The new Mental Disorder Tribunal

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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]

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.

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

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

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

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.

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:

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,

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

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.*