants such admission in the interests of the person's welfare or for the protection of other persons. Once admitted to guardianship a person can be required to:
   a) live at a specified place;
   b) attend at specified places for the purposes of medical treatment, occupation, education or training;
   c) provide access to medical practitioners, social workers and other specified persons.

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* *Head of Policy Development, MIND*

[1] *Reform of the Mental Health Act 1983 - Proposals for consultation (1999) HMSO, London.*

4. A power (under section 25A) to make a person previously liable to detention under section 3 subject to supervised discharge on the grounds that they suffer from mental illness, severe mental impairment, psychopathic disorder or mental impairment and there would be substantial risk of serious harm to the health or safety of the patient or the safety of other persons or of the patient being seriously exploited if they were not to receive section 117 aftercare services whose receipt will be facilitated by use of this power. Once a person is subject to supervised discharge requirements can be imposed on them identical to those available under guardianship and in addition there is a power to take and convey them to the place they are required to live or attend for other specified purposes.
5. Once a person has been detained they can be subjected to compulsory treatment under Part 1V of the Act. This allows treatment for mental disorder [recently controversially expanded] to be given without consent except for certain specified treatments which are subject to additional safeguards. These are ECT and drug treatment lasting more than three months which require either consent or the support of a second opinion from a doctor appointed by the Mental Health Act Commission and psychosurgery and surgical implantation of hormones which requires both consent and a second opinion.
6. Various powers also exist to allow compulsory detention and treatment of those appearing before the criminal courts. These account for about 10% of formal admissions and are not dealt with in this article.

## Proposals for reform

In July 1998 the then Secretary of State for Health - Frank Dobson - announced that he was appointing a group of experts, to be chaired by Professor Genevra Richardson, to carry out a review of the Mental Health Act 1983. The stated aim of this review was "to ensure that mental health legislation supports the safe and effective delivery of modern patterns of clinical and social care for people with a mental disorder and to ensure that we achieve a proper balance between individual rights and the requirements of the safety both of the individual and the wider community. The Government wanted "a legal basis to ensure individuals get supervised care if they fail to comply with their medication or if their condition deteriorates for any other reason". This thinking was expanded on by the then relevant Minister Paul Boateng in his speech to the first meeting of the review team. He described the 1983 Act as reflecting a bygone age in which treatment for mental illness was largely hospital based. He said that community care had failed and needed to be replaced by a system which:

a) made the full range of high quality interventions available to provide proper positive support to those living within the community;
b) placed a responsibility on individual patients to comply with their programme of care. "Non-compliance", he said, "can no longer be an option when appropriate care in an appropriate setting is in place".

The Government received the report of their review team in July 1999[2] and in November published in a Green Paper their own outline proposals. In relation to compulsion these are as follows:

1. The Act should apply to all those with a "mental disorder" to be defined broadly as "any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning". This would be broad enough to include not only mental illnesses such as schizophrenia but also learning disability, personality disorder, epilepsy, Parkinson's disease or even temporary effects resulting from alcohol or drugs.
2. There should be a single point of entry for all patients (apart from those who enter from the criminal justice system) who are to be subject to compulsory care and treatment. This would be via a formal structured assessment, lasting for up to 28 days, which could take place either in the community or in hospital. Worryingly, the Green Paper gives no indication of the criteria which would have to be satisfied in order to justify the use of compulsory assessment powers. I have heard it suggested informally by Department of Health officials that the criteria will be the same as those for a longer-term compulsory order (see c) below). However, it seems difficult to see how this could be the case since they depend on the existence of an appropriate care and treatment plan which will not exist at the start of the assessment period. From the information available it seems likely that the Government have in mind very broad criteria on the lines of :
    - The presence of mental disorder requiring referral to specialist mental health services;
    - Assessment appearing necessary for the health and safety of the patient or the protection of others from serious harm or the patient from serious exploitation.
    - Assessment being unable to be implemented without the use of compulsory powers.

    The Green Paper also fails to address how compulsory community assessment will work. The Review team concluded that the most that could be done in the community would be to require a person to co-operate with the assessment process on the understanding that failure to do so would lead to compulsory admission to hospital for assessment purposes. They described this process as "formal" rather than "compulsory" assessment. The Green Paper does not refer to this distinction. Will their version of compulsory assessment require a person effectively to remain at home under a form of house arrest? Will they use electronic tagging in this context?
3. Following assessment further imposition of compulsory powers would require the authorisation of an independent tribunal. A key issue here is whether or not the capacity of the detained person to take treatment decisions is a relevant consideration. The Government suggest that it should not be on the grounds that the only important consideration is the degree of risk presented. They put forward the following criteria for use of compulsory powers:
    - The presence of mental disorder which is of such seriousness that the patient requires care and treatment under the supervision of specialist mental health services; and
    - The care and treatment proposed for the mental disorder, and for conditions resulting from it, is the least restrictive alternative available consistent with safe and effective care; and
    - The proposed care and treatment cannot be implemented without use of compulsory powers; and

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[2] *Review of the Mental Health Act 1983 - Report of the Expert Committee (1999) Department of Health. Free copies of this report can be obtained from the Department of Health by telephoning 020 7972 4471 or 020 7972 4670.*

- The proposed care and treatment is necessary for the health and safety of the patient and/or for the protection of others from serious harm and/or for the protection of the patient from serious exploitation.

The Government do acknowledge that the review team recommended a higher threshold for the imposition of compulsion on those with capacity. They recommended that in such cases the grounds for compulsory treatment should be that "there is substantial risk of serious harm to the health and safety of the patient or to the safety of other persons if s/he remains untreated and there are positive clinical measures included within the proposed care and treatment which are likely to prevent deterioration or to secure an improvement in the patient's mental condition." The Government is seeking views on the merits of this alternative approach.

Assuming a person meets the criteria for use of compulsory powers it would then be for an independent tribunal to decide whether these powers should be exercised by detention in hospital or via a community order. Community orders could:

- Say where a person should live.
- Define a proposed care and treatment plan.
- Require the patient to allow access and be present for scheduled visits by identified caseworkers.
- Impose a duty on health and social services to comply with arrangements set out in the plans.
- Set out the consequences of non-compliance including powers to:
  enter premises
  convey the patient to a specified place for the care and treatment set out in the care plan
  convey the patient to hospital.

The overall effect of these proposals is to widen vastly the numbers of people who could find themselves subject to a compulsory order. Under the present system, the criterion of hospital admission acts as a limiter. That limiter is now removed leaving all those in contact with the psychiatric system beyond the primary care level potentially subject to compulsion if they do not agree with the proposed treatment plan. This can perhaps best be illustrated by an example.

*Ms A has been to see her GP because she is feeling very low and tearful and frightened at having suicidal thoughts. The GP is relatively inexperienced in mental health matters and, because of the mention of suicidal thoughts, refers her to specialist mental health services. Ms A is not keen on taking medication and would like access to talking treatment of some kind. The only talking treatments in the area have long waiting lists and the psychiatrist therefore only offers anti-depressants. Ms A does not want to go along with this and attempts to disengage from services and seek the assistance she wants elsewhere. Under existing law Ms A would not come within the scope of compulsory powers because there are no grounds for believing that she needs admission to hospital. However, under the government's proposals she could meet the criteria for a community order because:*

*a) she has been referred to specialist services;*

*b) taking medication is, in the doctor's view, necessary for her health and is the least restrictive alternative available other than doing nothing which the doctors argue would not be effective care.*

*c) Ms A has indicated that she will not voluntarily co-operate with the proposed treatment plan.*

The Government may argue that in practice the powers would not be used in such circumstances. However, it would appear to be both bad and dangerous legislative practice to extend the scope of such draconian powers wider than those to whom it is specifically intended they should apply. I would suggest the Government need to consider some limitation on the scope of community powers by, for example, confining their use to people who, were they not to receive the proposed community interventions, would need to be detained in hospital.

### Principles relevant to this area of law

2 issues fall to be considered here:

a) what is the justification, if any, for the use of compulsion in mental health law;

b) if it is justified, what principles should govern such a legal framework.

### Justifying compulsion

There would appear to me to be two possible justifications for the use of compulsion in mental health law - protection of the health and safety of a person who is incapable of making healthcare decisions for themselves ("the health justification") and protection of the public ("the public safety justification").

### The health justification

Leaving aside the Mental Health Act, the general position in relation to medical (or other) treatment for adults aimed either to improve health or save life is that it can only be given with a person's consent even if a refusal risks permanent injury or premature death unless a person lacks capacity. Adults are presumed to have capacity but this is rebuttable. The test of capacity centres on:

a) being able to comprehend and retain treatment information;

b) being able to believe it;

c) being able to weigh it in the balance to arrive at choice[3]

Thus the law will not intervene if:

- (As in the case of Re C) a person with a diagnosis of schizophrenia refuses amputation of a gangrenous leg which doctors argue is necessary to save his life.
- A person refuses to take prescribed medication because it makes them feel sick or their hair drop out.

In these situations the law respects a person's autonomy.

If a person is found to lack capacity for whatever reason then medical treatment can be given in a person's best interests which are essentially determined by the clinical team. There are few safeguards.

Compare this with the situation in relation to mental health. Under the Mental Health Act 1983 the law allows a person's consent to be overridden regardless of capacity. The only safeguard, after medication has continued for three months, is a second opinion from a doctor appointed by the Mental Health Act Commission who will be concerned only with whether the treatment proposed is in accordance with

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[3] *Re C (Adult: Refusal of Medical Treatment) [1994] 1 All ER 819*

good medical practice. The Government appears to propose that this should continue by retaining a person's health alone as justification for use of compulsory powers regardless of capacity. Take, for example, a person with a diagnosis of schizophrenia who takes the view that the medication which has been prescribed is dulling their perceptions and ability to function or having physical side-effects such as shaking or dribbling. They may decide that they prefer, say, to hear voices and find other strategies for coping with this than to suffer these side-effects. Under the Government proposals such a person could be compulsorily treated with powerful anti-psychotics by a doctor who had a negative view of voice hearing and substituted their values for those of the patient. Indeed, the Green Paper specifically states that best interests should be determined by the professional opinion of the care team and not by the patient.

Mind believes that there is no justification for the continuing legal discrepancy in relation to medical treatment decisions between physical and mental health. In both cases, we believe that treatment should always require consent unless the person lacks capacity. Where the person does lack capacity then, subject to certain safeguards, treatment should be allowed in a person's best interests. Where they are capably refusing treatment and assessed as posing a high risk to others then compulsory detention may be justified under the public safety criterion as discussed below.

It may be that Paul Boateng is right in this respect to say that the current Mental Health Act reflects a bygone age in that it assumes either that all people with mental health problems who are compulsory detained must lack capacity to take treatment decisions or at least that their views should be assumed to have less weight than the views of those responsible for their care. Research shows however, that most people with mental health problems are as capable as any other member of society of taking decisions about their lives. Mental health and incapacity are not inextricably linked, although there are times when mental health problems do affect capacity.

The MacArthur Treatment Competence Study[4], supported by the Research Network on Mental Health and the Law of the John D and Catherine T MacArthur Foundation found that:

- Patients hospitalised with mental illness more often showed deficits in their decision making performance compared with hospitalised medically ill patients and non-patient control groups. This was especially true for patients hospitalised with schizophrenia, and to a lesser extent for patients with depression.
- Nevertheless, the majority of patients hospitalised with schizophrenia performed adequately on any particular measure of decision making ability, and about half did well on all the measures combined. When patients with schizophrenia performed poorly, they usually had more severe psychiatric symptoms, especially disturbances of thought and perception (e.g. disorganised thinking and delusions). In contrast, decision making performance was not associated with simple demographic variables (e.g. age, gender, race) or other mental status variables (e.g. degree of anxiety).
- Patients hospitalised with depression showed intermediate levels of decision making performance, with about three quarters performing well on all measures combined. Patients with more severe depression did not necessarily perform more poorly than those with less serious depression.

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[4] *Appelbaum P.S., Griiso T., (1995) The MacArthuer Treatment Competence Study: 1 Mental illness and competence to consent to treatment. Law and Human Behaviour 19 pages 105-126.*

- Medically ill patients, although hospitalised with a potentially life-threatening condition, performed about as well as healthy persons in the community, although a small proportion of these patients did show some decision making deficits.
- When patients hospitalised for schizophrenia were re-tested after a two week period of treatment, substantial improvement in decision making abilities was observed for patients whose psychiatric symptoms had decreased in severity.

Clear definitions of both capacity and best interests will be required. Mind accepts the view of the Law Commission[5] that any definition of incapacity must be a functional one. In other words capacity must be assessed separately in relation to each type of decision. At any one time a person may have capacity in relation to one decision but not another. They may, for example, have capacity to buy goods in a shop but not to enter in to a more complex contractual arrangement such as a mortgage. Capacity must also be reviewed over time especially when dealing with fluctuating conditions such as mental distress. The focus of definition should not be on the content of the decision made (i.e. Is this decision sensible? Does this person accept my advice?) but on the process by which it was made (i.e. Does this person possess the ability to understand what this decision is about, to take in relevant information and use that information to reach a decision?)

Mind supports the following definition as proposed by the Law Commission in their 1995 Report.

**"Incapacity**

A person is without capacity if at the material time he or she is:

(i) unable by reason of mental disability to make a decision on the matter in question, or

(ii) unable to communicate a decision on that matter because he or she is unconscious or for any other reason.

**Mental disability**

Any disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning.

**Unable to make a decision by reason of mental disability**

The person is:

(i) unable to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or failing to make the decision, or

(ii) unable to make a decision based on such information (for example, some people may be unable to exert their will, whether because of delusions or compulsions, or because of susceptibility to influence, or any other reasons connected with their disability)."

"Best interests" is again something which has been considered in depth in the Law Commission's report.[6] They recommended that in determining a person's best interest regard should be had to the following factors:

- the ascertainable past and present wishes and feelings of the person concerned and the factors they would consider if able to do so;

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[5] *The Law Commission (1995) Mental Incapacity Law Commission no 231 (HMSO) pages 36-40.*

[6] *Law Commission (1995) op cit. pages 42-48*

- the need to permit and encourage the person to participate or improve his or her ability to participate as fully as possible in anything done for and any decision affecting him or her;
- the views of other people whom it is appropriate and practical to consult about the personís wishes and feelings and what would be in his or her best interests; and
- whether the purpose for which any action or decision is required can be as effectively achieved in a manner less restrictive of a person's freedom of action.

Mind supports this approach.

Proper safeguards will be required where treatment is proposed to be given without consent. These will include:

1) Right of appeal to an independent body in relation to a decision on capacity.
2) The right of the person themselves to have a free independent advocate representing them throughout the process.
3) Regular review. The right to continue treatment without consent would lapse once capacity was regained. Reviews would need to be built in at appropriate intervals which would need to vary according to a person's condition. Perhaps the initial decision as to capacity should specify the appropriate timescale for review.
4) Controls on certain controversial treatments. In the case of mental health this would include psychosurgery; ECT and drug treatments.
5) Appointment of attorneys as substitute decision makers as recommended in the Law Commission's report.[7]
6) Advance directives.

The other issue here is whether compulsion is always justified to save a person's life. Attempted suicide ceased to be a criminal offence in 1961 and the law does not currently see fit to intervene in all situations where a person is putting themselves at risk of serious harm. For example:

a) A person has the right to refuse a blood transfusion on religious grounds even if such refusal means inevitable death;
b) A heavy drinker has the right to refuse to go for detoxification or stop drinking even though, without this, a doctor says they will die of cirrhosis of the liver within six months;
c) Hunger strikers such as Bobby Sands or Barry Horne are allowed to starve themselves to death.

However, the Mental Health Act 1983 does allow a person to be detained and treated against their will if they are deemed to be suffering from a mental disorder and their safety is at risk whether from self-neglect or more active self-harm/attempts at suicide. Under the Government's proposals this justification would continue.

Mind again believes that the key issue here is capacity. As before, the question is can the person understand and retain information relevant to the decision including information about the reasonably foreseeable consequences and can they make a decision based on that information? For example, if a

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[7] *Law Commission (1995) op.cit Part VII.*

person is hearing voices telling them that they should kill themselves or cause themselves serious harm then they would not, in our view, meet the Law Commission's proposed definition of capacity because they would be making their decision as a result of an external influence and not based on relevant information. If, however, a person had weighed up all the relevant issues and been offered services to help but still decided that their preferred option was to kill themselves then, difficult as that may be, their autonomy should be respected. That is not to say that every effort short of compulsory intervention should not be made to prevent this outcome.

## The public safety justification

It is important to state at the outset that a mental health diagnosis is not a predictor of violence and that there has in Mind's view been serious misreporting in the media of the risks represented by people with mental health problems. A recent report by John Gunn and Pamela Taylor[8] which analysed the data extracted from Home Office statistics for England and Wales between 1957 and 1995 and found that, despite media and public perceptions there had been little change in the number of homicides committed by people with mental illness. In fact, the research shows that since 1957 there has actually been a steady 3% annual decline in the proportion of homicides committed by people with mental disorders.

Nevertheless there will be occasions when people with mental health problems do present a risk to others and may not be prepared to accept treatment.

There are physical health powers based on this justification. The most obvious example is the Public Health (Control of Disease) Act 1984 which allows for the compulsory medical examination of persons suffering from specified notifiable diseases such as tuberculosis and for their subsequent compulsory detention (but, interestingly, not treatment) in hospital if they are likely to spread the disease in the event of being allowed to leave. In physical health these powers are the exception rather than the rule. For example, there are health conditions which, if not properly managed, can put others at risk. There was a case last year of a diabetic who did not properly manage his insulin and drove at a time when he was passing in and out of consciousness. As a result he mounted the pavement and killed two pedestrians. Yet no-one suggests that there should be compulsory treatment of diabetics. Is this because the risk of the spread of tuberculosis and other notifiable diseases is virtually certain whereas other types of risk are much less predictable?

The current Mental Health Act allows both compulsory detention and treatment on the grounds of protection of others. The Government not only propose that this should continue but propose extending its scope by removing any requirement of treatability. Under present law, there is a requirement for those detained under the categories of mental impairment or psychopathic disorder that the medical treatment proposed for them is likely to alleviate or prevent a deterioration of their condition. The Review Team similarly recommended that before confirming any long-term compulsory order in the case of a person with capacity the tribunal would have to be satisfied that three were positive clinical measures within the proposed care and treatment plan which were likely to prevent deterioration or secure an improvement in the patient's mental condition. None of this appears in the Government's proposals. Under their scheme any one with a diagnosis of personality disorder would fall within the

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[8] *Taylor P J and Gunn J (1999) 'Homicides by people with mental illness: myth and reality' in British Journal of Psychiatry Vol 174 pages 9-14.*

widened definition of mental disorder. If such a person were receiving treatment from specialist mental health services who concluded that although there were no positive interventions which could assist them they posed a risk to others and should therefore be kept in a secure setting they would appear to be able to be indefinitely detained. Why should this group alone be subject to a preventive detention regime when other groups which pose as high - if not higher risks - are not covered? Is this really the remit of mental health law?

## Other relevant principles

The Government propose to include in the new Act four principles to act as a guide as to how the Act should be interpreted. The proposed principles are:

- Informal care and treatment should be considered before recourse to compulsory powers.
- Patients should be involved as far as possible in the process of developing and reviewing their own care plans.
- The safety of both the individual patient and the public are of key importance in determining the question of whether compulsory powers should be imposed.
- Where compulsory powers are used, care and treatment should be located in the least restrictive setting consistent with the patient's best interests and safety and the safety of the public.

These principles differ markedly from those recommended by the review team who particularly highlighted the principles of patient autonomy and the need to ensure that wherever possible the principles governing mental health care should be the same as those which govern physical health. They suggested 10 principles overall which were informal care; least restrictive alternative; consensual care; participation; reciprocity; respect for diversity; equality; carers; effective communication and provision of information.

In line with these principles the Review Team made a number of important recommendations which have been largely rejected or ignored by the Government. These were:

a) A user's right to an assessment of mental health needs. This was intended to ensure that an individual's needs were taken seriously when they asked for help. The team referred to a recent survey[9] which suggested that one in three people with a severe mental illness were turned away when seeking help. The proposal was designed to remedy this gap and presumably thus reduce the need for resort to compulsory powers at a later stage. The Green Paper makes no reference to this proposal.

b) An obligation on care teams to provide all patients, prior to discharge from compulsion, with information about and assistance with the creation of an advance agreement about care. Again this was intended to promote informal and consensual care. The recommendation has not been accepted.

c) A duty on the Secretary of State to ensure the adequate provision of advocacy for those subject to compulsion. The review team described such access as "vital" to the achievement of the aims of their report. The government are not minded to accept this recommendation and state that the value of advocacy requires further research.

d) The protection of remaining civil liberties for those detained including the right to safe containment

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[9] *Better Act Now National Schizophrenia Fellowship 1999*

consistent with respect for human dignity. This would cover issues such as use of seclusion and restraint and protection from sexual assault. Again this is not referred to in the Green Paper.

There is a further issue around reciprocity. The Review Team expressed a desire to ensure that those subject to compulsion received an appropriate standard of treatment and care. They recommended that, if feasible, as part of the assessment process there should be an assessment of a person's community care needs under section 47 of the NHS and Community Care Act 1990. They also recommended that before approving any care plan the Tribunal would have to be satisfied that it was in a person's best interests. Once a care plan existed health and social services would be under an obligation to deliver what had been promised. The Government have accepted the last of these recommendations but by rejecting the first two they have made it less likely that a care plan will truly reflect a person's full needs rather than just what is readily available and easy to administer. I would suggest that it is arguable that where a person is being compelled to accept medical care and treatment they should have an entitlement to the best possible care for their condition. Much has been made of the Department of Health's proposal to produce league tables of hospitals and doctors so that, for example a parent could have chosen to avoid the Bristol hospital for their child's heart operation. Will those subject to compulsory powers be entitled to treatment only from those at the top of any league table or will they have to put up with what they are given? Would it not be true reciprocity to give those subject to compulsion a right to whatever treatment they were objectively assessed as needing rather than just what was readily or cheaply available?

The Government's principles (and their rejection of many of the 'softer' recommendations of the review team) seem likely to encourage a very different culture in mental health care and one which it seems will inevitably lead to greater use of compulsion and alienation of users of services from the psychiatric system.

## The European Convention

Article 5 of the European Convention on Human Rights (Right to Liberty and Security of Person) does allow the detention of "persons of unsound mind" provided that it is in accordance with a procedure prescribed by law and meets the criteria set down in the leading case of *Winterwerp v. Netherlands*[10]. These are that:

1. The decision to detain has to be supported by objective medical evidence.
2. The evidence has to show that the patient's disorder is of a kind or degree warranting compulsory confinement.
3. The disorder must persist throughout the period of detention.

Article 5 does not include a requirement of treatability. However Article 3 (Freedom from inhuman or degrading treatment or punishment) does include an obligation to provide adequate medical treatment (including psychiatric care) for persons in detention so that would presumably preclude indefinite detention without the offer of positive interventions of some kind.

In the past it has been argued that compulsory community treatment orders would breach the Convention. Indeed it was partly fears on that point which led the previous Government to accept the

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[10] *Winterwerp v Netherlands (1979-80) 2 E.H.R.R. 387.*

compromise of supervised discharge rather than introducing full-blown community treatment. However opinion now seems to be that such orders would not in themselves breach either Article 3 or 5. It seems unlikely that forced community treatment would be held to be inhuman or degrading treatment. In the case of *Grare v France*[11] a patient alleged a breach of Article 3 on the basis of being obliged to receive psychiatric treatment with unpleasant side effects. The Commission held that the consequences of the treatment were insufficiently severe to engage Article 3 and rejected the application as manifestly ill-founded. In *Herczegefalvy v Austria*[12] a far more extreme form of treatment was held not to breach Article 3. The applicant complained that he had been forcibly administered food and neuroleptics , had been isolated and attached to a security bed with handcuffs. The Court held that "…..as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading".

In relation to Article 5 there seems some doubt about whether requiring a person to attend at a particular place for treatment or to make themselves available for visits would even be held to amount to deprivation of liberty.

In the case of *W v Sweden*[13] where a provisional discharge was in issue the Commission held:

"The provisional discharge was accompanied by an order that the applicant should take medicine and present herself for medical control at the hospital once every second week. The Commission considers that these conditions attached to the provisional discharge were not so severe that the applicant's situation after her provisional discharge could be characterised as a deprivation of liberty."

That is not to say, however, that things would be entirely plain sailing in European terms. Difficulties may arise in respect of Article 5 if a person refuses to comply with a community treatment order and enforcement action is to be taken. In these circumstances where a person is to be compulsorily conveyed and forced to accept treatment such as an injection it is likely that it would be unsafe to discharge them immediately and they would need to be kept in hospital at least for a short while for observation. The criteria for compulsory detention of persons of "unsound mind" laid down in the *Winterwerp* case would therefore have to be met. That means that the individual would have to be shown, on the basis of objective medical expertise, to be suffering from a mental disorder of a kind or degree warranting compulsory (in-patient) confinement. This may not always be the case at the time of non-compliance with any community treatment order.

## Where next

The consultation period on the Green Paper lasts until 31st March 2000. Responses should be sent to:

Will Niblett

Department of Health,

Wellington House,

135-155 Waterloo Road,

London SE1 8UG.

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[11] *Grare v France 15 EHRR 300*

[12] *Herczegefalvy v Austria 15 EHRR 437*

[13] *W v Sweden Application 12778/87, D & R 158-161*

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1 *Final Report of the Expert Committee: Reform of the Mental Health Act 1983 (Department of Health November 1999)*

2 *On which see for example Peay, J., Tribunals on Trial (Oxford: Clarendon Press 1990), the recent research into decision making in the MHRTs of Dr E. Perkins of Liverpool University (in press), Thorold, O., "the ECHR and UK Mental Health Legislation" EHRLR p. 619 (1996), Richardson, G., and Thorold, O., "Law as Rights Protector: Assessing the Mental Health Act 1983" in Eastman and Peay eds. "Law without Enforcement integrating Mental Health and Justice (Oxford: Hart 1999), Richardson, G., and Machin, D., "A Clash of Values Mental Health Review Tribunals and Judicial Review" Journal of Mental Health Law February 1999 p.3.*

3 *Reform of the Mental Health Act 1983 Proposals for Consultation Cm 4480 November 1999*

4 *Professor Richardson has made her own views on the way in which the Green Paper deals with the Committee's report clear. Vol. 3. Issue 5, Mental Health & Learning Disabilities Care, (January 2000)*

5 *Green Paper Chapter 4 para. 7.*

6 *Green Paper Chapter 5 para.9.*

# The new Mental Disorder Tribunal

*Mark Mullins**

## Introduction

In its final report the Expert Committee on reform of the Mental Health Act 1983 chaired by Professor Genevra Richardson[1] proposed a new Mental Disorder Tribunal. This tribunal would have fundamentally different functions, composition, procedure and powers to the present Mental Health Review Tribunals (MHRTs). The Committee's objective was not merely to repair the failings of the present MHRT system[2] but to replace it with a new structure promoting the principles of patient autonomy and non-discrimination. Reading the Committee report and the Government's Green Paper proposals in response[3] together it soon becomes clear that the Government has rejected the recommendation that the a new mental health law should be based on principles of autonomy and non-discrimination[4]. In their place the Green Paper puts "safety" and "risk". While it will incorporate safeguards to ensure compliance with the Human Rights Act 1998, the "dual aims" of the new Mental Health Act are to be to ensure the health and safety of patients and safety of the public.[5] Whereas the Committee saw the new tribunal as an active guarantor and promoter of individual rights the Green Paper recasts it as a body preoccupied with risk and safety, stating as a fundamental "principle" that:

"Issues relating to the safety of the individual patient and of the public are of key importance in determining the question of whether compulsory powers should be imposed"[6]

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[7] *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-57 (HMSO 1957)*

[8] *Response of the Royal College of Psychiatrists to the draft proposals of the Committee, 11th May 1999 The response also set out the alternative view within the Royal College that the imposition of compulsory powers was the business and responsibility of doctors.*

[9] *Committee Report paragraphs 5.47 - 5.49*

## Responsibilities of the new tribunal

A key proposal is that decisions to authorise the use of long term compulsory powers be made by a new tribunal and not by professionals, reversing the policy introduced by the Percy Commission[7] and the Mental Health Acts of 1959 and 1983. This responsibility for imposing compulsion is one that many psychiatrists seem happy to relinquish. In its response to the draft proposals of the Committee the Royal College of Psychiatrists said of the suggestion that a quasi-judicial body implement longer term compulsory powers:

"will be especially welcome to young general psychiatrist practicing in inner city areas with the threat of mandatory homicide enquiries hanging over their heads and the stigma of being a "jailer" interfering with their relationship with patients"[8]

The Committee set out its justifications for this policy shift in some detail.[9] In fact its draft proposals received "overwhelming support" and are accepted by the Green Paper. The new tribunal will decide whether to authorise the use of compulsory powers beyond a 28 day initial period for up to six months. The tribunal itself will consider whether the clinical team has satisfied it that defined statutory criteria are met and whether an appropriate care plan is in place, decide whether treatment should take place in an in-patient setting or elsewhere and set out the details of its order.

The new tribunal will have other responsibilities in "civil" cases as summarised below:

a) The Committee recommended that the tribunal carry out a paper independent review in every case after 7 days and then either confirm a provisional order for a maximum of 28 days, call for further information or arrange an expedited hearing. The Green Paper suggests that it is not necessary for the tribunal to carry out the 7 day review.

b) The tribunal will hear expedited applications made by patients made within the first 14 days of assessment and treatment within 7 days of the application.

c) The tribunal will hear applications made by patients for discharge during periods of the application of compulsory powers. One application would be allowed during any order lasting longer than 3 months.

d) The tribunal will consider cases in which patients have been returned to hospital for persistent non-co-operation with the requirements of a compulsory order in the community.

e) The tribunal will consider whether to renew the use of compulsory powers at the end of the period of a compulsory order on application by patient's clinical supervisor.

f) The tribunal will on discharge confirm the patient's ongoing care plan. It may, if proposals in the Green Paper are taken up, regulate discharge of the patient.

g) The tribunal will consider references from clinical supervisor or independent doctor in respect of controversial proposed treatments and if necessary to refer the matter to the High Court Family Division

h) The tribunal will appoint nominated persons for patients who had not appointed one and lacked to capacity to do so and remove and replace nominated persons in certain circumstances.

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[10] *As is the case with some social services appeal tribunals. Council on Tribunals Annual Report 1998/9 para. 2.208.*

[11] *Peay, J, suggests that the requirement in its present form was introduced in order to retain the confidence of the judiciary rather than the public. "Tribunals on Trial" (Oxford: Clarendon Press 1989).*

[12] *R v Mental Health Review Tribunal , ex p Clatworthy [1985] 3 All ER 699*

## Composition and membership of the new tribunal

The Committee suggested three models for the composition of the new tribunal. The first involved a three person panel with a legal chair, a medical member and a third member with experience of mental health services. An independent doctor from an approved panel would examine the patient and present medical evidence to the tribunal. Independent experts with social care expertise would also be available to report to the tribunal. Under the second model the tribunal would comprise a legal chair and 2 other members with experience of mental health services. The third model suggested was that of a single person tribunal consisting of a specialist lawyer. Under the second and third models the tribunal would be able to obtain medical evidence from an independent tribunal panel doctor and refer the case to a panel of approved social care experts. The Committee confined itself to alternative models of either a three or one person tribunal. One alternative to the three person tribunal could be a two person tribunal[10] with a casting vote for the legal member if necessary.

In the case of "restricted" cases the Committee recommended that in order to retain the confidence of the public the tribunal should continue to be chaired by a lawyer specially approved by the Lord Chancellor. In practice under the 1983 Act this has meant that restricted cases are heard by circuit judges or QCs who are also recorders. A curiosity of this policy is that the Regional Chairmen, who have the most experience of hearing MHRT cases, are excluded from hearing any cases involving restricted patients.[11]

## The problems of medical membership of the MHRT

Medical members of the current MHRT are required to interview the patient and report their findings to the tribunal as a witness and then to take part in the decision making of the tribunal. This arrangement gives rise to a number of difficulties. The medical member will usually report on the results of the interview to the other members of the tribunal before it hears other evidence. Despite advice to restrict these comments to a factual report and to leave questions of opinion until the discussion after the hearing, it is in practice extremely difficult, if not impossible to separate out opinion from fact. As this all takes place in the absence of the patient and his representative, the appearance of unfairness, if not unfairness itself is introduced before the tribunal proper begins. The problem is exacerbated because these comments may, consciously or unconsciously, influence the whole approach of the tribunal to the patient's case. If a medical member forms an opinion on an issue in the case which might be adverse to the patient a further problem arises since this opinion will not have been disclosed in advance of the hearing to the patient or his representative. While the existence of an adverse view held by the medical member should be disclosed to the patient and representative it is unclear what detail need be presented and how often this disclosure takes place in practice.[12] In any case the patient or his representative has no means of cross examining the medical member on his or her view. These specific difficulties could be addressed by removing the requirement that the medical member carry out an assessment of the patient, as the first model above does. Assuming that it is an advantage to the tribunal to have a member with medical knowledge and background of the three this model appears likely to produce the highest quality of decision making. However, it requires the participation of three doctors of consultant status for each tribunal. Given the cost and complexity of such a structure, the additional

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13 *Committee Report 5.71.*

14 *Green Paper Section 4 para.39*

time doctors would have to spend away from clinical work and the current national shortage of consultant psychiatrists the model is likely to be unworkable. The Government rejects it in the Green Paper on these grounds. In any case it cannot be cannot be assumed that the inclusion of a doctor on the tribunal itself would promote independent decision making. It might be that a tribunal with medical membership would tend to overvalue clinical views of the benefits of treatment and compulsion at the expense of patient autonomy.

## A three or one person tribunal?

The new tribunal will be asked to make more complex decisions over a wider area and to assume far more responsibility that the present MHRT. It will consider and approve care plans and suggest their revision, make orders for compulsory care and treatment, including orders for compulsory care and treatment in the community, consider questions of capacity and decide whether to remove and replace nominated persons. According to the Green Paper its central task will be to make judgments about questions of risk and safety to patients and to the public.

The range and nature of the demands imposed by these tasks indicate that a three person tribunal should be retained. The quality of the tribunal's decision making would be enhanced by debate and discussion between the three members. The procedures of the tribunal are to remain inquisitorial and it would, as the Green Paper partially recognises, place a tremendous strain on a single legal member if s/he was expected to conduct the hearing and come to a decision alone. If patients, carers, clinical and social care professionals and the public are all to develop and retain respect and confidence in the tribunal it is suggested that a tribunal made up of more than a single lawyer is required. The importance of retaining such confidence will be all the greater in the early years of a new mental health act when procedures and outcomes will be unfamiliar and potentially unsettling. The retention of a three person model would also provide an opportunity to bring onto the tribunal persons with more varied experience than at present, perhaps gained as service users or carers.

The Committee was concerned that psychiatrists might object to being the only professional group excluded from the new tribunal, and recommended further consultation.[13] However the main advantage of a single legal member tribunal appears to be that as compared to a three person tribunal the costs of recruiting and training two members, as well as their fees and expenses would be saved. The work of organizing and arranging tribunals would also be simplified with some additional savings in administrative overheads.

The Committee was anxious to retain the principle that whatever the composition of the tribunal an automatic oral hearing in front of an independent tribunal would be held in all cases at the 28 day point. In a significant departure from these recommendations the Green Paper suggests that a significant number of patients will decide not to "contest" the care team's application to the tribunal for a compulsory order. In such cases it is said that the tribunal's decision should be "straightforward", that

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15 *Committee Report 5.60*

16 *The President of the Independent Tribunal Service is reported as being in favour of the appointment of more full time legal members to his service in order improve the quality and consistency of decision making. Each full time legal member monitors the performance of 9 or 10 part time legal members. (Council on Tribunals Annual Report 1998/9, para.2.215)*

17 *Council on Tribunals Annual Reports 1996 (paras 2.70 - 2.79), 1997 (paras. 2.87 - 2.91), 1998 (para. 2.112)*

18 *The abolition of managers' reviews "as soon as a legislative opportunity permitted" was announced in September 1996. (Council on Tribunals Annual Report 1996 para. 2.80)*

19 *Committee Report para. 5.49 v*

20 *Committee Report para. 5.49 vi*

21 *Royal College of Psychiatrists response to the draft proposals of the expert Committee, 11th May 1999 page 7.*

22 *Committee Report paras. 5.53 to 5.55*

a single person panel should be sufficient in any event and there should usually be no need for an oral hearing. Neither will it be essential for the tribunal to refer the case for a second medical opinion.[14] The suggestion that a single member tribunal of lesser perceived status be convened for a whole class of case is worrying. Of even greater concern is the proposal that "compliant" patients would not have an automatic access to a tribunal hearing. Given that there would be no independent review at day 7, under this system many patients could be made subject to compulsion in hospital or in the community for long periods with only the most formal of tribunal oversight.

## Resources and administration

The Committee was convinced that more than a mere extension of the existing MHRT was needed.[15] In order to emphasise its independence it recommended that responsibility for the tribunal be transferred from the Department of Health to the Lord Chancellor's Department. A national presidential structure is also suggested along with more training and formal accreditation of tribunal members. There might be an argument for appointing a number of full time legal members in order to improve the technical quality of the service provided.[16]

Historically the MHRTs have been grossly underfunded and understaffed. Readers of successive annual reports of the Council of Tribunals will not have been surprised by the Committee's recommendations for the organisation of the new tribunal and its plea that it be provided with adequate resources. The Council has repeatedly commented on the lack of resources provided to the current MHRTs[17], on unacceptable delays in listing and hearing cases, on the need for training for tribunal members and on the numbers of tribunal hearings going unclerked. Some of the Committee's proposals will lead to cost savings. The Committee recommends the abolition of manager's power to discharge.[18] It hoped that compulsory assessment followed by a provisional order would reduce the need to resort to long term compulsion and so limit the number of cases proceeding to a full tribunal.[19] By delaying the automatic full tribunal hearing to day 28 it also anticipated limiting numbers of tribunal hearings.[20] However neither the Committee report or the Green Paper makes any attempt to cost the effect of the changes being proposed. The Royal College of Psychiatrists suggested that the additional costs of the new system were unlikely to be offset by the abolition of other parts of the legal framework and warned of a prolonged battle between the Department of Health and the Lord Chancellor's Department over the funding issue.[21]

## The independent review at day 7

The Committee's original proposal that the care team would have to apply to a full tribunal for approval of long term order after only 7 days was heavily criticised as unrealistic. In its final report the Committee

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[23] *Committee Report paras. 5.57 to 5.58*

[24] *Green Paper Chapter 6 para. 1.*

[25] *Committee Report para. 5.91 to 5.93*

remained convinced that early, automatic independent review of compulsion was needed. The Committee's 7 day review[22] would be a paper exercise. The independent reviewer would be a legal member of the tribunal. If on the evidence currently available the statutory criteria were fulfilled the provisional order would be confirmed. Otherwise the tribunal could request further information from the clinical team or call on more expert colleagues for advice, refer the case to an expedited tribunal or discharge the patient if "conclusively not satisfied" the statutory criteria were not met. The Green Paper questions the value this independent review on the ground that a paper based exercise would not influence the use of compulsory powers or drive up the quality of care provided. In any case a legal member of the tribunal would not usually have the expertise to decide at 7 days whether the provisional care plan proposed was appropriate. Instead the Green Paper suggests that the responsibility for ensuring that statutory processes are followed should lie with the "registered person" (a senior manager) and that prompt assessment and care planning could be achieved through internal audit and clinical governance.

## The expedited hearing

The Committee recommended, and the Green Paper accepts that a patient who wished actively to challenge the use of compulsion should be entitled to ask for an expedited tribunal during the first 14 days of the use of compulsion, whether or not there had been an independent review. The tribunal would be obliged to hear such an application within 7 days.[23] On hearing such an application the tribunal would have all the powers available at a "28 day" hearing, including the power to make a compulsory order. An expedited hearing would replace, not supplement such a 28 day hearing. In the Government's view the fact that a patient could call for an expedited tribunal hearing to be held between days 7 and 21 means that a separate process for automatic independent review of compulsion at day 7 (see above) would not be necessary to comply with the provisions of the ECHR.

## The powers of the tribunal at a full hearing

In every case if the care team wished to extend compulsion beyond the 28th day an application for a compulsory order would have to be made to the tribunal. At a full hearing the tribunal would[24]:

a) If the statutory criteria are met and a properly constituted care plan is in place, authorise the further use of compulsory powers, whether in hospital or in the community[25], for an initial period of up to 6 months.

b) If it is not satisfied the criteria are met, decline to authorise the use of compulsory powers and discharge the patient from any current compulsion.

c) If satisfied that the statutory criteria are met but not that a properly constitute care plan is in place to issue a short term order pending submission of a fresh care plan.

At a full hearing the burden would be on the treating team making the application to show that the criteria for the continued use of compulsory powers were met. There would be no equivalent to the much criticised "double negative" test which patients now have to overcome, and which would probably not survive a challenge brought under the Human Rights Act 1998.

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26 *Committee Report paras. 5.94 to 5.104*

27 *Green Paper Chapter 5 para. 6*

28 *Committee Report para 5.106*

## The statutory criteria and the new tribunal

In its proposals[26] the Committee set out the statutory criteria upon which the tribunal would have to make its decisions. It recommended basic statutory criteria requiring that the mental disorder be of a certain seriousness, that the care and treatment proposed was the least restrictive and invasive alternative consistent with safe and effective care and that it was in the patient's best interests. In addition the Committee recommended further alternative criteria making a distinction between patients with and without capacity to consent to treatment and care. Where a patient lacked the capacity to consent, use of compulsion could be justified when necessary for the health or safety of the patient or for the protection of others from serious harm or for the protection of the patient from serious exploitation and when treatment cannot be implemented unless s/he is compelled. Where a patient retained capacity, the criteria would be stricter, requiring a substantial risk of serious harm to the health or safety of the patient or to the safety of other persons if s/he remains untreated and proof of positive clinical measures, which are likely to prevent deterioration or to secure improvement in the patient's mental condition. The Green Paper dismisses this differentiation on the basis of capacity, which to the Committee was central to its fundamental principles of non-discrimination and patient autonomy. "Notions" of capacity are described by the Green Paper as "largely irrelevant" to the practical question for the tribunal of whether or not a compulsory order should be made.[27] Instead the Green Paper emphasises the "degree of risk" that patients with mental disorder are seen to pose to themselves or to others as crucial to this decision. Compulsion may be justified, it suggests, irrespective of capacity, if the proposed care and treatment cannot be implemented without the use of compulsory powers and:

a) Is necessary for the health or safety of the patient; and/or
b) for the protection of others from serious harm; and/or
c) for the protection of the patient from serious exploitation.

## Compulsion outside hospital

The Committee was asked to devise a means of implementing compulsory care and treatment in the community and have proposed that a single form of compulsory order should apply to both. The new tribunal will be required to produce detailed orders when it authorises the use of compulsory powers whether inside or outside hospital. The Committee recommended[28] that a compulsory order relating to care and treatment outside hospital contain detailed provisions in relation to:

a) The nature of the proposed care and treatment and the location where such care and treatment is to take place.
b) The services which the health, social services, or other provider is required to provide under the principle of reciprocity.
c) The place of residence of the patient and an obligation to report any change of address.
d) The obligation on the patient to allow access and to present him or her self for visits by identified case workers. There would be a parallel obligation on the care team to keep to such arrangements.
e) The consequences of non-compliance with the conditions on the part of the patient which could include:

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[29] *Committee Report par. 22.*

[30] *R. v MHRT, ex p Hall, CA 30th July 1999, Code of Practice under the MHA 1983 3rd ed. 1999.*

[31] *Committee Report para. 5.32.*

i) The power to convey to the place of care and treatment.

ii) The power of entry by an identified member of the care team.

iii) The power to convey to hospital.

As well as being used "directly" for patients who have not been receiving in-patient treatment in hospital, an order for compulsory care and treatment in the community can be used for patients leaving hospital who continue to satisfy the statutory criteria. In these cases the order will work in a way somewhat similar to the current conditional discharge now available only in the case of restricted patients. As the order would set out the consequences of non-compliance, the tribunal would not need to authorise them separately though a review of the case if a patient is returned to hospital for "persistent non-co-operation" is proposed. Until safe facilities for treatment outside hospital are developed the Committee suggested that forcible medication could not be given outside a hospital setting.[29]

## Scrutiny of the care plan by the tribunal and powers on discharge

One constant difficulty of the present system is that both medical and social circumstances reports are provided late to the MHRT. It has been common for no section 117 aftercare meeting to have been held before the tribunal. Case law and the Code of Practice[30] now make it clear that MHRT hearings should be provided with aftercare plans. However the MHRT has no powers to enforce positive entitlements to services inside or outside hospital. An important element in the Committee's attempt to improve the quality of decision making in the new tribunal is the requirement that a full set of assessments be carried out[31] by the care team and a detailed care plan be presented to the tribunal. The assessments would include:

a) An assessment of the person's mental condition;

b) an assessment of the person's physical condition;

c) an assessment of risk in terms of both the seriousness of the feared harm and the likelihood (in terms of probability and imminence) of its occurrence or reoccurrence;

d) an assessment of the person's capacity to consent to care and treatment for mental disorder;

e) the production of a proposed care and treatment plan;

f) at least a preliminary assessment of the patient's community care needs;

g) an assessment of the person's social and family circumstances.

A further innovation is the proposed requirement that the tribunal scrutinise the care plan put forward and only authorise compulsion when satisfied it is appropriate and consistent with the principles of the Act. The precise bounds of the new tribunal's powers to influence care plans and enforce rights to services under the principle of reciprocity are unclear. The Green Paper says that the details of the treatment - for example what specific medication should be prescribed, or what types of non medical therapies should be provided would be for the care team. However the tribunal would not only be able to refuse to authorise compulsion if not satisfied with the care plan, but could also make suggestions concerning its revision and,

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[32] *Green Paper Chapter 6 para. 2.*

[33] *Green Paper Chapter 3 para. 8.*

[34] *In R v MHRT, ex p Hall, 30th July 1999 the Court of Appeal has recently decided that it is not the function of the MHRT under the 1983 Act to enforce the statutory obligations of health and social services authorities. The situation concerning both "care" and aftercare" would seem to differ for the proposed new tribunal.*

[35] *Green Paper Chapter 8 para.11.*

[36] *Committee Report para. 15.19.*

[37] *Committee Report para. 15.26.*

in exceptional circumstances, to refer questions on it to the High Court Family Division. A specific area of potential conflict arises from the Green Paper's suggestion[32] that the care team is to construct the most appropriate care package "in the light of what is available in the locality". Reciprocity will require that a patient subject to compulsion be provided with the services included in their care plan[33]. However it is unclear to what extent the lack of availability of resources locally can influence the content of a care plan and the extent to which the new tribunal can or should intervene in this situation. For example what should and could a tribunal do if faced with a situation in which the evidence shows compulsory treatment in the community would be effective and safe but resources for such care are lacking and as a consequence the care plan presented provides for hospital care?[34]

## Responsibilities and powers of the tribunal in "criminal" cases

While the Committee report suggests that a wholesale review of the law relating to mentally disordered offenders is required, the Green Paper contents itself with the assertion that the provisions of Part III of the 1983 Act are "fundamentally sound".[35] The Green Paper suggests that in "criminal" cases where the original use of compulsory powers is authorised by a criminal court the current distinction between "restricted" and "non-restricted" cases should remain. The main functions of the new tribunal would be to:

a) Consider renewing the use of compulsory powers for periods of up to 12 months in respect of persons made subject to a compulsory order by a criminal court without restrictions.

b) Make decisions varying conditions (e.g. as to leave) in an order made by a criminal court without restrictions, with the power to delegate such decisions to the clinical supervisor.

c) In "restricted" cases, as now the tribunal could conditionally discharge patients subject to conditions and liability to recall.

d) The tribunal would review immediately the cases of prisoners directed to hospital.

e) The Tribunal would consider applications made by the clinical team in respect of persons transferred to hospital whose sentence is at an end.

The Green Paper ignores the recommendations of the Committee in a number of areas of particular controversy concerning "restricted" patients and the present MHRT, each of which raise questions under the Human Rights Act 1998. It is difficult to know what the response of the Government is to these points. First the lack of an MHRT power to direct transfer or leave for "restricted" patients was described by the Committee as something it could not condone[36]. Such steps were often an essential precursor to discharge and should not be left in the hands of the executive. Second the inability of the MHRT to enforce entitlements to aftercare services was a particular concern in the case of "restricted" patients and sometimes led to long delays in discharge. Third it was a concern that conditional discharge could be imposed on patients who no longer suffered from mental disorder.[37] The Committee also made suggestions about the role of the Home Office in "restricted" tribunals, arguing that the expertise of its Mental Health Unit would be better utilised and both the quality of the tribunal's decision making and fairness to the patient enhanced if fuller reports and more frequent oral evidence were provided by the Unit to the tribunal. The Committee also suggested that in appropriate cases the Home Office should

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[38] *See JT v. UK, Appn. 26494/95, and FC. v UK, Appn. 37344/97. F.C. was settled in April 1999 on the basis that the law would be changed to allow psychiatric detainees to apply to change the person who acts as nearest relative, the payment of costs and £2,000 compensation.*

[39] *Appelbaum, P., Almost a Revolution: An International Perspective on the Law of Involuntary Commitment J Am Acad Psychiatry Law, Vol. 25 No 2 1997*

provide more information about the views of the victims to the tribunal.

## Nearest relatives and nominated persons

The nearest relative system under the 1983 Act is not compliant with the European Convention of Human Rights and does not respect the principles of autonomy and non-discrimination. It causes particular difficulties in case where there has been a history of abuse or alleged abuse by the person identified as the nearest relative by s. 26 of the Act[38]. Patients have no voice in displacement proceedings under s.29. The Green Paper proposes replacing the nearest relative with a "nominated person", who wherever possible would be chosen by the patient using advance directives where appropriate.

The Committee recommended that the nominated person should be notified when a patient is made subject to compulsory powers and consulted during the course of a compulsory assessment and before discharge of a substantial variation of the order.

The nominated person would also have a power to apply to the tribunal for discharge on behalf of the patient and have the right if the patient wished to attend any tribunal and to be present at any consultation with a tribunal approve doctor with a view to authorising treatment. The nominated person would not have the powers and applications and discharge presently possessed by the nearest relative. The tribunal would have new powers to appoint a "nominated person" for patients which did not appoint anyone and lack the capacity to do so. In place of the current power of the County Court to displace nearest relatives the tribunal will be given a new power to remove a nominated person and appoint a replacement.

The Green Paper, which accepting the Committee's recommendations, raises questions about the procedures to be applied by the tribunal. It asks whether specific criteria should be applied by the tribunal when appointing a nominated person, and if so what these criteria should be. While accepting that when the patient does express a choice it should be respected subject to the consent of the nominee, it asks what should happen when a patient changes this choice frequently. It also asks whether an advance directive should take precedence over a decision at the time.

## Conclusions

A comparison of the Committee report recommendations for the new tribunal with the Green Paper proposals is an absorbing if frustrating exercise. The Government has rejected the principles offered to it as the foundation for a new mental health law without engaging with the arguments of the Committee. Those arguments have been ignored in favour of reliance on measures of "risk" and "safety". For those convinced by the Committee's arguments crumbs of comfort may be derived from its own observation that even where its relevance is most direct, the law is likely to have only a limited impact unless it is congruent with the values of those who use it. An opportunity to make a radical and principled change in mental health law may have been missed, but as Paul Appelbaum has suggested[39], law is not self-enforcing and is delegated to a variety of participants. If law is contrary to the moral intuitions of these participants, they will act at the margins to modify it in practice to achieve what seem to them to be more reasonable outcomes. If this is in fact the case, then the effects of implementing either the proposals of the Committee or the Government will depend in part on the way in which the law was used by these participants, including of course members of the new tribunal. If, as reactions to the Committee's proposals suggest, there is widespread support for a role for capacity in decisions on compulsory treatment, it may be that at the margins at least the harsher consequences of a risk based dominated approach will be avoided.

Nevertheless, on a practical level the proposed changes to the tribunal system have the potential to improve the fairness and effectiveness of decision making about compulsion in mental health care. While the battle over the principles of non-discrimination and autonomy seems to have been lost, important issues remain to be decided concerning the composition, powers and procedure of the new tribunal. Above all it must be properly funded and resourced if its it is to discharge its functions properly. The history of the MHRT, if it teaches us anything, is that this funding will not be easy to secure and will have to be fought for.

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[1] *The bare bones of the argument found in this article formed the submission that I made, on request, to the Richardson Committee (Expert Committee, Review of the Mental Health Act 1983 (Department of Health, 1999), Chair: Professor Genevra Richardson, Queen Mary and Westfield College, University of London. The Report is available at www.doh.gov.uk/mhar/report.htm.). These ideas were developed for a paper presented to the Colloquium on Medical Law held at University College London in June 1999 and will form my inaugural lecture at The Nottingham Trent University on April 6th 2000, which will subsequently be published in the Nottingham Law Journal. What appears here is very much a shortened version, allowing me to reserve my full argument for my inaugural lecture.*

[2] *See Mill, J.S., On Liberty (1859) and Feinberg, J., Moral Limits of the Criminal Law (4 vols., 1984-1990).*

[3] *See Ashworth, A., Principles of Criminal Law (3rd ed., 1999), at pp. 30-31.*

[4] *Such authorisation may be provided at the time of the treatment or in advance: Re C [1994] 1 W.L.R. 290.*

[5] *[1990] 2 A.C. 1.*

# Reform of the Mental Health Act 1983: The Relevance of Capacity to Make Decisions[1]

*Professor Michael Gunn**

Depriving someone of their liberty is a serious step to take. It demands justification. Harm to others is always a sufficient justification,[2] presuming that "harm" is sufficiently clearly defined and at a sufficient level of seriousness and that sufficient due process requirements are in place. Paternalistic justifications are not, I wish to assert, sufficient. Other justifications may be sufficient, and I certainly recognise the worth, at least, of the principle of welfare in any debate about the use of State force.[3] Where State force is used, there is a consequent obligation to minimise its use.

When considering general principles in relation to health law, primacy is rightly given to the principle of respect for autonomy as revealed in legal recognition of the primacy of self-determination. Thus, it is for the individual to make decisions about what is to happen to their body. In legal terms it is for the individual to authorise[4] treatment that involves a bodily interference, so thereby preventing what would otherwise be a trespass to the person (assault, battery or false imprisonment). This authorisation takes the form of consent, where the person is capable of consenting. Where they are not capable, the decision is to be taken, according to the House of Lords in *Re F*,[5] by way of determining what is in the best interests of the person not capable of making the decision for themselves. Such a decision must take into account the views of the person themselves, and, it is submitted, the right standard to adopt where such views are clear is the substituted judgement test, thus making the decision that the incompetent person would have made had they been able, and so relying on the best interests test only where that has to be relied upon, because insufficient information is available to use a substituted judgement test.[6]

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[6] *For example, in* Curran v Bosze *(1990) 141 A.L.R. 5th 1163, the Supreme Court of Illinois made clear, at p. 1184, the logical and obvious point, in cases where the person facing treatment was incompetent (as in the instant case), that "Notwithstanding the language used by the courts in reaching their determination that a transplant may or may not occur, the standard by which the determination was made was whether the transplant would be in the best interest of the child or incompetent person."*

[7] *Ashworth, op. cit., n. 3, at pp. 27-28.*

[8] *Ibid., p. 29.*

[9] *Raz, J.,* The Morality of Freedom *(1986), at p. 425, as quoted in Ashworth, op. cit., n. 3, at p. 29.*

[10] *Ashworth, op. cit., n. 3, at p. 29. For the principle of welfare, see ibid., pp. 30-31.*

[11] *Section 3 is the existing equivalent to the Compulsory Order as proposed by the Richardson Committee, and is the existing power of compulsory admission that is renewable and may last for a long time. Its precursor is section 26 of the Mental Health Act 1959.*

The principle of individual autonomy, "that each individual should be treated as responsible for her or his own behaviour," is also, as Andrew Ashworth states, "one of the fundamental concepts in the justification of criminal laws...." He, then, points out that this "principle has factual and normative elements.... The factual elements [being] that individuals in general have the capacity and sufficient free will to make meaningful choices.... [I]ts normative elements [are] that individuals should be respected and treated as agents capable of choosing their acts and omissions, and that without allowing independence of action to individuals they could hardly be regarded as moral persons."[7] Ashworth recognises that there are limits to following the principle through, though it does give "welcome strength to the protection of individual interests against collective and State interests." The limits that he identifies are a recognition that there are "forms of bias - such as gender bias - ... evident in the law's assumptions and reasoning. In some of its formulations the principle of autonomy pays little or no attention to the social context in which all of us are brought up, which both restricts and facilitates the pursuit of certain desired ends, and the context of powerlessness in which many have to live."[8] These are timely warnings and reminders. Ashworth draws attention to the three features of autonomy-based theories identified by Joseph Raz: (1) "the promotion and protection of positive freedoms which is understood as the capacity for autonomy, consisting of the availability of an adequate range of options, and of the mental abilities necessary for an autonomous life." (2) "the state has the duty ... to promote [freedom] by creating the conditions of autonomy." (3) pursuing goals "by means which infringe people's autonomy" are not permissible "unless such action is justified by the need to protect or promote the autonomy of those people or others."[9] From the third point, Ashworth concludes it involves a "minimalist approach to use of the criminal law" and "all three features reappear [in his] principle of welfare."[10]

We may now be in a position to begin to identify what might be appropriate bases for permitting compulsory use of detention in hospitals on the basis, at least in part, of a person's psychiatric illness or disorder. Such bases would appear to be the safety of others (the so-called police power of the State) and a capacity-based approach (i.e. that those capable and consenting may enter hospital; and also an approach based upon incapacity to be considered briefly below). The important first step is to recognise that a power based upon some general *parens patriae* power of the State is not sufficient to justify compulsory detention in hospital. A *parens patriae* basis for compulsory admission has traditionally been present in mental health legislation. It exists in the Mental Health Act 1983 (the source of which was the Mental Health Act 1959). Thus, compulsory detention is permissible, under section 3,[11] where it is either "for the protection of other persons" - the police power - or "for the health or safety of the patient" - the *parens patriae* power. The requirement that the detention of a person be "for the protection of other persons" is, it is suggested, too elastic to satisfy the police power. There is no requirement that the patient be dangerous to others, since "protection from others" sets a lower standard. "Danger" is used elsewhere in the legislation (section 25 where it provides the responsible medical officer with the power to prevent a nearest relative discharging a patient from hospital). Thus the police power, as

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[12] *This statement appeared in a note that I was requested to submit to the Richardson Committee as it commenced its work, and which may have had an influence upon the Committee's thinking.*

[13] *This appears to follow from Article 5 of the European Convention on Human Rights, though the Court has not yet followed through its logic.*

[14] *Maximisation of the capacity of incompetent adults follows as a principle from the argument propounded by Raz, see p. 40 above. It is possible to engage in relatively simple strategies to improve the decision-making abilities of individuals identified as not being competent, see Gunn, M.J., Wong, J.G., Clare, I.C.H. & Holland, A.J., "Decision-Making Capacity" (1999) 7 Medical Law Review 269, at pp. 281, 283-4, 286-8 & 302.*

currently phrased, is insufficient to warrant the exercise of a power of detention, since the harm being prevented is not sufficient to warrant the permitted liberty interference. If a *parens patriae* justification were thought to be sufficient, what appears in the Mental Health Act 1983 is not adequate for the purpose. The "health or safety" requirement is not limited, as regards its first limb, to the mental health of the patient. The fact that it is extended to either the patient's (mental) health or safety (or both) will not infringe the power as a justification, but only provided that justification is explicitly paternalistic in focus (a stance that has been rejected).

Presuming that a police power justification is sufficient, but not a *parens patriae* justification, it is submitted that an acceptable alternative to the police power of the State would be the right to admit someone not capable of making decisions about treatment for their own mental health.[12] A capacity-based alternative would permit a short term admission to assess capacity, where there was uncertainty about the individual's ability to make the relevant decisions. In the case of both bases for compulsory admission there would be the usual procedural protections, such as the requirement that hospitalisation be the least restrictive alternative for provision of the treatment that was deemed necessary. Length of permissible detention would need to be reliant upon the continuing existence of the mental health problem[13] and of either the need for the protection of others or the incapacity of the person admitted (dependent upon the basis for the original detention).

What treatment and care can be provided once a person has been admitted might be justifiable on two streams. Where the person is admitted on the basis of the police power, such treatment only as to reduce the risks to others that that person presents would be permissible. Where the person is admitted on the basis of incapacity, the treatment should be aimed at (a) making the person capable where possible,[14] and (b) in the interim, providing him or her with treatment that is necessary whether for his or her mental or physical health needs (necessary being determined by the time scale of incapacity and whether it is possible to wait for capacity to be acquired/recovered). The proposals of the Law Commission and of the Government in "Who Decides?" and, thus in the Government's proposals for reform in *Making Decisions*, seem to be consistent with such an approach as outlined in (b).

The above does not reflect the legal position as to be found in the current Mental Health Act, but it is a preferred approach to reform and limitation of the existing powers. It is less of an interference with the freedoms and privacy rights of potential patients. It seems widely, though not exclusively, to be accepted that the broad power of detention on the basis of the health or safety of the prospective patient is too wide, as witness the significant debate at the time of the second edition of the Mental Health Act Code of Practice, paragraph 2.9 which attempted merely to reflect what was the current position under the statute, but highlighted coincidentally the breadth of the compulsory power in section 3.

Essential to any reliance upon capacity is a generally accepted, understood and reliable definition of, and assessment tool for, incapacity.[15] This suggests the need for an approach that not only involves reform of the Mental Health Act, but also, and alongside it, the introduction of the Mental Incapacity Bill as proposed by the Law Commission, and which will largely be introduced when Parliamentary time allows.

Not surprisingly, the argument propounded above will not become legislation. It is too radical, because,

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[15] *Law Commission, Mental Incapacity (Law Com 231, 1995), Lord Chancellor's Department, Making Decisions (Cm 4465, 1999) and Gunn, et al, op. cit., n. 14.*

[16] *Department of Health, Reform of the Mental Health Act 1983: Proposals for Consultation (1999, Cm 4480), available at www.doh.gov.uk/mentalhealth.htm.*

[17] *Expert Committee, Review of the Mental Health Act 1983 (Department of Health, 1999), available at www.doh.gov.uk/mhar/report.htm.*

[18] *Ibid., at para. 5.95.*

not least, there is an accepted (though not I would say well articulated or argued) desire to permit compulsory detentions in situations that the preceding argument would not permit. The Government published its proposals for consultation, *Reform of the Mental Health Act 1983*[16] with the final report of the Richardson Committee, *Review of the Mental Health Act 1983*,[17] in November 1999. The Richardson Committee (formally entitled the Expert Committee, but named here after its chair, Professor Genevra Richardson of Queen Mary and Westfield College, University of London) had produced an interim report that had signalled a particularly interesting approach to the basis upon which admission to hospital, outside the criminal justice system, might be justifiable. This approach was based upon using the concept of capacity to make decisions as a factor in the criteria to be satisfied for compulsory civil admission to hospital. This approach remained in the final Report.

The Richardson Committee recommended that the criteria for a compulsory order (the potential long term form of compulsory admission to hospital) should be

> "i. the presence of mental disorder which is of such seriousness that the patient requires care and treatment under the supervision of specialist mental health services;
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> and
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> ii. that the care and treatment proposed for, and consequent upon, the mental disorder is the least restrictive and invasive alternative available consistent with safe and effective care;
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> and
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> iii. that the proposed care and treatment is in the patient's best interests;
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> and, either
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> iv. that, in the case of a patient who lacks capacity to consent to care and treatment for mental disorder, it is necessary for the health or safety of the patient or for the protection of others from serious harm or for the protection of the patient from serious exploitation that s/he be subject to such care and treatment, and that such care and treatment cannot be implemented unless s/he is compelled under this section;
>
> or
>
> v. that, in the case of a patient who has capacity to consent to the proposed care and treatment for her/his mental disorder, there is a substantial risk of serious harm to the health or safety of the patient or to the safety of others persons if s/he remains untreated, and there are positive clinical measures included within the proposed care and treatment which are likely to prevent deterioration or to secure an improvement in the patient's mental condition."[18]

The intriguing development here is the difference in criteria based upon whether the patient has the "capacity to consent to care and treatment for mental disorder." This was introduced as a reasoned consequence of the Richardson Committee's commitment to general principles that should underpin

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[19] *This for now at least must remain an assertion based upon anecdotal information.*

[20] *This, again, must remain an assertion based upon anecdotal information. It is not to suggest that all practitioners are happy as stated.*

[21] *Reform of the Mental Health Act 1983: Proposals for Consultation, op. cit., n. 16, at p. 32.*

[22] *Home Office and Department of Health, Managing Dangerous People with Severe Personality Disorder: Proposals for Policy Development (1999).*

[23] *I reached this conclusion in preparing papers to present as a Lent Lecture for the Centre of Medical Ethics and Law, King's College London (1999) and for a conference paper at the University of Leicester (1999).*

[24] *There is a well known and huge literature on this topic, for a particularly valuable introduction and review, see Henham, R., "Protective Sentences: Ethics, Rights and Sentencing Policy" (1997) 25 International Journal of the Sociology of Law 45.*

mental health legislation. The Committee has stayed committed to two essential principles, that is non-discrimination and patient autonomy. Their logical consequence being the distinction proposed above. The distinction certainly provides much greater respect for the principle of autonomy than has previously been the case. However, the criteria still retain the "health or safety" criteria so it would seem that the proposals by the Richardson Committee are not pure and are infected by its perception of what is practical in law reform. Whilst wishing to continue to make the argument above, I accept that that perception may well be an accurate one. Whilst capacity is an issue for many practitioners in determining whether to use the Mental Health Act,[19] it is not for all. Further, it is clear that practitioners seem to be comfortable with using the legislation on the paternalistic grounds that currently appear in the legislation.[20]

The Government is not happy with the capacity-based distinction at all. But its reasoning is not apposite. It states

"The principal concern about this approach is that it introduces a notion of capacity, which, in practice, may not be relevant to the final decision on whether a patient should be made subject to a compulsory order. It is the *degree of risk* that patients with mental disorder pose, to themselves or others, that is crucial to this decision. In the presence of such risk, questions of capacity - while still relevant to the plan of care and treatment - may be largely irrelevant to the question of whether or not a compulsory order should be made."[21]

If my argument were to be followed, capacity would be central, where the police power was not being used. The Government's response really only addresses the police power justification. This would, on my argument, still be a sufficient ground, and is according to the Richardson Committee proposals. It is hardly surprising that this is the focus of the Government. It is almost fixated by the need to protect society from people with mental illnesses. The clearest example of this is to be seen in its proposals to handle people with dangerous and severe personality disorder,[22] which, whilst seeming to be compliant with the European Convention of Human Rights,[23] are, it is suggested, unacceptable. They potentially involve long term incarceration without the subject having been found guilty of a crime, but on the basis of predicted (and then presumed) dangerousness. If justifiable, it must be by analogy with quarantine laws, that is the removal of a person from an environment where he or she will cause significant harm to others that can only be prevented by that removal. This places enormous reliance upon the accuracy of dangerous prediction, a subject of considerable controversy, though the prediction here is clinically based and about individuals rather than groups.[24]

In summary, I would adopt an alternative approach to that likely to become legislation as reform of the Mental Health Act. It might be possible, however, to secure a Mental Health Act predicated solely on a police power justification for compulsory admission, provided that a Mental Incapacity Bill is introduced. Alternatively, the distinction propounded by the Richardson Committee must be retained.

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# Capacity as the Gateway: an alternative view

*Robert Robinson**

The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (the Percy Commission) in its 1957 report put the case for providing "forms of control, within stated limits, over people suffering from mental disorder which do not apply to other people". Paragraph 314 (i) of the report offers the following justification for compulsory treatment in the interests of the patient's health: "When an illness or disability itself affects the patient's judgment and appreciation of his own condition, there is a specially strong argument for saying that his own interests demand that the decision whether or not to accept medical examination, care or treatment should not be left entirely to his own distorted or defective judgment. Admission to hospital against the patient's wishes at the time may be the only way of providing him with the treatment or training which may restore his health or enable him to take his place as a self-supporting member of the community or to develop his limited capabilities to the greatest possible extent. The better the prospects are of treatment or training being successful, the more important this consideration becomes." The report goes on to say: "No form of mental disorder should be considered to be, by itself, a sufficient ground for depriving a person of his liberty. It is necessary to balance the possible benefits of treatment or training, the protection of the patient and the protection of other persons, on the one hand, against the patient's loss of liberty on the other."

This rationale, which is reflected in the provisions of the 1983 Act, is rejected in the Report of the Expert Committee on the Review of the Mental Health Act 1983 because it discriminates against the mentally disordered by depriving them of the right to patient autonomy, that is the right of people to make effective treatment choices. Crucially, the right depends upon the patient having capacity to make such choices: "Patient autonomy brings with it an inevitable emphasis on capacity." (para.2.4) The purpose of this paper is to argue that the Expert Committee's approach is flawed. First, because it would merely, to use the terminology of discrimination law, replace direct discrimination with indirect discrimination. Second, because in conceptualising the detainable mentally ill patient as lacking capacity to make choices about treatment it erodes the validity of other choices which such a person may make. Third, that it tends to weaken the criteria for compulsion to what is, in effect, a best interests test. Fourth, that the justiciability of questions of capacity is problematic where the incapacity both results from mental illness and is considered in the context of treatment for mental illness.

## Discrimination

It is instructive to compare the Percy Commission's justification for compulsion with the Expert Committee's discussion of the application of the concept of incapacity to those suffering from mental illness: "Thus we propose a broad model of incapacity which accepts that a person may lack capacity where, although intellectually able to understand and apply the information, that person nonetheless reaches a judgment which s/he would not have reached in the absence of the disorder." (para.7.5) If the proposals of the Expert Committee on the use of compulsion rest on the same analysis as those of the Percy Commission, namely that mental illness may deprive the sufferer of the insight necessary to seek treatment, then it is hardly surprising that broadly the same group of people for whom the justification for compulsory treatment now amounts, in the opinion of the Expert Committee, to discrimination would still be subject to compulsion under their proposals. That this is the case can be demonstrated with reference to those parts of the Expert Committee's report where they analyse the impact of their proposals on the compulsory treatment of mental illness. The clearest example is the Committee's analysis of "The patient with a Deteriorating Condition" in paragraphs 7.12 - 7.14 where we find the following statement: "Under a proper understanding of the boundary between capacity and incapacity we would consider that such a person [who has no current symptoms of mental illness but who is refusing treatment] should be regarded as lacking capacity .... provided that there is a clear history of relapse and positive response to treatment." It can thus be seen that the concept of incapacity applies to the mentally ill in a unique way and will apply disproportionately to people suffering from mental illness as opposed to those suffering from other illnesses. The principle of patient autonomy is more a matter of form than substance for a person diagnosed as suffering from a serious mental illness who declines to accept medical treatment. If a capacity test leads to this result is it not a form of indirect discrimination? Or does this not simply demonstrate that the concept of discrimination is unhelpful in this area of law.

## Autonomy and the detainable patient

Almost all those who are subject to compulsion under the 1983 Act are classified as suffering from mental illness as opposed to other forms of mental disorder. Of these the great majority are treated as having capacity, in that the presumption of capacity has not been rebutted. The only point at which the Act requires a consideration of capacity is when the patient's consent to treatment must be sought under section 57 or 58. But the capacity test in those sections is cognitive ("is capable of understanding its nature, purpose and likely effect") and is therefore satisfied by those patients who are "intellectually able to understand", without further enquiry into whether the patient believes that he is mentally unwell and will benefit from treatment. A patient lacking in insight may therefore give a legally effective consent to treatment. Similarly, the mentally ill patient faced with a formal assessment for compulsory admission has the choice to opt for informal admission. This is regarded as a voluntary choice, albeit constrained by the patient's circumstances, and the patient is in effect treated as if he has capacity. Such a person is exercising a form of patient autonomy, although no enquiry is made into his capacity to do so.

The effect of the Expert Committee's proposals would be not only to make capacity fundamental to the admission process, but to impose a capacity test which, as the Committee acknowledge in paragraph

5.100 of their report, most mentally ill people who may be subject to the use of compulsory powers will fail. A person, such as "the patient with a deteriorating condition", who does not believe he suffers from mental illness or that medication is therapeutic will fail the capacity test. If he wishes to opt for voluntary admission, fully understanding that he will be expected to stay in hospital and take medication for his mental illness, should his choice be respected, given that he fails the capacity test on which true patient autonomy depends? If we deem him to lack capacity, why should we be parties to his decision to opt out of the statutory safeguards provided for detained patients? The answer must surely be that it is obviously far better that such a patient should be treated as capable of making a valid choice, regardless of his beliefs about his medical condition and treatment. The alternative is to consign him to the ranks of the Bournewood-type patients, compliant but incapacitated, and turn him into an object of paternalism. It can therefore be argued that there are important features of existing mental health law which promote autonomy. This is because in general mentally ill patients are treated as being capable of making choices and exercising rights, even if their judgment can be overridden by the use of compulsion.

## The criteria for compulsion

The policy of existing mental health law is that those invoking or reviewing the use of compulsory powers must be satisfied that the patient's mental disorder is of a nature or degree which makes hospital treatment appropriate. This test is rightly criticised by the Expert Committee as being open to may different interpretations. They say that a capacity test, which would in their view be apt to cover compulsion both in hospital and in the community, would lead to "a more precise and objectively justifiable use of compulsory powers". (para. 7.10)

The difficulty with what the Expert Committee propose, when setting out the criteria for compulsion in paragraph 5.95 of their report, is that in practice, where the (mentally incapacitated) mentally ill patient is concerned, the criteria amount to little more than a best interests test, coupled with a requirement that the proposed treatment is the least restrictive alternative. This is consistent with the general law on medical treatment of the mentally incapacitated which confers on doctors power to give treatment which they judge to be in the patient's best interests. It should be contrasted with the notion that in detaining a person and treating them without consent we are acting in opposition to their wishes and against what they judge to be in their own best interests. The model within which we now operate says in effect that the patient's wishes are to be respected unless and until his mental illness becomes so serious, whether in its nature or degree, that his wishes should be overridden, to the extent that this is necessary to provide appropriate treatment. The incapacity model simply fails to capture this and for this reason is not apt to provide for the balancing of competing interests which was referred to by the Percy Commission. It is driven by the logic of its own paternalism to treat the patient in a way consistent with what others deem to be his best interests. Indeed, it is difficult to see why, in considering treatment for the mentally incapacitated, we should, except in a clinical sense, act differently according to the nature or degree of the incapacitated patient's condition. After all, we do not regard other forms of medical treatment for the mentally incapacitated as representing an infringement of their rights: the only relevant right of the incapacitated patient is to be treated in accordance with "best interests". This represents a fundamental difference of approach. While the present statutory criteria no doubt provide scope for misinterpretation and abuse of compulsory powers, they do at least have the potential to act as barriers which hardly seem necessary or appropriate if the patient is mentally incapable.

## Justiciability

The determination of whether or not a person who may be made subject to compulsory treatment does or does not have capacity would, under the Expert Committee's proposals, be the central issue for mental disorder tribunals in deciding whether to confirm compulsion. For people with mental illness this would seldom turn on their cognitive abilities. The argument would be directed towards the second limb of the Expert Committee's proposed capacity test which is to be found at paragraph 7.5 of their report. Applying this test, the question for the tribunal would be whether or not the patient "is able to make a decision based on the information relevant to the decision". This requires a consideration of whether the patient believes the medical information about diagnosis and treatment which is provided by the doctor and whether the patient is capable of weighing this information in the balance to arrive at a choice about treatment. The tribunal would therefore have to decide what information is relevant to the treatment decision such that if the patient did not believe it he would fail the capacity test. It would then have to go on to consider whether the patient does in fact believe the relevant information and whether the patient's decision to refuse treatment is based on a rational consideration of that information. The examples given in paragraph 7.9 of the Committee's report illustrate some of the difficulties. Example v) is: "A patient with schizophrenia who is known to respond well to medication is convinced he is well after an initial and incomplete improvement, and refuses medication although he is demonstrably still unwell." Example vi) is : "A patient with schizophrenia responds well to medication and after an initial improvement says he no longer wishes to take it because he can manage without. He appreciates that his condition may well deteriorate and if it does so he has authorised a friend to re-engage with the mental health services on his behalf." The Expert Committee's opinion is that the first but not the second would fail the capacity test. It is hard to avoid the conclusion that capacity is being equated with the psychiatric concept of insight. While it may make clinical sense to talk about partial insight since, according to the Oxford Textbook of Psychiatry, "insight is not simply present or absent, but rather a matter of degree", capacity is something you either do or do not have. At what point along the continuum does the patient's lack of insight amount to incapacity? Is this a question which can sensibly be asked, let alone be satisfactorily answered by a judicial process? While it must be conceded that under their present jurisdiction mental health review tribunals routinely have to consider the patient's insight as being relevant both to the nature and degree of the illness and to the question whether treatment could be given without compulsion, these are essentially medical issues and are a normal part of psychiatric assessment. Capacity is a different sort of concept, medico-legal in nature, which would be likely quickly to lose its objectivity and clarity in being reduced to a proxy for insight.

Returning to the two illustrative examples, the relevant differences can be well conveyed in terms of insight since the first patient, though apparently not the second, at least appears to acknowledge that he may be suffering from a persistent mental illness. While the suggested result accords with the outcome one might expect under the existing law, it is not clear why one but not the other is to be regarded as incapacitated since neither seems to believe the treatment information, which flows from a diagnosis of schizophrenia, that he requires prophylactic medication to remain well. It is also unclear how the conclusion that the first patient has capacity can be reconciled with the example referred to above of "the patient with a deteriorating condition". It would appear that the notion of capacity is being used pragmatically to reflect views about the appropriateness of compulsion based on qualitiative assessments of a particular individual's mental illness. If the capacity test were to be applied in this way, it is difficult to share the Expert Committee's optimism that their proposals would result in "a more precise and objectively justifiable use of compulsory powers". On the contrary, viewed purely as a judicial process, decisions about detainability and compulsion are more likely to command confidence if they continue to be articulated as judgments, supported by psychiatric and other evidence, about the nature of the patient's mental illness and the consequences of it not being treated rather than appearing to be founded on an enquiry into the patient's own understanding and beliefs about his condition and the need for treatment.

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[1] *Reform of the Mental Health Act: Proposals for Consultation. Department of Health. (1999).*

[2] *Report of the Expert Committee. Review of the Mental Health Act 1983. Department of Health. (1999).*

# Unethical Mental Health Law; History Repeats Itself

*Zigmond, A.* and Holland, A.J. ***

## Introduction

The powers enshrined in mental health legislation go directly to fundamental principles central to any caring and democratic society. The tension and dilemma that exists is, on the one hand, the importance of respect for an individual's right to make decision's affecting his/her own life to, on the other, the recognition that there are people with mental disabilities that may be vulnerable to abuse and/or neglect and who throughout their lives or at particular times need care and/or treatment, which they may not seek or be able to consent to themselves. In any society it is through case law and statute that an attempt is made to resolve this tension and to ensure that individual rights are not infringed and that those who need care and treatment receive what is in their best interest. Thus a change in such legislation requires the most rigorous of examination and must be judged on the grounds that it a) does not infringe accepted principles such as those of the United Nations Declaration of Human Rights and the European Convention, b) is based on sound ethical principles and does not conflict with the established law of the country, and c) it is practicable and achieves the right balance with respect to the potential tension described above. As practising clinicians (one working in an acute psychiatric service the other in a district learning disability service) we are not in a position expertly to judge the first of these but we believe we can contribute to the second and the third. In this paper we consider specifically the reasons for, and the consequences that follow, the failure on the Government's part to accept the central importance of decision-making capacity assessment in any new mental health legislation.

The Green Paper proposals for a new Mental Health Act for England and Wales have now been published[1]. A broad definition of 'mental disorder' has been retained, a new system of tribunals is to be established and compulsory treatment in the community would become lawful. However, it rejects the recommendation of the expert committee chaired by Professor Richardson[2] that the assessment of

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[3] *Lord Donaldson, M.R. in Re T. (Adult: Refusal of medical treatment) [1992] 4 All ER 649.*

[4] *Lord Reed in S.v.S., W. v. Official Solicitor [1972]*

[5] *Judge L Jay in St George's Health Care NHS Trust v S. [1998] 3 All ER 673.*

[6] *County Asylums Act 1808*

[7] *Journal of Mental Science 110 (1898) taken from The British Journal of Psychiatry, vol. 174, April 1999.*

[8] *Terman, L. (1916) The measurement of intelligence, Houghton, Boston*

[9] *Goddard, H. 1913 The Kallikak Family, Macmillan, New York.*

an individual's decision-making capacity should be a determining factor in the use of compulsory detention. Given this, it does not address the relationship between this legislation and the proposed Mental Incapacity Act. The failure to recognise the central place of decision-making capacity in a modern Mental Health Act is, we believe, a serious omission as it is a reflection of a failure to acknowledge that the basic principle of autonomy is central to such legislation.

## Background

"Prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death"[3]. The principle underlying this proposition may be taken from Lord Reed[4] "There is no doubt that a person of full age and capacity cannot be ordered to undergo a blood test against his will..... The real reason is that English law goes to great lengths to protect a person of full age and capacity from interference with his personal liberty. We have too often seen freedom disappear in other countries not only by coup d'etat but by gradual erosion; and often it is the first step that counts. So it would be unwise to make even minor concessions". Indeed in 1998[5], Judge L Jay said, "The importance of this salutary warning remains undiminished".

So what is it that makes it proper for the Government in the Green Paper to go against the recommendation of its expert committee and suggest that the notion of capacity "may not be relevant to the final decision on whether a patient should be made subject to a compulsory order. It is the degree of risk that patients with mental disorder pose, to themselves or others, that is crucial to this decision"? Why is it that the mentally disordered may be considered to be lesser citizens to such a degree that interference with their personal liberty, *despite* the fact that they may have the capacity to make that decision for themselves, is considered perfectly proper? History may be instructive.

People were detained in asylums in ever increasing numbers from 1808 onwards[6] leading, in 1845, to the formation of the "Alleged Lunatic's Friend Society" by James Luke Hansard, "for the protection of the British subject from unjust confinement on the grounds of mental derangement" which, in turn, lead to the Lunacy Act of 1890.

An article in the Journal of Mental Science[7] entitled "Lunatics at Large and the Public Press" argued that the 1890 Act was highly restrictive to compulsory detention "as it required periodic re-certification" and that it had led to an increase in assault, homicide and suicide. The authors blamed the popular cry of "the liberty of the subject" as being responsible for this "foolhardy" legislation. The article ended "the public should be clearly instructed that the annually recurring and possibly increasing horrors from the crimes of "Lunatics at Large" are the price it pays, under the existing lunacy law, for protection from an illusory danger to the "liberty of the subject"

Similarly, the 'science' of eugenics was used to justify the compulsory detention in 'colonies' (later hospitals) of the 'feeble-minded' and of 'idiots' and 'imbeciles'. At that time it was considered that there was a direct link between 'feeble-mindedness' and 'criminality' - "the fearful role played by mental deficiency in the production of vice, crime and delinquency...not all criminals are feeble minded but all feeble-minded are potentially criminals[8]". Goddard[9] in a study of two families of common descent stated that "....the best material out of which to make criminals, and perhaps the material from which

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[10] *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-57, Chairman - Lord Percy, cmnd 169.*

[11] *F v West Berkshire Health Authority and another (Mental Health Act Commission intervening) [1989] 2 All ER 545.*

they are most frequently made, is feeble-mindedness".

Whilst in the late 19th and early 20th centuries the medical profession and eminent scientists of the day may have been arguing for greater restrictions it was subsequent legislative change that fundamentally led, very appropriately, to more enlightened practice and modern service developments. The irony is that this position would now appear to have been reversed.

Following the Royal Commission of the Law Relating to Mental Illness and Mental Deficiency[10] the Mental Health Act 1959 made many radical changes including the recognition that informal admission to hospital for treatment of a mental disorder was preferable to compulsory detention. Lord Russell likened the care of the mentally ill to that of the physically ill; "A doctor is not that sinister figure which in former times he was represented to be, anxious simply to confine a man in a dungeon for life... he is treating mental disorder in exactly the same way as he treats any other disease, with a sole view to its cure. When we use such phrases as 'the liberty of the subject' - and no-one attaches more importance to real liberty that I do - let us reflect on what the circumstances are. If you daughter has a fever, is she not restrained to bed instead of being allowed to run out into the cold air to die of double pneumonia? You do not invite the justices to do that - you do it as a matter of course... when the patient has recovered the patient is grateful for it".

Although the new Act was framed in a more positive manner and reflected the role of treatment and rights to appeal it still rendered possible the detention in hospital of people with different types of mental disorders including mental illness, psychopathic disorder and what was then referred to as 'mental subnormality'. The 1983 MHA made some further relatively small changes including changing terminology from 'mental subnormality' to 'mental impairment' and restricting the definition further, this being a compromise between those who wished for this category of mental disorder to be removed completely and those who wished for no change.

However, more recently it has been recognised that the law, as it stands, is unsatisfactory. The two main concerns expressed come from different perspectives but it is important to consider them both as, together with the historical background, they set the scene for the present day context of the Green Paper. They are as follows:

First, as described above, development of case law established the central importance of autonomy and with this the common law framework[11] that sets out the principles of 'necessity' and 'best interest' for substitute decision-making for those lacking decision-making capacity. However, this highlighted the lack of statute to provide a legal framework for substitute decision-making on behalf of adults who lacked the capacity to make decisions for themselves and with this the fact that there was no easy means for lawful intervention if a vulnerable and incapacitated person is at risk of abuse, or needs health treatment. In addition, the present lack of statute means that there is no method of appeal, other than seeking judicial review, if there is a disagreement as to what is in that particular person's 'best interests'. This came to a head with the case of *Bournewood* and Mr L.

Secondly, there remains a continuing Government perspective carried over from previous Conservative administrations, that the 'mentally disordered' may be dangerous. For this reason, it is said, mental health legislation must be framed in a manner that separates it from the principles that guide the treatment of physical illness. A series of tragic incidents and subsequent enquiries led not only to the

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*12 Making Decisions, Lord High Chancellor, The Stationary Office 1999.*

care programme approach and the establishment of the supervision register but to a belief that mental health legislation is not effective because it is neither applicable to all 'mentally ill' patients in all settings nor does it have the 'correct focus'. 'Protection of the public' is seen as central and any consideration as to whether increasing restrictions and greater legal powers are really the most effective method of care and risk reduction would appear to have been lost.

The contrast between these two perspectives is most striking when comparing the report of the review of the Mental Health Act chaired by Professor Richardson and the Government's Green Paper. The former explicitly recognises the place and limitations of mental health legislation and lays out, for example, the key principles of non-discrimination, respect for autonomy (consensual care), and reciprocity. Whilst some, including the authors of this article, would argue it does not go far enough, it recognises the central ethical and legal importance of decision-making capacity. In the Green Paper it is accepted that for 'most people' these principles hold true nonetheless they should not be guiding principles in legislation that will be primarily concerned with the provisions covering compulsory care and treatment for mental disorders. This is remarkable, as such legislation should be precisely the legislation that should be based on sound ethical principles!

Imagine two people, one with depression and one with cancer. In both cases it is clear that they *are* able to make rational judgements about their treatment. They both recognise that they are ill and that their illnesses can be treated and that there are consequences to not receiving treatment. In the case of the former the fact he/she has capacity has no relevance and even if fully capable his/her unwillingness to consent can be over-ridden. In the case of the latter it is central and for treatment to proceed without the consent of this person with capacity, would be an assault. Is this right? The position becomes absurd when it is realised that the depressed patient may be entitled to refuse treatment for an accompanying cancer - just not for his/her depression.

## Present proposals

There are many patients who may require care and protection within a legal framework, on the grounds that they may not able to make decisions for themselves, for example, unconscious patients, young children, those with acute confusional states, people with dementia and those with severe learning disabilities. The events relating to paediatric cardiac surgery at Bristol would support the view that many such patients may require greater protection than is currently available. Two current proposed statutes are relevant, the proposed Mental Incapacity Act[12] and the proposed new Mental Health Act. We consider the issues relevant to both.

The need for a statutory framework for substitute decision-making for those people with a mental disability resulting in incapacity has been recognised in the government's proposals for making decisions on behalf of mentally incapacitated adults. The question, therefore, is whether additional legislation and protections for those with a mental disorder should be greater than, or different from, that proposed for other potentially mentally incapacitated adults. There are a number of reasons for believing that separate legislation is damaging to the care of people with a mental disorder.

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13 *Coker, R Public health, civil liberties and tuberculosis. British Medical Journal, 7196, 29th May (1999).*

14 *Department of Health. Statistical Bulletin. The Stationary Office (1999).*

First, the two statutes at present refer essentially to the same populations although the proposed mental health legislation could include a wider group as it does not depend on the presence or not of incapacity. The consequence that follows from having two statutes is the need to determine which applies when and if both apply, which takes precedent and how to deal with the problem of double jeopardy that will potentially face some people. For example, in future what about Mr L (*Bournewood*) if he really did need admission. Because of his severe learning disability he is very likely to remain incapable of making treatment decisions for himself. Should he therefore be admitted without consent (because he is unable to consent) using the Mental Incapacity Act or a new Mental Health Act? Similarly, if a person with a learning disability is considered to have the capacity to accept or reject particular advice and therefore the Mental Incapacity Act cannot apply, can and should his expressed wishes be overridden using the new Mental Health Act? Presumably any treatment for a physical disorder would be through the use of the Mental Incapacity Act and any treatment relating directly to his mental disability, through the use of the Mental Health Act!

Secondly, such an approach is undoubtedly stigmatising. Patients believe so; that is one of the reasons why they may reluctantly agree to informal admission in order to avoid detention. Families know this, in that it is not unusual for relatives to want the patient kept in hospital for treatment, but are reluctant to agree to formal detention. Indeed the Expert Committee reviewing the Mental Health Act recognise this and give it as one of their reasons for believing that the learning disabled should not be included (on the basis solely of learning disability) within the framework of a Mental Health Act. Clearly a law which covered all incapacitated patients, whatever the cause, would be less stigmatising than one which refers specifically to mental health and the treatment of mental disorder.

Thirdly, a Mental Health Act, which enables the compulsory care and treatment of patients, reduces the need to make provision that is acceptable to patients. Comments in a recent editorial in the British Medical Journal, although it was referring to tuberculosis, is just as true for the mentally ill: "If public anxiety rises, and this is allied to physicians' and public health officials' frustration over failures to ensure and monitor compliance, calls for detention of non-compliant individuals will be heard loudly. These calls for coercive measures, where individuals fail to recognise their social obligations, need to be tempered with a co-ordinated approach, which supports individuals with tuberculosis. Both civil rights and public health can be protected, but the emphasis should be on resource and organisational requirements, rather than on coercion."[13]

A counter argument might be that the Mental Health Act saves lives. Even if this were true there would still be grounds for concern as it is recognised that those with physical illnesses should be autonomous and there is no reason to believe that patients with mental disorder who have the capacity to make health-care decisions should be treated differently. However, there is no reason to believe that such legislation does reduce mortality. In the 10 years 1987/88 to 1997/98 the number of detentions under the Mental Health Act increased by 63%, indeed the rate of detention of informal patients in hospital using Section 5(2) increased by over 80%[14]. There has been no commensurate fall in the suicide or homicide rate during this time.

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[15] *Taylor, P.J. and Gunn, J. Homicides by people with mental illness: myth and reality. British Journal of Psychiatry, 174, 1999.*

[16] *Managing Dangerous People with Severe Personality Disorder, Proposals for Policy Development, Home Office, 1999.*

[17] *Power, S. A patient's choice. British Medical Journal, 7206, 7th August (1999).*

[18] *Grisso, T. and Applebaum, P.S. Comparison of standards for assessing patients' capacities to make treatment decisions. American Journal of Psychiatry 152, 1033-1036, (1995).*

Fourthly, perhaps the real concern of legislators is not for those people who may harm themselves, but for those who may harm others. Surely, it is argued, the public has a right to be protected from such patients. This needs to be explored further. A Medical Incapacity Act could authorise the detention of patients who lacked capacity when appropriate and in the person's best interest. The courts could deal with patients with capacity charged or convicted of offences. The core concern appears to be those patients who suffer from mental disorder, retain capacity and might, just might, be a danger to others. This issue of the dangerousness of the mentally ill has been comprehensively examined and in the context of society generally shown to be a serious misconception[15]. There is also a further problem with respect to 'dangerousness' and 'public protection' that particularly applies to an additional piece of proposed legislation[16]. There are a number of ways of assessing the effectiveness of a particular treatment or medical intervention; this is the notion of "number needed to treat". That is how many patients would need to receive a drug or other intervention in order for one patient to benefit. This concept could be applied to the idea of detention (under a Mental Health Act) to prevent homicide. How many patients would need to be detained (unnecessarily) to prevent each homicide? Is it ten, a hundred, a thousand? The reality is that the ability to predict an act of violence to be committed by a particular individual at a particular time is extremely poor. For those people who are not mentally disordered the courts, when assessing guilt, use the "beyond unreasonable doubt" test on the grounds that it is better to let ten guilty men go free than imprison one innocent man. One must question why people with mental disordered are to be treated so differently.

There is recognition within society, including the medical profession, that there are a very small number of patients with medical conditions who present a clear serious risk to the public and yet who refuse medical intervention. Such patients can currently be detained under the Public Health (Control of Diseases) Act 1984. This legislation, with amendment, would enable the courts to detain those very few patients about whom there is no doubt of the risk they present.

Finally, it may be worth returning to another item from the British Medical Journal, a Personal View entitled "A patient's choice". "For my uncle life without drink was no life at all. He drank heavily from the age of sixteen until two weeks before his sixtieth birthday, the day he died. It runs against much of what I feel as a doctor but I admire him for his refusal to listen. Informed he made his choice and a patient's choice - no matter how damaging it seems to those who only see the small picture - should always be respected"[17]. People who are mentally ill and able to make treatment decisions for themselves fit the same category.

## The Future

There is a danger that just like molecular genetics or brain scanning becoming the 'holy grail' for neuroscientists, 'capacity' becomes the same for 'enlightened' professionals and campaigning organisations. Whilst much research has been undertaken, particularly in the USA, on mental illness and capacity[18], there remain many uncertainties, most importantly how it might be assessed and then applied within the context of English and Welsh and Scottish Legislation. However, the concept of decision-making capacity is being clarified with a clear move to the concept that decision-making

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19 *Assessment of Mental Capacity, Guidance for Doctors and Lawyers, British Medical Association and The Law Society, British Medical Association, (1995).*

20 *Wong, J.G., Clare, I.C.H., Gunn, M.J. and Holland, A.J. Capacity to make health care decisions: Its importance in clinical practice. Psychological Medicine, 29 (2): 437-446, (1999).*

21 *Wong, J.G., Clare, I.C.H., Holland, A.J., Watson, P.C. and Gunn, M.J. The capacity of people with a 'mental disability' to make a particular health care decision. Psychological Medicine (in press)*

capacity is determined functionally not by diagnosis and that it is decision specific. For example, the following would be considered to be critical; the ability to understand and retain information, to appreciate its significance and to be able to communicate one's choice[19]. A person with a learning disability or with dementia may be capable of some but not all decisions. Someone with a relapsing and remitting mental illness may be perfectly capable of making decisions when mentally well but not when mentally ill (see Wong, et al, 1999, for review)[20]. Capacity maybe enhanced through the way information is given with the identification of what it is that should be expected of a person[21].

There are undoubtedly people with a mental disorder who require treatment for their illness and their health or safety or the safety of others may be at risk because of their behaviour. Treatments, particularly for people with mental illness, are of potential benefit and people with progressive illnesses associated with increasing mental disability or with lifelong disabilities need care and support even if they cannot determine that for themselves. A means of lawful intervention in the absence of consent is necessary. We end this paper with a brief summary of options.

First, it should be accepted that adults who are *able* to make treatment decisions for themselves have the right to expect that their decision about whether to accept treatment would be respected. This applies to the treatment of both physical and mental disorders. For those that do not have the capacity to make that decision for themselves, due to the presence of a mental disability, treatment can take place under the direction of the proposed new Mental Incapacity Act. Under these circumstances treatment (and if necessary admission to hospital) can proceed if it is in the person's best interest and the least restrictive alternative. Additional safeguards in the case of specific interventions (ECT, medication etc) would need be made. Where treatment takes place it will be influenced by the nature and degree of the person's mental or physical disorder and the risks to his/her health, his/her safety and the safety of others. Subject to further consideration about how capacity might be assessed this is, in our view, the favoured option. It meets the key ethical considerations laid out by Professor Richardson - it would be non-discriminatory (i.e., treats mental and physical disorders similarly) and respects the principle of autonomy for those with capacity and would resolve the issues raised by '*Bournewood*'.

A second option would be similar to that expressed above. However, acknowledging the possibly (albeit not in the view of the authors) insurmountable problems of assessing decision-making capacity, to opt for the Richardson Committee compromise of a differential threshold for detention as between those patients with and those who lack capacity.

Thirdly, if the above is not acceptable, any future mental health legislation should be much more focused and only concerned with the assessment and treatment of acute mental illness rather than providing a legal framework for people with life long or progressive disorders (e.g. dementia) that might affect a person's decision-making capacity. The definition of 'mental disorder' in any new legislation would be limited to mental illness. The focus of mental health legislation would be exclusively the assessment and treatment of acute and serious mental illness in the short term. The Mental Incapacity Act would provide the wider framework for substitute decision-making including the admission to hospital for treatment of physical or mental disorder (other than mental illness). From the Government's perspective the former would not include the concept of decision-making capacity but the latter would. This solution continues to discriminate against the mentally ill but does ensure, for example, that as far as people that are presently detained under the category of 'mental impairment' are concerned, their autonomy is respected if they are capable of making such admission or treatment decisions for themselves (except if mentally ill and requiring treatment). It would also go some way in resolving the dilemma highlighted by *Bournewood*, in that as the patient lacked the capacity to make that decision for himself, the Mental Incapacity Act would have provided a legal framework for admission (and thereby a means of appeal), but he would not have been subject to detention under mental health legislation as he was not mentally ill.

Fourthly, that the new legislation remains essentially as proposed in the Green Paper. We believe that such an approach fails on many counts, most importantly it does not show the leadership that we might have expected from this Government in countering historical prejudices against those with mental disorders and ensuring a just and non-discriminatory legislation, nor will it address public safety fears. These are much better addressed through enhancing the respect for and quality of relevant health, housing and social care services. The combination of the broad definition of mental disorder and the removal of the need for a capacity assessment as a 'filter' in the process of compulsory detention opens the door to the potential detention of many people. For people with learning disability it turns the clock back to the 1959 MHA and possibly even further, to the 1913 Mental Deficiency Act. The lack of any requirement to consider the 'treatability' of the person's mental disorder carries the risk of making this closer to a Public Order, rather than a Mental Health Act.

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[1] *Review of the Mental Health Act 1983. Report of the Expert Committee. Department of Health.*

[2] *Reform of the Mental Health Act 1983. Proposals for Consultation. Department of Health.*

[3] *Wall, S., Churchill, R., Hotopf, M., Buchanan, A., Wessely, S. Systematic review of research relating to the Mental Health Act 1983. Department of Health.*

# Department of Health Review of Research on the Mental Health Act 1983

*Martin Humphreys* and Helen Smith***

At the same time that the Government published the Report of the Expert Committee on the Review of the Mental Health Act 1983[1] and the accompanying consultation document[2], the Department of Health produced a systematic review of research relating to the Mental Health Act 1983[3]. This was written jointly by a team made up of researchers and senior academics from King's College School of Medicine and Dentistry, St George's Hospital Medical School and the Institute of Psychiatry in London. It represents a major undertaking and will be an invaluable tool, particularly for those involved in research into mental health law and allied legislation, both in the UK and further afield, but also anyone involved in the care of detained patients. It is strengthened greatly by the fact that it was undertaken in a structured, rigorous and scientific manner and involved those with not only a formidable academic background, but also clinical experience in the use of the Act itself.

The review is comprehensive, both in form and content. The authors stated aims to summarise the available current data and from that, determine how the Act has been used, and describe which parts are effective or otherwise, has generally been achieved.

## Part I

The review is divided broadly into two parts. The first is a description of changes in the use and operation of the Mental Health Act 1983 based on information collected by the Department of Health between 1984 and 1996. While the authors acknowledge the limitations on what they can say based on the difficulties interpreting what may be, in some part at least, quite inaccurate data, they do point to some interesting and important trends. These include the increase in the proportion of involuntary admissions to psychiatric beds over that period, the increase in the number of individuals transferred to hospital from prison and the paradoxical and somewhat inexplicable reduction in the number of hospital orders made by the courts.

## Part 2

The main part of the report consists of the systematic review of research into the Mental Health Act 1983. The methods used to gain access to data containing research papers were exhaustive and included conventional database trawls, the use of the internet and extensive hand-searching. More than 700 papers were identified, although quite remarkably, given the importance of mental health law as a whole, only just over 20% of them could be included in the review as they contained original research data. Most disappointing of all was the fact that only one article on training and the use of the Mental Health Act qualified for inclusion. Almost equally disquieting was the fact that seemingly mainstream general and psychiatric journals published relatively few papers in this area. What was encouraging despite this, was the fact that the Psychiatric Bulletin has emerged as perhaps the most important current source of access to work in this field. Unfortunately, reference to it is not to be found on electronic databases.

The review section describes in detailed tabular form each of the relevant identified papers. For each section including those on the use of the Act as a whole, the operation of Parts II, III and X, as well as a variety of other topics, there is discussion of the findings from each piece of work and then suggestions for future allied research. Important and recurring themes are the dearth of qualitative work reported and the need for increased user centred research, particularly in relation to patients' experience of compulsion, as well as the issue of outcome following the use of the Mental Health Act. One of the more surprising findings was how few database publications there were related to important matters such as violence in the Act, the use of ECT and the Mental Health Act in forensic and other specialist settings.

There are carefully prepared references to Parts 1 and 2 of the report and also appendices, including lists of journals identified, a summary of the studies included in the review, a precis of important parts of the Act for those unfamiliar with it, and lists of papers originally identified which were not included in the process and the reasons for that. These sections, particularly those detailing the excluded material are of immense value in themselves as a reference point for future research and writing.

## Conclusion

The systematic review of research relating to the Mental Health Act 1983 provides an invaluable resource for researchers and clinicians alike. It is an important starting point for anyone undertaking a review of practice, audit or research into any aspect of mental health law at the current time in the United Kingdom despite being about the 1983 Act alone. It does not include an analysis of publications which did not include original data, something which may be significant in an area where attitudes and opinion can be so important and influential. It does, however, contain substantial listings of review papers, as well as those concerning related matters in other jurisdictions and countries. It clearly identifies a number of important areas which have been under-researched. In addition it serves to confirm the view that findings from research into mental health law and allied areas are published relatively infrequently in widely read general journals, but that certain more specialist publications such as the Psychiatric Bulletin, are an increasingly rich and important source of information.

Has the review come too late, published at the same time as the Scoping Study Committee's report on the 1983 Act and the consultation document, both of which anticipate new legislation? In some ways the answer must be yes, as presumably certain parts of the 1983 Act will have no equivalent and therefore become obsolete when the new law is enacted. On the other hand the review provides a vital starting point for consideration of future research and serves to emphasise very clearly the need to put in place systems for the collection of data and review of operation of the new Act from the outset. Read carefully it also provides an insight into areas of practice which should be considered again in far greater detail before any new law is passed.

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1 *See Kennedy, I. & Grubb, A., Medical Law: Text with Materials (2nd ed., 1994) at pp. 1011-1024. The history of human research and experimentation has highlighted how vulnerable members of society can be abused by unethical researchers or political regimes: Katz, J., Experimentation with Human Beings (1972) as quoted in Kennedy & Grubb, pp. 1012-1024; Beecher, H.K., "Ethics and clinical research" (1966) 274 New England Journal of Medicine 1354; and National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, The Belmont Report: Ethical Principles and Guidelines for Protection of Human Subjects of Research (1979).*

2 *A brief summary of the experiments is to be found extracted in Kennedy & Grubb, op. cit., n. 1 at pp. 1012-1013.*

3 *A further ethical dilemma is the use to which the results of such experiments may be put. E.g., the hypothermia experiments carried out for the benefit of the Luftwaffe "produced a range of data which is genuinely useful in the avoidance and treatment of the victims of hypothermia" (Gunn, M. & McCoubrey, H., "Medical Ethics and the Laws of Armed Conflict" (1998) 3 Journal of Armed Conflict Law 133, at p. 148.) Probably the appropriate ethical conclusion is that, despite the abhorrence rightly felt for the experiments, the results should nevertheless not be ignored. To ignore the results would be to heap insult on top of almost unimaginable injury.*

4 *Kennedy & Grubb, op. cit., n. 1 at p. 1067.*

5 *See, e.g., McHale, J., "Guidelines for Medical Research" (1993) 1 Medical Law Review 160. See also Kennedy & Grubb, op. cit., n. 1, at pp. 1032-1042 and Kennedy, I., "Research and Experimentation" in Kennedy, I. and Grubb, A., Principles of Medical Law (1998-), at paras. 13.55-13.56.*

# Medical Research and Incompetent Adults

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## Introduction

The spectre of Nazi medical experimentation during the Second World War undoubtedly hangs over any discussion of medical research and incompetent adults.[1] The concentration camp experiments[2] denied the rights of people who would have been able to give or withhold consent but were, of course, not asked.[3] The fears raised by the nature of these experiments has given rise to a real, understandable and genuine concern that research participants, particularly those who are vulnerable, may be abused through their participation. For example, Professors Kennedy and Grubb take the view that non-therapeutic research on incompetent adults is prohibited and go on to say that "given the history of Europe in the 1930s and 1940s which culminated in the Nuremberg Trials ... it is entirely understandable that some European countries would hold the view that an absolute prohibition was the only defensible [position]."[4] The question that arises is whether prohibition is always the correct approach, or whether some forms of research should be permissible, recognising that strict protections will be necessary.[5] We reflect upon the rigidity of the distinction between therapeutic and non-therapeutic research in the context of a research project that we undertook.

## Medical research: general ethical position

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6 *See, e.g., the Nuremberg Judgment (that is the opinions of the judges at the end of the post-Second World War war crimes trials) which contains a set of ten principles to control medical experimentation (available in Kennedy & Grubb, op. cit., n. 1, at pp. 1022-1024; hereafter Nuremberg Judgment). The relevant principle is 2, which states, "The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature."*

7 *Subsequent to the Nuremberg Trials, the World Medical Association considered medical research and issued the Declaration of Helsinki in 1964 (subsequently amended). The relevant principles of the Declaration are (from the introduction): "The purpose of biomedical research involving human subjects must be to improve diagnostic, therapeutic and prophylactic procedures and the understanding of the aetiology and pathogenesis of disease.... Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, the World Medical Association has prepared the following recommendations as a guide to every physician in biomedical research involving human subjects. They should be kept under review in the future. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Physicians are not relieved from criminal, civil and ethical responsibilities under the laws of their own countries."*

8 *"Medical progress is based on research which ultimately must rest in part on experimentation involving human subjects:" Declaration of Helsinki, introduction.*

9 *See also the discussion in relation to distributive justice, below at p. 63.*

10 *See n. 40, below.*

Medical research that is scientifically, ethically and legally sound enhances the welfare of society and its members.[6] It produces advances in medical knowledge and takes that knowledge to general application.[7] Medical research with human participants is, therefore, desirable.[8] It is also essential, as the alternatives to the human participant (such as laboratory and animal-subject research) are often limited in their scientific and practical value. Sometimes medical research that has used human participants has general application. However, this is not always the case, as the nature of the condition of a group of human beings may be sufficiently particular that research, in at least some areas, can only be valid if carried out with humans having that condition being the research participants. There will be some research that must be undertaken with persons who cannot give or withhold consent by the nature of the condition that produces the incompetence.[9]

## The ethical position, medical research and incompetent adults

International medical ethical instruments draw a distinction between therapeutic and non-therapeutic medical research. It does not necessarily follow from the distinction between the two that non-therapeutic research should be prohibited. This distinction between therapeutic and non-therapeutic research has a long tradition. It did not form part of the Nuremberg Judgment, but the distinction was drawn by the World Medical Association in the Declaration of Helsinki. Its introduction states:

> "In the field of biomedical research a fundamental distinction must be recognised between medical research in which the aim is essentially diagnostic or therapeutic for a patient, and medical research, the essential object of which is purely scientific and without implying direct diagnostic or therapeutic value to the person subjected to the research."

This basic premiss was developed in the principles enunciated by the WMA. Section II of the Declaration is concerned with clinical research and section III with non-clinical biomedical research. The distinction is also fundamental to the latest international consideration. In the European Convention on Human Rights and Biomedicine,[10] the distinction is relevant to research on people not able to consent to it.[11] Article 17.1 lays down the principles where the research has "the potential to produce real and direct benefit to his or health". Article 17.2, "exceptionally and under the protective conditions prescribed by law," allows for some non-therapeutic research.[12]

Examining the European Convention on Human Rights and Biomedicine in more detail, it can be seen that it lays down, in Article 16, the following criteria for research where the adult is competent:

> "Research on a person may only be undertaken if all the following conditions are met:
>
> i there is no alternative of comparable effectiveness to research on humans,
>
> ii the risks which may be incurred by that person are not disproportionate to the potential benefits of the research,
>
> iii the research project has been approved by the competent body after independent examination of its scientific merit, including assessment of the importance of the aim of the research, and multidisciplinary review of its ethical acceptability,
>
> iv the persons undergoing research have been informed of their rights and the safeguards prescribed by law for their protection,

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[11] *The distinction is not drawn where the research participant is capable of consenting to it: ibid., Article 16.*

[12] *See below, p. 71.*

v the necessary consent as provided for under Article 5 has been given expressly, specifically and is documented. Such consent may be freely withdrawn at any time."

In Article 17, the Convention proceeds to consider the situation where the adult is not competent. Here it draws the distinction between therapeutic research, in paragraph 1, and non-therapeutic research, in paragraph 2:

1. Research on a person without the capacity to consent as stipulated in Article 5 may be undertaken only if all the following conditions are met:
    - i the conditions laid down in Article 16, sub-paragraphs i to iv, are fulfilled;
    - ii the results of the research have potential to produce real and direct benefit to his or her health;
    - iii research of comparable effectiveness cannot be carried out on individuals capable of giving consent;
    - iv the necessary authorisation provided for under Article 6 has been given specifically and in writing, and
    - v the person concerned does not object.
2. Exceptionally and under the protective conditions prescribed by law, where the research has not the potential to produce results of direct benefit to the health of the person concerned, such research may be authorised subject to the conditions laid down in paragraph 1, sub-paragraphs i, iii, iv and v above, and to the following additional conditions:
    - i the research has the aim of contributing, through significant improvement in the scientific understanding of the individual's condition, disease or disorder, to the ultimate attainment of results capable of conferring benefit to the person concerned or to other persons in the same age category or afflicted with the same disease or disorder or having the same condition.
    - ii the research entails only minimal risk and minimal burden for the individual concerned.

There are at least two ethical arguments in support non-therapeutic research. Whilst there may be an ethical imperative on scientists to undertake medical research,[13] this is not sufficient to impose a moral obligation on any given individual to participate as a subject in it. Distributive justice requires a fair distribution of both the burdens and the benefits of research.[14] Obviously, it is important that nobody, regardless of their level of ability to engage in the distributive process, is unfairly burdened with being participants in research. Therefore, people without capacity to make such a decision should not be

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[13] *The argument is based on the ethical principles of beneficence and non-maleficence, as considered by Gillon: Gillon, R., Philosophical Medical Ethics (1986), at Chapters 12 & 13.*

[14] *Levine, R.J., Ethics and Regulation of Clinical Research (2nd ed., 1988), at pp. 17-18.*

[15] *Roberts, L.W., "The ethical basis of psychiatric research: conceptual issues and empirical findings" (1998) 39 Comprehensive Psychiatry 99.*

[16] *Of course, such research has to be carefully regulated, as is required, e.g., by the European Convention on Human Rights and Biomedicine, as identified in this paper.*

[17] *Harris, J., "The ethics of clinical research with cognitively impaired subjects" (1997) 5 Italian Journal of Neurological Science 9.*

[18] *Tomossy, G.F. and Weisstub, D.N., "The reform of adult guardianship laws: the case of non-therapeutic experimentation" (1997) 20 International Journal of Law and Psychiatry 113.*

involved in research just because they are vulnerable and available. However, a complete prohibition on research with incompetent adults as participants, for the sake of the protection of their welfare, may represent an injustice in itself.[15] Owing to the close link between their condition/illness and the impairment in decision-making, advancement in knowledge about people falling in these groups cannot be obtained by studying other groups of people whose members are more intellectually able. Scientifically sound research needs to include appropriate test populations. Allowing research only on individuals with capacity to consent will limit the generalisability of any consequent research outcomes. Research with incompetent adults as participants is necessary to ensure that, as a group, adults with intellectually incapacitating conditions are not deprived of the benefits of scientifically sound research, and, therefore, are not doubly disadvantaged by their mental disability.[16]

Secondly, it is argued that, if one wishes to gain the benefit of medical research, one has an obligation to offer oneself for participation. Otherwise, the person gaining the benefit of the research is a mere parasite on society, taking only the advantages and undertaking no risks. Professor John Harris has taken this argument further. He argues that, with regard to incompetent adults, the same moral argument applies. He wishes that the preferred position be that people should consent or not object to research, but makes it clear that "free-riding is not an attractive principle; nor is it a moral principle. We should not ... assume that those incompetent to consent would wish to be free-riders, nor that they be excluded from discharging an obligation of good citizenship which we all share."[17] This argument, we would suggest, is consistent with principles of normalisation and social inclusion. It challenges stereotypes that incompetent adults are a drain on society. Of course, such an argument will not be received well by all interested parties. Tomossy and Weisstub have warned of reliance on what they term "imagined altruistic motivations of mentally incompetent subjects." They argue that the presumption of desire for altruistic action cannot be attributed to individuals who can neither conform or deny such a presumption.[18] Of course, Harris' argument is not that simple, and communitarian values inherent in being a human being are worthy of recognition.

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[19] *See, e.g., Royal College of Psychiatrists, "Guidelines for research ethics committees on psychiatric research involving human subjects" (1990) 14 Psychiatric Bulletin 48.*

[20] *Law Commission, Mental Incapacity (1995, Law Com 231), at para. 6.28.*

[21] *Ibid., para. 6.29.*

[22] *See also, Kennedy & Grubb, op. cit., n. 1, at p. 1054.*

[23] *Ibid.*

An ethical argument that we believe does not have a role to play is that identified as a moral fiction by Tomossy and Weisstub. It is the argument that research on incompetent adults is justified by their 'right' to participate in research.[19] Potential participants do have rights, but they do not extend to this purported position. If there were to be a right to participate, this could imply a duty on researchers to engage a particular person in a research project. It is clear that such a duty does not exist. No one can demand to be a participant. He or she may be invited by a researcher, if the latter either identifies the other as a potential participant or the other responds to an invitation to participate. The potential participant has a freedom or liberty to participate, but not a right strictly so called.

## The legal position, medical research and incompetent adults

In its impressive investigation of decision-making by adults, the Law Commission relied upon this distinction between therapeutic and non-therapeutic research procedures. "The former covers procedures which, whether or not there is also a research objective, are intended to benefit the individual participant."[20] "'Non-therapeutic' research, on the other hand, does not claim to offer any direct or immediate benefit to the participant."[21] Whilst such procedures may be ethically and scientifically sound, they are contrary to the law unless either the participant is competent and consents or the participant is not competent and the research procedure falls within the best interests criteria. So, it is possible for therapeutic medical research to be carried out on an incompetent adult, provided it falls within the best interests test in *Re F*.[22] However, non-therapeutic research, it would appear, cannot be in the best interests of an incompetent adult. This conclusion is reached by the Law Commission, which points out that the "simple fact is that the researcher is making no claim to be acting in the best interests of that individual person and does not therefore come within the rules set out in *Re F*."[23] The same conclusion is also reached by the leading medical lawyers, Professors Kennedy and Grubb. In their book, *Medical Law: Text with Materials*, they state

"The first criterion that must be satisfied is that there is a real and justified need for research on *incompetent* adults, ie that the knowledge sought may not be discovered from research on competent consenting adults. This is only a particular illustration of the general legal principle that the law seeks to protect the vulnerable. Satisfying this criterion by no means implies that it is lawful thereafter to carry out non-therapeutic research. Indeed, it would appear that such research cannot lawfully be carried out. There is no one who, in law, can authorise it as a proxy. Even the court if it were to have a *parens patriae* power could not authorise such research since the power exists specifically for cases where 'some care should be thrown around [the ward]' (*Wellesley v Duke of Beaufort* (1827) 38 ER 236 at 243). Also, of course, the approach of the House of Lords in *Re F* would not assist since non-therapeutic research could not be said to be in the '*best* interests' of the incompetent adult. If, however, the law does permit any non-therapeutic research on an incompetent adult, the curious situation would arise that such research may be permissible in the case of children but not in the case of adults. This apparent anomaly could be explained by noticing that in the case of children the parent can act as the protector of the child's interests whereas no such person exists in the case of the adult. Whatever the legal position, it is undoubtedly the case that there has been a shift in thinking about the ethics of non-therapeutic research on the incompetent adult."

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*24 See below, at p. 66-67.*

*25 Kennedy & Grubb, op. cit., n. 1, at p. 1067.*

*26 As for the European Community's Guidelines, see CPMP, Guidelines on Good Clinical Practice for Trials on Medicinal Products in the European Community (1991).*

*27 445 S.W. 2d 145 (1969) (Kentucky Court of Appeals), and see Gunn, M.J., "Treatment and Mental Handicap" (1987) 16 Anglo-Am. L.R. 242.*

*28 (1990) 4 A.L.R. 5th 1163.*

*29 Ibid., at p. 1185.*

*30 Ibid., at p. 1204.*

There are proposals for reform of the law from the Law Commission,[24] but these do not alter the current legal position. Professors Kennedy & Grubb note the Law Commission's proposals and then state[25]

"Notwithstanding the Law Commission's proposals it is important to notice the position adopted in the [European Community's Guidelines on Good Clinical Practice]. While paragraph 1.13 permits in limited circumstances *therapeutic* research on the incompetent if certain safeguards are observed, paragraph 1.14 provides:

1.14 Consent must always be given by the signature of the subject in a non-therapeutic study, ie where there is no direct clinical benefit to the subject.

It could not be clearer from this paragraph that the European Guidelines prohibit non-therapeutic research on incompetent adults. ... Many might regret the absolute nature of the prohibition. Given the history of Europe in the 1930s and 1940s which culminated in the Nuremberg Trials which we referred to at the outset, however, it is entirely understandable that some European countries would hold the view that an absolute prohibition was the only defensible one."[26]

Of course, the ethical position is not, at a European level, the same as that from which Professors Kennedy and Grubb were operating, but their view is likely to be one held by others. In the short term, at least, the legal question is whether non-therapeutic research on an incompetent adult could be in that person's best interests. It is easy to see the argument why it is not, since the person gets no direct or personal benefit from the research. However, there is, implicit at least, in the European Convention on Human Rights and Biomedicine an argument that non-therapeutic treatment might be in the best interests of an incompetent adult. This presumes the possibility that a person's interests may include, e.g., providing assistance to others now or in the future.

The courts have not had to address the question of whether medical research with incompetent adults is lawful, but some guidance may be found in the following American cases. In *Strunk v Strunk*[27] it was held, by the Court of Appeals of Kentucky, that a court could authorise a kidney donation from an incompetent adult to his brother. Whilst the court endeavoured to apply a substituted judgement test, the reality is that, in the light of the lack of information about the value system or preferences of the proposed donor, a best interests test was used. It is an extension of what might normally be regarded as being in an incompetent adult's best interests to include his quality of life taking into account the essential support that his brother provided. In *Curran v Bosze*[28] the Supreme Court of Illinois explicitly recognised that, in a case where there is no knowledge or information as to "the incompetent person's intent," the substituted judgement test is impractical. Following *Strunk* (amongst other State court decisions), the Court held that "a parent or guardian may give consent on behalf of a minor daughter or son for the child to donate bone marrow to a sibling, only when to do would be in the minor's best interest."[29] It was then for the court to determine the circumstances in which such a donation might be authorised. It held that there are "three critical factors which are necessary to a determination that it will be in the best interests of a child to donate bone marrow to a sibling. First, the parent who consents on behalf of the child must be informed of the risks and benefits inherent in the bone marrow harvesting procedure to the child. Second, there must be emotional support available to the child from the person or persons who take care of the child.... Third, there must be an existing, close relationship between the donor and recipient."[30] The court considered what benefits might accrue to the donor child.

[31] *Ibid.*

[32] *Kennedy, op. cit., n. 5, at paras. 13.40-13.45.*

"The evidence clearly shows that there is no physical benefit to a donor child. If there is any benefit to a child who donates bone marrow to a sibling it will be a psychological benefit. According to the evidence, the psychological benefit is not simply one of personal, individual altruism in an abstract theoretical sense, although that may be a factor. The psychological benefit is grounded firmly in the fact that the donor and recipient are known to each other as family. Only where there is an existing relationship between a healthy child and his or her ill sister or brother may psychological benefits to the child from donating bone marrow to a sibling realistically be found to exist. The evidence establishes that it is the existing sibling relationship, as well as the potential for a continuing sibling relationship, which forms the context in which it may be determined that it will be in the best interests of the child to undergo a bone marrow harvesting procedure for a sibling."[31]

On the evidence of this particular case, it was not in the best interests of either of the three and a half year old twins to donate bone marrow to their half-brother whom they hardly knew and with whom they did not have an existing family relationship. This contrasts with the factual outcome in *Strunk*, which arose because of the significant life-enriching benefit that the donor brother would gain from the continued contact with his ill brother.

Of course, it is a significant step further to say that involvement in a research project that is unlikely to provide personal benefit may also be in that incompetent adult's best interests. However, it should not be regarded as impossible to contemplate cases where such a benefit might be identified, though we recognise that such an argument is not likely to gain much favour with many commentators. The importance of medical research for incompetent adults as well as competent adults and a realisation that not all relevant and important non-therapeutic research can be carried out on competent adults is the basis for arguing that some, restricted, non-therapeutic research can be permissible and therefore ought to be regarded as being in the best interests of the incompetent adult. For these reasons it may be likely to be the case that non-therapeutic research would normally not be regarded as in the best interests of the incompetent person, and so, we would argue in favour of the changes proposed by the Law Commission to allow such research in carefully circumscribed circumstances as they propose.

Kennedy has proposed an approach that may allow limited forms of non-therapeutic research to be undertaken with incompetent participants, namely that research would be legally permissible where it was "not against the [participant's] interests."[32] Whilst this was argued strongly with regard to children, Kennedy recognised that it could only be put forward much more tentatively with regard to incompetent adults. Nevertheless, we support the argument.

## The legal/ethical position: the future

Not all commentators will approve of the ethical permission thereby given for some forms of non-therapeutic research on incompetent adults. But, e.g., the Law Commission has made proposals which

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[33] *Mental Incapacity Bill, clause 4(1) in Law Commission, op. cit., n. 20 at p. 224.*

[34] *Ibid., at para. 6.31. We would wish to see element (1) extended beyond the "incapacitating condition" for the reasons that we give below at p. 71.*

[35] *Mental Incapacity Bill, clause 11(3) in Law Commission, op. cit., n. 20, at p. 228.*

[36] *Ibid.*

[37] *Lord Chancellor's Department, Making Decisions: The Government's proposals for making decisions on behalf of mentally incapacitated adults (1999, Cm 4465).*

would make some non-therapeutic research legally permissible. The Law Commission's review was undertaken in a particularly principled fashion, which has resulted, largely, in a consensus about its general thrust and the majority of its proposals.

What the Law Commission proposed is that therapeutic procedures (including research) should fall within the general authority to provide care. Anything that falls within the general authority is something that it is lawful for another to do, "if it is in all the circumstances reasonable for it to be done by the person who does it."[33] This, it is submitted, introduces little change to the existing position. Significantly, the Law Commission recommends that "research which is unlikely to benefit a participant, or whose benefit is likely to be long delayed, should be lawful in relation to a person without capacity to consent if (1) the research is into an incapacitating condition with which the participant is or may be affected and (2) certain statutory procedures are complied with."[34] The statutory procedures would include approval of the research by a Mental Incapacity Research Committee. The Committee would be able to approve any proposed non-therapeutic research if it was satisfied

> "(a) that it is desirable in order to provided knowledge of the causes or treatment of, or of the care of persons affected by, mental disability;
>
> (b) that its object cannot be effectively achieved without the participation of persons who are or may be without capacity to consent; and
>
> (c) that it will not expose such a person participating in the research to more than negligible risk and that what is done in relation to such a person for the purposes of the research will not be unduly invasive or restrictive and will not unduly interfere with his freedom of action or privacy."[35]

Further statutory procedures would be that the research would be lawful if one of the following requirements were to be satisfied:

> "(a) the approval of the court;
>
> (b) the consent given within the scope of his authority by the donee of a continuing power of attorney granted by the person concerned or by a manager appointed for him by the court;
>
> (c) a certificate in writing by a registered medical practitioner not involved in the research that the person concerned is without capacity to consent and that his participation in the research is appropriate;
>
> (d) the designation by the committee of the research as not involving direct contact with the person

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[38] *This is a very simple procedure with negligible risks. Indeed it is one of those treatments recognised by the Medical Research Council as an example of a procedure involving negligible risk: Medical Research Council, The Ethical Conduct of Research on the Mentally Incapacitated (1991), at para. 6.3.3.*

[39] *The team has published an overview paper of issues in relation to capacity and decision-making: Wong, J.G., Clare, I.C.H., Gunn, M.J. and Holland, A.J., "Capacity to make health care decisions: its importance in clinical practice" (1999) 29 Psychological Medicine 437; and a paper assessing the outcomes of our research from a legal perspective: Gunn, M.J., Wong, J.G., Clare, I.C.H. & Holland, A.J., "Decision-making capacity" (1999) 7 Med. L. Rev 269. A detailed data paper is in press with Psychological Medicine.*

[40] *This is required, e.g., by the European Convention on Human Rights and Biomedicine, Article 16.iii: Council of Europe, Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine Convention on Human Rights and Biomedicine (1997, ETS 164), available at www.coe.fr/eng/legaltxt/164e.htm*

[41] *This satisfied, e.g., the European Convention on Human Rights and Biomedicine, Article 16.iii and the Declaration of Helsinki, Principle I.2.*

[42] *Whilst there are other protections (including assessment of risk, etc), the consent of the participant is the most important ethical principle, see, European Convention on Human Rights and Biomedicine, Articles 16.v & 5, and also Nuremberg Judgment, Principle 1; Declaration of Helsinki, Principle 9.*

concerned."[36]

It seems to us that these proposals achieve a reasonable balance by providing significant protections for the vulnerable person without prohibiting what would be important medical research. Thus we welcome them. However, the Government has decided not to progress such proposals. In its recent White Paper, *Making Decisions*,[37] it is noticeable that there is no commitment to deal with research, although introducing most of the recommendations made by the Law Commission are adopted. We have presumed that this is for the perceived practical difficulty of getting new provisions with regard to research through Parliament rather than any view that they are unacceptable. Whilst understanding the view, and recognising that some Parliamentarians may struggle to understand the importance what the Law Commission proposes, we regret this decision.

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43 *Assuming that the law would require consent, which is discussed below in the text.*

44 *European Convention on Human Rights and Bioethics, Articles 16.v and 5.*

45 *E.g., if they were clearly becoming disturbed or distressed by involvement in the assessment procedure, it was terminated.*

46 *Whilst not legally valid, it is both common sense to involve carers interested in the welfare and interests of the potential research and it has an ethical value: European Convention on Human Rights and Biomedicine, Articles 17.iv and 6.3. The Law Commission, in its review of the law in relation to adults and decision-making, discovered that "some funding bodies and Ethics Committees stipulate for consent by a relative where the research participants cannot consent. As a matter of law, such 'consent' is meaningless:" Law Commission, op. cit., n.20, at para. 6.29.*

47 *Whilst one cannot always make presumptions from the ability to make one decision to the ability to make another decision, it would seem to follow that were someone unable to consent to venepuncture that they would also not be able to consent to participate in the research, though the matter would need to be assessed separately.*

48 *E.g., it would be good ethical practice to ensure that each patient consents to the oral taking of drugs. This may be signalled by the fact that the patient does take them. Legally there is unlikely to be an assault or battery or false imprisonment, so no interference demanding the consent of the patient. Ethically, it would be right to wish to ensure that the patient understands sufficiently what he or she is taking and why.*

## Our research project

We have undertaken a research project that has caused us to reflect on medical research and incompetent adults. We are interested in how a person's capacity to make health care decisions can be assessed and maximised. To that end, we sought, and received, funding support from the Nuffield Foundation. We had four groups of participants. Three of the groups consisted of people with particular mental health conditions that have often given rise to a concern about their decision-making capacity. These three groups consisted of people with a learning disability, people with dementia and people with chronic schizophrenia. The fourth group, the control group, would consist of people with no mental health problems. This could have been undertaken by way of an hypothetical or an actual treatment. There are research projects that work on the basis of hypothetical treatments or health care procedures, but our practical and research experience led us to believe that that research would have less validity than if an actual treatment or procedure were part of the research project for the participating individuals. We felt that the treatment or procedure would have to be a relatively minor one, and selected venepuncture, that is the taking of a blood test.[38] We were able to recruit sufficient research participants who were identified, on independent clinical grounds, as being in need of venepuncture. The procedure, therefore, was one that each of the research participants would be having (or not having) regardless of any impact that our research project might have. In other words each of the research participants was facing the real prospect of a blood test and had to make an actual decision. The outcomes of our research are not, for present purposes, relevant.[39] What is relevant is that we were clearly faced with the need to ensure that participation of the research participants was lawful and ethical. Ethical approval of our research programme was provided by the funding body itself and by the local research ethics committee.[40] Further, a multi-disciplinary and multi-agency body was appointed to act as an Advisory Board[41] and this approved the approaches that we proposed to take.

## Research participant involvement

Some of our intended research participants were capable of deciding whether to participate.[42] It was gratifying to discover, at the end of the research, that we identified all the participants in the comparison group as being capable of deciding to have the blood test. The members of this group were also

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49 *[1990] 2 A.C. 1.*

50 *We did respect both the dignity and privacy of the research participants, as the Law Commission notes is relevant to research where an assault, battery or false imprisonment may be involved, but also where alternative methods of research are involved, as in the case of our research: Law Commission, op. cit., n. 20, at para. 6.30.*

51 *See Kennedy, op. cit. n. 5, at para. 13.01..*

52 *If anyone was not interested in the procedures we adopted or was showing signs of distress, etc, the research was terminated.*

53 *The House of Lords would not regard it as false imprisonment to decide to prevent someone from leaving, even though currently no procedure has been used to detain a person at all: R v Bournewood Community and Mental Health NHS Trust, ex parte L [1998] 3 All E.R. 289 at p. 298. We believe this not to be the correct view of the law, and would rather take the view of Lord Steyn in the House (at 306) that this is false imprisonment, which accords with that of the Court of Appeal as expressed by Lord Woolf M.R. [1998] 1 All E.R. 000; see Gunn, M.J., "De Facto Detention" (1996) 2 Tizard Learning Disability Review 11 and Smith, J.C., Smith and Hogan: Criminal Law (9th ed., 1999), at p. 436, n. 3.*

54 *The Law Commission accepts that "questions of dignity and privacy arise [where the non-invasive research is based on observations, photography or videoing of participants (sometimes covertly)] where the project is not designed to benefit the research participant:" Law Commission, op. cit., n. 10, at para. 6.30. The manner in which our research was conducted respected the dignity and privacy of the participants. See also Kennedy, op. cit., n. 5, at paras. 13.57-13.64.*

55 *Mental Incapacity Bill, clause 11(4)(d), and see above at p. 67.*

56 *As for ethical compliance, see below at p. 71.*

57 *See Gunn et al, op. cit., n. 39, at pp. 286-8.*

identified as being capable of deciding to participate in the research project, after having been given appropriate information.

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58 *The European Convention on Human Rights and Biomedicine, Articles 16.iv & v and 5. Article 16 is reproduced above. Article 5 establishes the general rule in relation to consent: "An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as in its consequences and risks. The person concerned may freely withdraw consent at any time."*

59 *Thereby, Article 16. i-iv were also satisfied.*

60 *Article 16, i - iv, compliance with which is required by Article 17.1.i, have already been considered above.*

61 *Article 17.1.iii. Whilst each demand independent consideration, the likelihood is that participation in research would demand more of the participants, if only because of its more abstract nature.*

62 *Article 17.1.iv.*

63 *Article 17.1.v.*

64 *Article 17.2.ii.*

Of course, it was not the case that all our other intended research participants were capable of deciding to participate. We wished to have participants from the groups who might be capable or might not. If all participants had clearly sat one side of the line, the research would have had little value, as it is only in assessing decision-making criteria in the borderline cases that we can begin to assess the validity of an approach and procedure that the law mandates.

We endeavoured to obtain the consent of our intended participants, after giving them appropriate information about the research project in appropriate, simple language. If they were competent and did not give consent, they were not involved in the research. If they did consent initially, but subsequently withdrew their consent, that withdrawal was immediately respected. This satisfies both the legal requirements[43] and the ethical requirements.[44] Where the potential participant was not competent to decide upon participation, we respected whatever expressions of opinion he or she might make,[45] through verbal or non-verbal communication. We also took into account the views of the carer(s) (even though, legally, the consent of a proxy when the research participants are adults has no validity[46]).

## The dilemma for our research

It is here that we begin to see the dilemma that has caused us to share our thoughts in this paper. Not only were some of our research participants not capable of deciding to have a blood test (in some cases even after the implementation of intervention techniques intended to maximise decision-making capacity), but also they were not capable of agreeing to be research participants.[47] Should we have undertaken our research in the light of the preceding ethico-legal discussion?

Research of the type in which we were engaged is, we believe, critical in enabling service providers to offer appropriate care and treatment to people who are not capable of making their own decisions. Capacity to make decisions is the basis upon which the individual either determines what will happen to him or her. Otherwise that decision is made by someone else. Having an effective and appropriate means of determining someone's capacity to make decisions is, therefore, critical to respect for the principle of autonomy. Only if someone cannot make a decision is it possible for a decision to be made for them. This question of capacity determination arises prior to any health care intervention being initiated. The law requires the consent of the patient when an intervention involves contact or apprehended contact with the person of the patient (whereby it would be a battery or an assault) or to involve the detention of the person (whereby it would be false imprisonment). On ethical grounds, consent would be required even if no such contact or detention were to form part of the intervention.[48] The patient's competence to decide must be determined so that the health care provider knows whether he or she is dependent upon the consent of the person for the legality of the intervention. If not dependent on the consent of the person, the health provider must turn to the best interests test developed by the House of Lords in *Re F*.[49]

Therefore, in so far as the lawfulness of our research might be concerned, first, we hold the view that it was not covered by the law under consideration.[50] Our research involved talking to the patient and performing neuropsychological tests. Strictly speaking, there was no direct physical contact as part of our research and, therefore, we were not engaged in an intervention that could have been regarded as an assault or a battery.[51] Moreover, it did not expose the participants to more than negligible risk. The research team was not involved in identifying the need for anyone to have a blood test. Nor was it involved in the carrying out of that blood test. It was a procedure which each of the research participants faced regardless of the research programme. Nor were we detaining people[52] and so there was no false imprisonment. Indeed we would not have prevented anyone from leaving the presence of the researcher. Such an act, or intimation of it, would have indicated dissent, and that was sufficient for us to terminate the participant's involvement.[53] There was, therefore, no activity for which a defence of consent or acting in the best interests of an incompetent adult was needed.[54] One particular advantage of the Law Commission's proposals is that research, such as ours, would still fall within the remit of the new procedure, but the lack of direct contact would be a good reason, providing the other requirements were satisfied, for approval of the research by the Mental Incapacity Research Committee.[55]

Secondly, and if we are wrong in law,[56] we argue that our research was therapeutic. The research either identified a participant as capable to make the decision or we used strategies that we anticipated would improve the individual's chances of becoming capable of making the decision.[57]

Finally, if our research were thought to be sufficiently invasive to fall within the area of the law requiring consent and our research was not categorised as being therapeutic, we would argue, on principle, that some non-therapeutic research should be permissible within the existing law. Our argument centres on the point that the nature of this research is critical to a proper respect for the principle of autonomy.

We have taken the stance that our research is clearly lawful for a variety of reasons. We also take the view that it is ethically sustainable. First, some of the participants were competent and did consent to the research, having been provided with the depth of information demanded by the European Convention on Human Rights and Biomedicine.[58] Further, our research complied with the other imperatives established by Article 16 for the protection of persons undergoing biomedical research. Research on humans is essential in determining the reliability of approaches taken by clinicians to assessing research participant's competence. The risks associated with our research were definitely negligible as we were not engaged in any health care intervention. Our investigations of the abilities of the research participants were terminated where someone no longer wished to participate. The research project was approved by the local research ethics committee and we were advised by an independent, multidisciplinary and multi-agency body during the course of our research. The research participants were informed of their rights and were clearly informed that they could say no and could withdraw from the research at any time, and that declining or withdrawing participation would have no clinical impact.[59]

We also had research participants who were not competent. Article 17 of the European Convention was satisfied.[60] Research of comparable effectiveness could not have been carried out only on individuals capable of giving consent. The whole point of the research was to determine how to assess capacity. Therefore, it was reasonable to presume, at the outset, that, if we had, as we expected, participants not capable of consenting to a blood test that they would not be capable of consenting to the research.[61] We had authorisation from carers for participation.[62] The participants did not object, and, if they did, the research was terminated.[63] The one problematic principle is the requirement in Article 17.1.ii that "the results of the research [must] have potential to produce real and direct benefit to his or her health." Our research was not likely to have any impact on the health of any of the research participants, unless a broad approach were to be taken to the concept to include the individual's capacity to consent. We

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[1] *See, for example: Lunacy Amendment Act 1889, section 12(2); Lunacy Act 1890, section 330(2); Mental Deficiency Act 1913, section 62; Mental Treatment Act 1930, section 16; Pountney v Griffiths [1975] 3 WLR 140, per Lord Edmund-Davies at pp 143-147*

[2] *7 & 8 Eliz. 2, c. 72*

believe that it would, putting at its lowest, be unfortunate if research of the type in which we were engaged, were to be regarded as unethical. We do not believe that such ethical instruments are intended to rule out our type of research. We suggest that non-invasive research, like ours, which is designed to address a key ethical and legal principle, competency, that lies at the heart of respect for autonomy, should be ethically valid.

Though we believe it not to be the case, if our research were regarded as non-therapeutic, it would be ethically valid under the European Convention on Human Rights and Biomedicine. The risks and burdens for the participants were minimal.[64] The Convention, in Article 17.2.i, requires that "the research has the aim of contributing, through significant improvement in the scientific understanding of the individual's condition, disease or disorder, to the ultimate attainment of results capable of conferring benefit to the person concerned or to other persons in the same age category or afflicted with the same disease or disorder or having the same condition." The problem is, again, that our research would have no effect on the participant's disease or disorder. It might, however, be regarded as having an effect on his or her "condition", provided a similarly broad approach is taken as to "health" in Article 16. Having greater understanding of the capacity assessment process and of maximisation of consent would certainly confer benefit upon any individual concerned or to other persons with similar difficulties.

## Conclusion

There are understandable concerns about research and people with mental disabilities, especially people who may lack capacity to make decisions. However, to ensure that people with mental disabilities which impair capacity benefit from scientifically sound research, research with such people is sometimes required and may be ethically justified, provided certain strict safeguards are in place. At present, this is recognised both at law and in ethics, provided that it is therapeutic research which is undertaken. Where the research is non-therapeutic, there is a discrepancy between ethical codes, such as the European Convention, and the law. We believe that this discrepancy should be addressed by introduction of the relevant recommendations made by the Law Commission. We, therefore, regret (as stated above) their omission in the Government's commitment to introduce proposals in relation to people incapable of making decisions.

In relation to our own research, we believe that research on decision-making capacity is important in examining how to assess capacity for decision-making and how to maximise that capacity. In so far as the research participants were competent to decide whether to participate, we complied with the law and the ethical requirements of the European Convention on Human Rights and Biomedicine. In so far as the research participants were not competent to decide whether to participate, we have argued that our research was both lawful and ethical, though there are issues that we have identified that might demand further consideration. In particular, we venture to suggest that the normal interpretation of the European Convention might be too limited since the only research that can be undertaken must address the health of the participant, which our research did not do. A more holistic approach ought to be adopted so as to enable improvement in the well-being and enhancement of life opportunities for people not able to make decisions for themselves.

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3 *Pountney v Griffiths [1975] 3 W.L.R. 140, at p 141*

4 *[1975] 2 W.L.R. 291*

5 *Op cit., at p 144*

6 *Ibid., at p 145*

7 *Ibid.*

# Something less than ready access to the courts: Section 139 & Local Authorities

*David Hewitt**

## Introduction

Psychiatric patients who wish to bring legal proceedings against those responsible for their detention or treatment can face an obstacle of which better-favoured litigants are free: because of a provision contained in section 139 of the Mental Health Act 1983 they will often have to obtain the prior leave of the High Court.

This paper will consider the origins of that provision. It will then focus on two of its key elements - the requirement for leave itself and the exceptions to it - and will analyse their impact upon subsequent case-law and upon current legal practice.

In so doing, this paper will describe an anomaly which continues to bedevil intending claimants, and will assess the extent to which it is attributable to the legal and political events of a generation ago, and to a legislative impulse which is even more keenly felt today.

## The 1959 Act

The requirement that the proposed proceedings of mental patients be subjected to preliminary scrutiny did not originate in the 1959 Mental Health Act.[1] However, as with so many other aspects of modern psychiatric law, it is from this statute that the current restrictions derive. Those restrictions are contained in section 141 of the 1959 Act,[2] which reads as follows:

> "(1) No person shall be liable, whether on the ground of want of jurisdiction or on any other ground, to any civil or criminal proceedings to which he would have been liable apart from this

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[8] *Original emphasis*

[9] *Op cit., at p 147*

[10] *Op cit., at p 294*

[11] *[1998] COD 199*

[12] *Pountney v Griffiths also played a key part in the yet more recent case of R v Mental Health Act Commission, ex parte Smith, Queens Bench Division, 11 May 1998, (1998) 43 BMLR 174*

[13] *Op cit., at p 141*

> section in respect of any act purporting to be done in pursuance of this Act or any regulations or rules thereunder, or in, or in pursuance of anything done in, the discharge of functions conferred by any other enactment on the authority having jurisdiction under Part VIII of this Act, unless the act was done in bad faith or without reasonable care."
>
> "(2) No civil or criminal proceedings shall be brought against any person in any court in respect of any such act without the leave of the High Court, and the High Court shall not give leave under this section unless satisfied that there is substantial ground for the contention that the person to be proceeded against has acted in bad faith or without reasonable care".

According to Lord Simon, these restrictions place "a hindrance on the recourse of a class of citizens to the courts of justice", the reason for which is easy to see:

> "It must have been conceived that, unless such classes of potential litigant enjoy something less than ready and unconditional access to the courts, there is a real risk that their fellow citizens would be, on substantial balance, unfairly harassed by litigation".[3]

## The case of Pountney v Griffiths

This was the most significant case to arise under section 141. Elvet Griffiths was a nurse at Broadmoor hospital. One visiting day, he approached a patient who was saying goodbye to his visitors and, with the words "Come on, you", allegedly punched him on the shoulder, almost causing him to lose his balance. In proceedings instituted by the patient, Mr Griffiths was convicted of common assault and conditionally discharged for two years. His conviction was, however, quashed by the Divisional Court of the Queen's Bench Division as the patient had not obtained prior leave of the High Court under section 141(2), and his proceedings were therefore a nullity.[4]

The patient appealed to the House of Lords, for whom the key question was whether acts of hospital staff in controlling patients were performed under the Mental Health Act, and therefore enjoyed the protection of section 141(2), notwithstanding the fact that such acts were not specifically authorised by that statute.

The appellant argued that the pre-1959 legislation dealt solely with the certification and reception of patients, that section 141 merely re-enacted that legislation, and that, as a result, it was similarly confined to those functions and could have no application to acts which went beyond them. Their Lordships did not agree. Lord Edmund-Davies held that the earlier legislation had been somewhat wider in ambit, and had included provision for acts performed to "carry out" the statutory purposes. From this he inferred "a right to control, its nature and extent depending upon all the circumstances".[5] Furthermore, the effect of the 1959 Act had not been simply to re-enact what had gone before: its long title stated an aim "to make fresh provision" and, Lord Edmund-Davies concluded, "its contents establish that the aim has been achieved",[6] not least by, *inter alia*, the introduction of a new system of definition and classification of mental disorder and the setting up of Mental Health Review Tribunals. It was clear that, "following upon the recommendations of the Royal Commission which reported in 1957, the legislature set out to establish an entirely new code for mentally disordered persons".[7]

Though conceding that hospital staff did enjoy powers of control over their patients, the appellant had

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14 *See, for example: David Jessel, Convenience, Compromise and Cash, (1991) New Law Journal, 1 March, p 267*

15 *Winch v Jones & another; Winch v Hayward and others [1985] 3 All E.R. 97, per Sir John Donaldson MR at p 99*

16 *Pountney v Griffiths [1975], see note 3, above*

17 *Op cit., at p 100*

18 *Ibid.*

further argued that such powers derived, not from the 1959 Act (nor any statute), but from common law, and that their implementation would not therefore fall within section 141. Once again, their Lordships did not agree. Accepting the respondent's submissions on this point, Lord Edmund-Davies held that as section 141(2) specifically relates to "*any* act",[8] and not merely to those specified under the statute, its ambit would be sufficiently wide to cover the facts of this case.[9] Dismissing the appeal, His Lordship adopted the view of Lord Widgery C.J. in the Divisional Court, that:

> " ... where a male nurse is on duty and exercising his functions of controlling the patients in the hospital, acts done in pursuance of such control, or purportedly in pursuance of such control, are acts within the scope of section 141, and are thus protected by the section".[10]

*Pountney v Griffiths* was more recently cited by Auld LJ in *R v Broadmoor Special Hospital and the Secretary of State for the Department of Health, ex parte S, H and D*,[11] a case which, though it did not concern section 141, did consider the extent to which ancillary powers - here, the power to subject patients to routine random searches - might flow from the express authority to detain contained in the Mental Health Act. Adopting and applying the judgment of Lord Edmund-Davies, the Court of Appeal held that such a power might be inferred in this case.[12]

## The 1983 Act

Lord Simon's speech in *Pountney v Griffiths* had concluded with the following injunction:

> "Patients under [the 1959 Act] may generally be inherently likely to harass those concerned with them by groundless charges and litigation, and may therefore have to suffer modification of the general right of free access to the courts. But they are, on the other hand, a class of citizen which experience has shown to be peculiarly vulnerable. I therefore presume to suggest that the operation of section 141 should be kept under close scrutiny by Parliament and the Department of Health and Social Security".[13]

As we shall we see, during the lengthy period of contemplation which preceded the introduction of a successor to the 1959 Act, section 141 received intense scrutiny. It was eventually replaced by section 139 of the 1983 Act which, though it replicated many of its predecessor's provisions, also departed from it in at least two key respects, those being: (i) the requirement for leave; and (ii) the nature of its exemptions.

## (i) The requirement for leave

In the absence of bad faith, section 141 and section 139 both provide - at sub-section (1) - a civil and a criminal defence for any act purporting to be done under the Act or its regulations. They contain a further provision, however, which differs considerably between them. In each, it is contained at sub-section (2), and in the 1983 version reads:

> "(2) No civil proceedings shall be brought against any person in any court in respect of any such act without the leave of the High Court; and no criminal proceedings shall be brought against any person in any court in respect of any such act except by or with the consent of the Director of Public Prosecutions".

It will be noted that, unlike its predecessor, the 1983 Act is silent as to the hurdle facing those seeking

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19 *Op cit., at p 103*

20 *Ibid., at p 104*

21 *Section 139(4); see below*

22 *Section 66(1), Sched. 9, para. 24(7)*

23 *Section 2(1), Sched. 1, para. 107(11)*

leave. The 1959 Act had, of course, required any intending plaintiff to show "substantial ground for the contention that the person to be proceeded against has acted in bad faith or without reasonable care", thus replicating the substantive defence in the criterion for granting leave. However, the burden omitted from the 1983 Act was very soon reintroduced, albeit not by legislation and in a somewhat less exacting form than had previously obtained.

## The case of Winch v Jones

The unfortunate story of Miss Mary Winch has been set out in detail elsewhere.[14] Finding herself embroiled in a dispute over her late mother's estate, and having dispensed with at least seven firms of solicitors, she refused to obey a court order to surrender the deeds to the family home and was committed to prison for contempt. She was subsequently transferred to a psychiatric unit, having been diagnosed as mentally ill and in need of compulsory treatment. Her state of mind at this point was subsequently, and somewhat acerbically, summarised as follows:

> "As a result of her experience she formed the view that all the solicitors whom she had consulted were conspiring together to stifle her justified complaints. Whilst it is inherently unlikely that she is correct, this is not an uncommon reaction by a dissatisfied client. If this were itself a justification for compulsory detention, the mental hospitals would be over-full".[15]

Once discharged, Miss Winch attempted to bring proceedings against a number of individuals - the two doctors responsible for her diagnosis and the hospital psychiatrist under whose care she had been detained for 12 months. However, her application for leave under section 139 of the 1983 Act was dismissed by the High Court, the judge having ruled that, though it was neither frivolous or vexatious, nor an abuse of the process of the court, it did not disclose a *prima facie* case of negligence. In the Court of Appeal, Miss Winch argued that she had in fact made out a *prima facie* case, but that she should only have been required to show that there was a serious issue to be tried.

Adopting Lord Simon's exposition of the purpose of section 141,[16] Sir John Donaldson MR identified two "fundamental difficulties" which beset this aspect of the law:

> "First, mental patients are liable, through no fault of their own, to have a distorted recollection of facts which can, on occasion, become pure fantasy. Second, the diagnosis and treatment of mental illness is not an exact science and severely divergent views are sometimes possible without any lack of reasonable care on the part of the doctor".[17]

He did not believe that the existing authorities were of assistance in determining the correct test to be employed in cases such as this: the "*prima facie* case approach", for example, "leads inevitably to a full dress rehearsal of the claim and the defence", which would be inappropriate in an application such as

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[24] *Ashingdane v Secretary of State for Social Services and others, Court of Appeal, 18 February 1980*

[25] *House of Lords Debates, Col. 106*

[26] *Ibid., Cols. 933-946; 957-1008*

[27] *Ibid., Cols. 526-536; 541-602*

[28] *Ibid., Cols. 756-820; 826-852*

[29] *Ibid., Cols. 1124-1184*

[30] *Ibid., Cols. 841-925*

[31] *Ibid., Cols. 1041-1106*

[32] *Ibid., Cols. 1394-1434*

[33] *Mental Health Services Law and Practice (1986, Shaw & Sons Ltd), para. 1.11.3*

[34] *House of Commons Debates, Special Standing Committee, 24 June 1982, Col. 722*

[35] *"Right to liberty and security"*

[36] *"Right to a fair trial"*

this. Electing to allow Miss Winch's appeal, he argued:

> "The issue is not whether the applicant has established a prima facie case or even whether there is a serious issue to be tried, although that comes close to it. The issue is whether ... the applicant's complaint appears to be such that it deserves the fuller investigation which will be possible if the intended applicant is allowed to proceed".[18]

For his part, Parker LJ considered why the 1959 burden was absent from the new Act. There could be no question, he insisted, "but that it was intended that the protection afforded to those purporting to act under the Mental Health Acts [sic] should be reduced", and he added: "If an action is neither frivolous nor vexatious, it is prima facie fit to be tried; and if it is fit to be tried, in my view leave ought to be given".[19]

Though Lord Justice Parker concurred in the decision to allow the appeal and grant leave, his implicit acceptance of the "*prima facie* case approach", or something very like it, would appear to contradict Sir John Donaldson's express rejection of the same. However, the possibility that a *prima facie* test might still have some part to play was reduced by the third judge, Lord Justice Balcombe, who declared himself in agreement with the test advanced by the Master of the Rolls.[20]

As for Miss Winch, she had already initiated proceedings against the detaining health authority, for which she did not require leave[21] and in which she secured a settlement of £27,000.

### (ii) Exemptions

The second difference between section 141 and section 139 is that the latter contains exemptions which are not contained in the 1959 Act. Leave is not now required for proceedings against the Secretary of State for Health, a Health Authority or Special Health Authority, or a NHS Trust. The root of these exemptions (which were widened following changes in the nature of health provision introduced by the National Health Service and Community Care Act 1990[22] and the Health Authorities Act 1995[23]) may be found in an unreported case from the mid-1970s.

### Mr Ashingdane's Case

Mr Ashingdane had been detained at Broadmoor Hospital for seven-and-a-half years when, in October 1978, his RMO recommended transfer to the less secure Oakwood Hospital. This recommendation, endorsed by a second consultant psychiatrist, was accepted by the Secretary of State for Social Services in December 1978, and in March 1979 by the Home Secretary. For some years, however, members of the Confederation of Health Service Employees, which represented the Oakwood nursing staff, had resisted the transfer of restricted patients into the hospital. They argued that resources were so scarce that the treatment, rehabilitation and security of such patients would be prejudiced. The Kent Area Health Authority, which was responsible for the hospital, believed that to insist upon Mr Ashingdane's transfer to Oakwood, or to another similar institution, would be to invite industrial action by the nursing staff

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37 *(1985) Series A, No. 93; 7 E.H.R.R. 528. But see also: Kynaston v Secretary of State for Home Affairs (1981) Cr. App. R. 281; Kynaston v United Kingdom (1981) European Commission of Human Rights (App. no. 9480/81) - which concerned acts of the Home Secretary and the Secretary of State for Health & Social Security, but not a Health Authority*

38 *House of Lords Debates, Col. 807*

39 *Ibid., Col. 804*

40 *Ibid., Col. 806*

41 *Ibid.*

42 *Ibid., 1 February 1982, Col. 1127*

43 *Ibid., 23 February 1982, Cols. 919-920*

and to imperil the health and welfare of other patients. It therefore refused to transfer Mr Ashingdane, and for his part the Home Secretary refused to direct such a transfer.

In August 1979, Mr Ashingdane sought to challenge the validity of his continued detention at Broadmoor. He sought declarations: that the Secretary of State for Social Services had a duty to provide him with hospital accommodation at Oakwood or other appropriate hospital; that both the Secretary of State and the Kent Area Health Authority had acted *ultra vires* in refusing to admit him to Oakwood; and that CoHSE had acted unlawfully in soliciting or causing the Secretary of State and the Health Authority to breach their statutory duty. He also sought an injunction to restrain CoHSE from acting in this way.

Proceedings against CoHSE were stayed by the High Court in December 1979, because they had been instituted without leave under section 141(2) of the 1959 Act. In January 1980, those against the Department of Health & Social Security and the Kent Area Health Authority were stayed on the same grounds. In February 1980, the Court of Appeal lifted the stay on proceedings against CoHSE, but maintained it in respect of those against the Secretary of State and the Health Authority.[24] Leave to appeal to the House of Lords was refused in May 1980. Ultimately, proceedings against CoHSE were discontinued. At this point, Mr Ashingdane initiated a complaint under the European Convention on Human Rights. It is clear that the result of that complaint - or rather, the *anticipation* of that result - exerted a profound influence upon debate concerning the new Mental Health Act.

## New legislation

The successor to the 1959 Act was only arrived at tortuously and by a process which involved, not merely a new statute, but also intermediate amending legislation.

The Mental Health (Amendment) Bill was introduced into the House of Lords by Lord Elton, then Parliamentary Under-Secretary of State for the Department of Health & Social Security, and received its First Reading on 10 November 1981.[25] The legislative chronology is significant: after a Second Reading on 1 December 1981,[26] the Bill was committed to a Committee of the whole House and further considered on 19 January,[27] 25 January,[28] 1 February,[29] 23 February,[30] and 25 February 1982.[31] It received its Third Reading on 4 March 1982,[32] and was then referred to a Special Standing Committee of the House of Commons.

However, the form in which the Bill eventually passed into law was somewhat different from that in which it had left the House of Lords: a further clause was subsequently added concerning the prohibition upon proceedings without leave. As we have seen, it provided that:

> "This section does not apply to proceedings against the Secretary of State or against a local authority within the meaning of the National Health Service Act 1977".

As Gostin notes,[33] this exemption - which was ultimately enshrined as Section 139(4) of the 1983 Act - was the product of a compromise between members of the Standing Committee and the government, and, because of its essentially apolitical nature, did not require any further Parliamentary debate. It was "brought up" in Committee, read a First and Second time, and added to the Amendment Bill all on 24

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44 *See also: House of Lords Debates, 4 March 1982, Cols. 1419-1420*

45 *(1985) Series A, No. 93; 7 EHRR 528*

46 *(1992) 15 B.M.L.R. 1, C.A.*

47 *See also: Jones, R, Mental Health Act Manual (sixth edition), 1-1115*

48 *Court of Appeal, 5 July 1999 (unreported)*

49 *Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, regulation 4(1)(e)(ii) - Form 9*

50 *[1994] 1 All E.R. 161*

June 1982.[34]

The principal reason for this compromise is not hard to divine: it was Mr Ashingdane's case, which, with its complaints of breaches of Article 5(4)[35] and Article 6(1)[36] of the European Convention on Human Rights, was declared admissible by the European Commission of Human Rights on 5 February 1982 - four days after the third debate at the Committee Stage of the Amendment Bill and little more than a fortnight before the fourth such debate.[37]

The European Commission's view - and its anticipated effect upon the judgment of the Court - clearly loomed large in proceedings in Their Lordships' House.

## The Amendment Bill in the House of Lords

In order to understand how section 139 came to contain the exceptions listed in sub-section (4) - and no others - it is instructive to examine the various debates in the House of Lords, debates which, because of Government's approach, were the only ones to take place on the Amendment Bill.

There was a divergence of views as to how the Government should proceed. Lord Mottistone took a decidedly sceptical line. Thinking of the doctors and social workers who would have most to lose from the abandonment of the statutory protection, he argued that it might be "rather better to look to the general well-being and morale of public servants than to bother with what is happening across the Channel in Europe".[38] Others, however, attached considerable weight to the Strasbourg view, and differed only in their assessment of how the Government should respond to it.

During the second Committee Stage debate on 25 January 1982, Lord Elton suggested: "we have to await, before producing our own solution to the problem, the view which the European Commission ... will express".[39] Lord Renton did not agree. Speaking for an amendment which would entirely remove the section 141 provision from the new Act, he noted that the Ashingdane case would come before the European Commission in eleven days' time. There was little doubt, he said, that that case "will be as successful as other cases brought in the European Court of Human Rights about other aspects of our law relating to mental health",[40] and he therefore asked:

> "May I make a suggestion to my noble friend, which could save a lot of public money and a great deal of concern on the part of those who are worried about Section 141; namely, that he accepts this amendment - that will perhaps convince the European Commission that there is no need for these cases to be proceeded with - and in due course comes up with a suitable Government amendment which he may discover would be acceptable to all concerned, including the European Court".[41]

During the third and last debate on the Committee stage, and facing further moves to repeal section 141, Lord Elton offered the suggestion that, "we are a little beforehand". The hearing of the Ashingdane case was a mere four days away, and "to anticipate the results of that would be unwise".[42] He persisted in this view even after the Commission's preliminary findings were known. Speaking at the Report stage, which commenced on 23 February 1982, he informed his brethren:

> "Less than three weeks ago the Commission declared that that application was admissible after an

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[51] *Re S-C. (Mental Patient: Habeas Corpus) [1996] 1 All E.R. 532, at pp 542-3*

[52] *Ibid., at p 544. Re S-C was subsequently considered by Owen J in R v Central London County Court, ex parte AX London, QBD, March 12 1997 [Ref CO/1842/96]. Its view of the distinction between the remedies of habeas corpus and judicial review was discussed but not followed in B v BHB Community Healthcare NHS Trust [1999] FLR 106, CA*

[53] *The considerations to which he might wish to have regard in framing his proceedings are detailed in Jaconelli & Jaconelli, Tort liability under the Mental Health Act 1983, Journal of Social Welfare and Family Law 20(2) 1998: 151-164*

[54] *S-C v Lancashire County Council, Court of Appeal, 5 July 1999 (unreported)*

> oral hearing ... I would not invite noble Lords to anticipate the judgment they will now consider on its merits. I do not consider it sensible to amend our law at the very moment when the Commission ... has the opportunity to consider it in relation to an individual's application to them".[43]

Though this position, which Lord Elton maintained throughout each stage of the Amendment Bill's progress,[44] would ultimately prevail in the House of Lords, the Government acted very quickly when the Bill moved into the House of Commons. So quickly, in fact, that the new provision, exempting the Secretary of State and health authorities from the Section 139 protection, was introduced even before the European Commission gave its final ruling. This was perhaps - and certainly for Mr Ashingdane - fortunate for, on 12 May 1983, having once ruled the complaints admissible, the Commission held that there had in fact been no breach of the European Convention on Human Rights. On 28 May 1985, this was also the conclusion of the European Court of Human Rights.[45]

## Subsequent cases

The doctrine established in *Winch v Jones* has subsequently been widened somewhat. In *James v Mayor & Burgesses of the London Borough of Havering*,[46] Farquharson L.J. held that the effect of section 139 is wider than suggested by Sir John Donaldson M.R. in that "it is not only protection against frivolous claims; it is also a protection from error in the circumstances set out in [sub-section (1)]." He suggested that the point of the section is to provide protection for a social worker or doctor "from the consequences of a wrong decision made in purported compliance with this Act", and that "what one has to look at in deciding whether they are entitled to the protection of [this section] is what appeared to the social worker and the doctor at the time and how they reacted to it".[47]

## The cases of Mr S-C

It would be easy to infer from sections 139(2) and (4), and from the case of *Winch v Jones*, that there are two classes of potential defendant in Mental Health Act claims - corporate entities and individuals - and that prior leave is required only for proceedings against the latter. In fact, as is demonstrated by the recent case of *S-C v Lancashire County Council*,[48] such an inference would be mistaken, for there is still at least one species of "corporate" defendant which enjoys the protection of the statute.

Mr S-C was considered to be mentally ill and in need of in-patient treatment. In completing an application for his admission under section 3 of the Act,[49] the approved social worker certified, *inter alia*, that to the best of her knowledge and belief his "nearest relative" under the Act was his mother, who did not object to the proposed admission. In fact, and as the ASW knew, it was Mr S-C's father who was his nearest relative, and he objected very strenuously to his son's compulsory admission to hospital.

An application for a writ of *habeas corpus* was dismissed at first instance. Approving the judgment of Laws J. in *R v Managers of South Western Hospital and Another, ex parte* M,[50] Turner J. held that a detention could not be vitiated by subsequent knowledge, even where that knowledge cast doubt upon the truth of statements contained in the statutory forms. The hospital managers were entitled, under section 6(3), to act "without further proof" upon any admission application "which appears to be duly made". They had no means of investigating the veracity of any after-acquired information and so;

> " … if, and so long as, the form exists and unless or until the statutory machinery for discharge is effectively brought into play, the managers' authority stems from the application form".

The Court of Appeal did not accept this analysis. The then Master of the Rolls, Sir Thomas Bingham, dismissed the conclusion drawn by Turner J. The existence of an apparently valid application would not preclude a patient from demonstrating subsequently that his detention was unlawful. The alternative was "horrifying":

> "It would mean that an application which appeared to be in order would render the detention of a citizen lawful even though it was shown or admitted that the approved social worker purporting to make the application was not an approved social worker, that the registered medical practitioners whose recommendations founded the application were not registered medical practitioners or had not signed the recommendations, and that the approved social worker had not consulted the patient's nearest relative or had consulted the patient's nearest relative and that relative had objected. In other words, it would mean that the detention was lawful even though every statutory safeguard built into the procedure was shown to have been ignored or violated … I find that conclusion wholly unacceptable".[51]

Concurring in this view, and likewise qualifying the decision in *R v South Western Hospital, ex parte* M, Neill LJ stated:

> " … section 6(3) is not intended to prevent, nor can it have the effect of preventing, a court, if satisfied that the original application was not made in accordance with section 3 of the Act, from issuing a writ of habeas corpus …".[52]

Mr S-C was immediately discharged from hospital, and subsequently sought to commence proceedings for damages in wrongful imprisonment.[53] He proposed to direct those proceedings against the employer of the errant ASW, a local social services authority.

As we have seen, because of factors specific to the case of *Ashingdane*, the exemptions introduced into section 139(4) of the Act do not embrace local authorities, and Mr S-C would still therefore require prior leave under section 139(2). Once again, he failed at first instance, Ognall J holding that the ASW could have applied for an order under section 29 of the Act dispensing with the consent of the nearest relative. In his view, that order would certainly - and almost immediately - have been granted, and Mr Simpson-Cleghorn "would have suffered precisely the same consequences as are now complained of whether the detention was lawful or not". His proposed proceedings, therefore, could have little or no prospect of success.

This view was, once again, overturned by the Court of Appeal. Lloyd LJ noted that, though such a course had indeed been open to her, and though it would in these circumstances have been the proper course, the ASW had not made an application to displace Mr Simpson-Cleghorn's father. She had instead signed an application which was, and which she knew to be, untrue, and Mr Simpson-Cleghorn had been detained as a result. The correctness of Ognall J's analysis "is not self-evident". The threshold to be crossed was that set out by Lord Donaldson, MR. In this case, Mr Simpson-Cleghorn had been correct to assert that his claim deserved "the further investigation which would bring it within the test in *Winch v Jones*". He might have his leave.[54]

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## Conclusion

The case of *Pountney v Griffiths* was the most significant to arise under section 141 of the 1959 Act, and it continues to be relevant even beyond the confines of that provision. The successor provision, contained in section 139 of the 1983 Act, differed from its predecessor in two ways. The first difference - the lack of specific criteria for the granting of leave - was quickly ameliorated by *Winch v Jones* and the introduction of a judge-made test which, though it was more liberal than the previous statutory test, would still place a substantive hurdle in the way of some intending plaintiffs. As the recent cases of Mr S-C have demonstrated, this common law test remains good law. It is, however, the second difference between sections 141 and 139 which is perhaps the more troubling.

It is intriguing to note the alacrity with which, almost a generation before the Human Rights Act 1998, the British legislature sought to give effect to what it believed to be the Strasbourg view. It is to be hoped that its predictive capabilities have sharpened somewhat with the passing of the decades.

Though Mr Ashingdane was undoubtedly fortunate that the British government decided to amend section 139 by removing the requirement for prior leave for proceedings against precisely those organisations whom he hoped to sue, and that it did so before the final outcome of his proceedings in the European Court was known, subsequent litigants have been less fortunate.

Mr S-C was compelled to go to the High Court, and thence to the Court of Appeal, only because, though it was no less "corporate" in nature, the local authority defendant whom he hoped to sue was of a species which had not figured in Mr Ashingdane's contemplated suit.

The anticipated result of that suit has cast a long - and perhaps disproportionate - shadow over subsequent practice. The inconvenient fact that the European Court ultimately rejected Mr Ashingdane's complaint has had no effect upon the subsequent application of section 139, nor has it led to the restoration of the exemptions removed by the Special Standing Committee.

For Mr S-C, it is undoubtedly a matter of regret that Mr Ashingdane did not bring a local social services authority within the ambit of his landmark proceedings. That this omission is the sole rationale for the immunity now uniquely enjoyed by such authorities is a matter for further regret.

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[1] *T Campbell and C Hegginbotham - Mental Illness, Prejudice, Discrimination and the Law (1991. Dartmouth: Aldershot).*

[2] *Law Commission, Mental Incapacity. Law Com No 231 (1995. HMSO: London)*

# Achieving Human Rights for People who Lack Capacity

*William Bingley**

**In November 1999 a conference entitled "Mental Incapacity. New Millennium - New Law" was organised by the Law Society, Royal College of Psychiatrists and the Mental Health Act Commission. It concluded with the Lydia Sinclair Memorial Lecture delivered by William Bingley.**

## Introduction

Being invited to give this lecture is probably the greatest honour of my 16 years in mental health. It is also a daunting one - not only because it is almost impossible to do justice to Lydia Sinclair's contribution but also because - being the last speaker after such a galaxie - I strongly suspect there is not much more to be said.

One of my major achievements in mental health was to recruit Lydia Sinclair to MIND in 1983 as its Legal Officer, and even that is a gross exaggeration - essentially she recruited herself. Her subsequent and distinguished career, which came to a grievously premature end with her death in May 1998, included the Legal Directorship of Mencap, private practice with Birnbergs and latterly Scott-Moncrief Harbour and Sinclair, membership of the Mental Health Act Commission and membership of the Law Society's Mental Health and Disability Committee. All provided vehicles for her unique and invaluable contribution to, amongst other things, the field that is the focus of our attention today - and I think it is important not to forget that back in 1983 when she joined MIND - *today* and what it represents would have been unimaginable. What Lydia Sinclair was about was rights and especially the rights of particular groups too often denied them. My presentation today is about "Achieving Human Rights for People Who Lack Capacity" and I would like to intertwine what I saw as some of the characteristics I observed in Lydia Sinclair with the challenge ahead, as I see it, in implementing, consolidating and taking forward the rights of those described as lacking capacity.

In particular, what I would like to do is:-

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[3] *Law Commission. Mentally Incapacitated Adults and Decision Making: An Overview. Consultation Paper No 119 (1991, HMSO: London)*

a. Identify three characteristics of Lydia Sinclair's work which I think are instructive for today;

b. Briefly address the challenge of ensuring that those who lack capacity do not become the new excluded;

c. Restate some of the fundamental political values which I think we should not forget especially as we review where we are today;

d. Briefly set out what the law can do and also look at the principles and values that should underlie not only legislation but maybe also our dealings with each other (including those whom we describe as lacking capacity); and

e. Make a plea for early action in relation to two areas.

What I will vigorously avoid is any studious philosophical examination of the strengths and weaknesses of the so-called "rights approach" to those who lack capacity. Some may take a rather narrow rights and responsibilities approach and, whilst not arguing that those who lack capacity do not have human rights, may suggest that in these particular circumstances such an approach is of limited value. I take a rather more imprecise view that human rights (as Chris Heginbotham and Tom Campbell said in Mental Illness, Prejudice, Discrimination and the Law)[1] are those rights which are the inalienable possession of every human being. This means that no distinction between individuals or groups is tolerable with respect to the enjoyment of human rights. I guess there is a difficulty - in a general sense - in that customarily the focus of the human rights approach and discourse is about increasing autonomy and some may argue that in relation to people who lack capacity, the room for this is much more limited. Whilst this is so, let us not forget that crucial part of the Law Commission's report[2] (3.5) when it talks about the "functional" approach to capacity - "most people, unless in a coma, are able to make at least some decisions for themselves and may have levels of capacity that vary from week to week or even from hour to hour."

## a. Lydia Sinclair

Any attempt to describe Lydia's contribution will not do her justice. She somehow combined tenacious casework, recognition of the importance of policy and its development, a true understanding of the law, an appreciation of the significance of research and a principled and yet realistic and pragmatic ability to contribute to the management of organisations. She managed to pursue these alongside an energetic, enriching and at times demanding family life a keen sense of humour and an energy that was truly and justifiably enviable. Above all else, what she managed to do in her years in the field of mental health and learning disability (and I suspect this was a characteristic of her whole life) was to keep intact her ability to be outraged when it was right to be so. All her professional life her activities focused on individuals and the infinite care which she took with individual cases as well as the way in which they influenced her activities in other areas sums up for me what Lydia Sinclair stood for.

Pursuing this a little further there were three things about Lydia which it is appropriate to mention, especially today:-

- Firstly, I think it is fair to say that she was amongst the first to recognise the potential significance of the concept of capacity - I think at MIND and more centrally at Mencap, she worked out the importance of capacity and incapacity as ideas, especially in relation to decision making.

- Second, Lydia did recognise very early, the potential (and the limitations) of the law as a vehicle for pursuing rights. What she was involved in, it seems to me, logically preceded and ties in with the approach that is implicit within the Human Rights Act and all that may gives us. If she was still here today it is not difficult to envisage the creative use she would have made of it.
- Thirdly, what Lydia Sinclair did was to go the extra mile. All her colleagues over the years have seen how that ability and willingness enabled her to engage with the most jaded, most damaged and most disengaged service users or carers in a way that was almost magical. At her best that extra mile could win cases and secure justice for people who never anticipated it.

## b. People who lack capacity - the new excluded

That ability to engage even the most excluded, to me, highlights a fundamental challenge that we face today if we turn to look at the group of people who we describe as lacking capacity. In many ways a heterogeneous group described by the Law Commission[3] back in 1991 as including some people with learning disability, some elderly people with mental infirmity, some people with mental illness and some people with brain damage, physical illness or physical handicap. This is a large group of people and taking them as a group for many purposes will not be terribly helpful. On the other hand they, or at least some of them, are not immune from society's well documented need from time to time to create demon groups on to whom we pour out, at times, our most irrational fears and terrors. At the moment I guess it is those with serious mental health problems whose needs, care and treatment have (for a number of reasons which I do not think are too difficult to identify) got tied up with, amongst other things, the debate about community safety. In terms however of getting a raw deal they are clearly not alone. For example, Age Concern tells us that older people are getting a particularly raw and discriminatory deal in relation to medical treatment. If their perceptions are true, then imagine what is happening if you are elderly, lack capacity and do not have somebody to fight for you.

Many of the people who fall within the group described as lacking capacity are still effectively excluded and it is that fact which gives particular importance to the Government's commitment to reduce social exclusion and, it seems to me, the potential value of the Human Rights Act in - without over-investing it with unrealistic expectations - securing for excluded people some basic rights and entitlements that too often they are deprived of.

## c. Incapacity and Fundamental Political Values

In pausing for a moment and attempting to see where we are it may not be unhelpful to return to some first principles in looking at the strength of our foundations especially in relation to where we want to go from here in pursuit of the human rights of people who lack capacity.

Chris Hegginbotham and Tom Campbell posited a set of principles and fundamental political values which they hoped might lead to a substantial consensus as to the most important values upon which to judge the morality of society's response to mental illness and in particular to provide a framework in which debate about discrimination can take place. Given and take a little, it struck me that the same

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4 *N Eastman and J Peay. Law Without Enforcement: Integrating Mental Health and Justice. (1999, Hart: Oxford)*

principles could provide a framework for us to determine the morality or at least a consensus as to how we should respond to those who lack capacity. They suggested the following values:-

## Basic Equality

A prior assumption of all acceptable systems is a belief in the inherent equality of all human beings. Not a matter of descriptive identity - what we are talking about is an assertion of the equal significance of each human being, in that one person's life and experience is, in itself and for its own sake, as important as anyone else's. This is a principle, as the authors state, which has general support, even if it is hard to reconcile with how we actually treat those who are unable to sustain a satisfactory existence - as a visit (and remember they were talking about the late 1980s) to many long-stay "back" wards in many a psychiatric hospital would bring home to us.

## Well Being

The most evident and uncontroversial human value which follows naturally from our minimal definition of what it is to be human is happiness or utility defined as the experience of pleasure and the absence of pain. In an extremely complicated argument - the details of which I will not bother you with - Hegginbotham and Campbell suggest that the value of wellbeing implies there should be in any acceptable polity, a practical concern for the welfare or wellbeing of all members of the community with priority being given to the relief of distress or unhappiness over the opportunity for pleasure or enjoyment.

## Autonomy

The authors identify that the basic utilitarian value of well being requires supplementation by other important moral and political values principal amongst which is the value of autonomy. In an important discussion they distinguish between **instrumental autonomy** (the freedom of individuals as to *how* they should pursue their objectives) **goal autonomy** (the capacity of an individual to make up their own minds as to the *ultimate objectives* of their daily lives) and **control autonomy** (best identified, they suggest, as the capacity of an individual to control his or her life).

Autonomy they argue is not a unified and all or nothing matter which contains an obvious threshold of reduced capacity beyond which individual choice has no value. Failure they argue to take account of this fact leads to much unnecessary curtailment of liberties for persons with mental disabilities and illness. This basis for discrimination is reinforced by giving excessive weight to instrumental autonomy over goal autonomy, thereby depriving the instrumentally less competent of the real opportunity to set their own goals in life.

## Justice

A fourth value that it is worth identifying in this context is justice. As Eastman and Peay in Law Without Enforcement[4] state, justice might be broadly conceived in terms of "being dealt with equitable and/or in

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[5] *Making Decisions. C.M. 4465. (1999. The Stationery Office: London)*

accordance with the law". It can relate to the substantive law as well as its procedural application and can be distinguished between the individual taken alone and the individual in relation to others. On a broader front we have wider and possibly more collective notions of justice - for example social justice.

Campbell and Hegginbotham argue that "there is ample evidence that rules as they are applied to persons with mental illness are so open-ended and so loosely interpreted as a result of the extensive de facto discretion enjoyed by those who have authority in this sphere, that there is much less formal justice in mental health matters than in other areas." They go on to say "The general idea that we should do what is best for those with mental illness tends to push to one side the thought that they have a right to be treated according to established rules." Maybe part of what we are talking about today is beginning to address that. Clearly justice is about the interaction of many other things - criminal behaviour and mental disorder, incapacity and criminal behaviour and the debate, almost as old as time, about the so-called mad, bad and the sad.

This list of values is not exhaustive - and of course they compete and conflict and have to be traded off against each other. Talking in a slightly different context about the relationship between justice and mental health, Eastman and Peay note that attempting to integrate or at least finesse these two objectives sets up different sets of harmonies and conflicts which both the law and services have to be able to respond to. The same I would suggest is true in relation to the concept of incapacity.

## d. The role of law in securing rights for people who lack capacity

If the law is one way in which to give effect to the results of the trade off in fundamental values we make when determining objectives for those who lack capacity, what role can it actually play in the pursuit of human rights? I guess that the law is essentially a social instrument or mechanism which balances the often competing rights and responsibilities of individuals, groups, organisations and of society as an entity and its purpose is to strike an appropriate balance between those competing considerations.

In his consideration of the possible role of the law, Larry Gostin constructed his so called Ideology of Entitlement in which he suggested that in relation to mental health you could ask the law to be involved in three principal areas:

i. **Entitlement to a service**

   Clearly state services are provided with a statutory basis but the extent to which the law has provided potential beneficiaries with an enforceable entitlement has been less apparent. The implications of the Human Rights Act are going to be particularly important in this regard.

ii. Second, the law could be asked to provide the authority to compel in certain circumstances and also set out the safeguards which should accompany that authority. That is the principle objective of the 1983 Mental Health Act.

iii. To protect and/or enhance the civil and social status of those with mental health problems. It seems to me that, for example, the proposals set out in Making Decisions[5] could be said to fall under this general category.

Not a bad breakdown of what you can ask the law to do and it may be that under those headings and in

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6 *R v Bournewood Community and Mental Health NHS Trust, ex parte L (Secretary of State and others intervening) [1998] 3 All ER 289.*

light of all that we have heard today - its contribution is going to be more considerable than before and more focussed. But as Eastman and Peay say "Changing the law is a laborious and time consuming process albeit it is much easier than changing people's practices". But the law, or the possibility of changing it, can set an agenda and it can facilitate good practice by "for example specifying for decision makers factors which they should take into account, the sequence in which they should be done and the weight to be attached to them". It seems to me that the Law Commission report Mental Incapacity to a considerable degree has had a profound effect on many professionals and service providers (may-be it was the consultation process that led up to its publication) and is a good indicator of how the law making process - even in its early stages can impact on real life.

I guess that the ultimate test for any legal change is, does it result in real changes - the better observation of what we describe as the human rights of people who lack capacity in everyday life - and in that context, law makes an important but not exclusive contribution. Societal attitudes, professional attitudes and the principles and values we attach to our relationships to each other (not lest those with incapacity) are equally important and as we peer into the future it may not be unhelpful to remind ourselves of the key principles that the Law Commission[3] identifies in its first discussion document eight years ago. It seems to me that they have stood the test of time and provide us with a clear set of future guidelines - even if the first is expressed slightly differently today:

a. **Normalisation** - valuing everybody as having a contribution to make to society - attempting to integrate them into mainstream life, maximising potential and promoting the highest degree of independence.

b. **The presumption of competence** Our dealings with everybody should be based on the premise that every individual is capable of looking after his or her own affairs until the contrary is proved. It follows that although people may have to be categorised for certain purposes their general type of disability should not be used as a criterion, otherwise, once the existence of that disability is proved, a finding of incapacity tends to follow almost automatically.

c. **Least restrictive alternative** This means that not only should treatment or care be provided in the least restrictive circumstances but that we should give preference to the means of accomplishing an end that is least restrictive of individual rights.

d. **Safeguards** Safeguards should be provided in the least stigmatic way possible - an argument perhaps in light of Making Decisions and the shortly to be published Scoping Committee report on future mental health legislation for a Health Bill and not a mental health bill.

e. **Best Interest** We should arrive at a definition of best interests that gives priority to the previously expressed wishes (where that is possible) of the person who lacks capacity;

f. **Balance** We should aim to provide a mechanism that maximises the chances of coming to a decision that defendably balances the inevitable overlaps and conflicts between these values when they actually have to be traded off.

It seems to me that today we have a set of legislative proposals in relation to incapacity - a set of possible proposals in relation to future mental health legislation (and here I would especially underline the significance attached to incapacity in the Scoping Committee Draft Outline Proposals) and a Human Rights Act that in relation to the limitation periods is in effective already in force - that provides us with