

Psychiatric detention and treatment: a suggested criterion

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Abstract

Calls for a new Mental Health Act for England and Wales, and the government's response to those calls, raise the question of why we have mental health legislation. One answer is that we wish to provide criteria for psychiatric detention and compulsory treatment. It is argued that we are willing to coerce some people with mental disorders in this way when we conclude that their ability to make a proper choice is impaired. Mental health legislation could and should be designed to take this into account.

Key words

Legislation, capacity, choice, detention, coercion, treatment

The 1990s heard repeated calls for a new Mental Health Act for England and Wales.¹ Before we design a new Mental Health Act we ought first to answer the question: "What do we want a Mental Health Act to do?" If, as the government's response² to these calls suggests, we want an Act which will provide criteria for detention in psychiatric hospital and compulsory treatment, we are required to answer a further question: "Why do we detain and treat some people with a mental disorder who pose a risk to themselves or others?" After all, we do not detain other people who pose this kind of risk unless they have been convicted of an imprisonable offence.

Some of the calls for reform expressed the view that the existing criteria for detention under mental health legislation in the UK, criteria which require, in general terms, the simultaneous presence of mental disorder and a perceived risk to the patient's own or someone else's health, were incorrect and should be replaced. The authors argued that new criteria should be based on the common law of capacity.³ The end of the decade saw discussion of this question by a government appointed Expert Committee⁴ and a decision, later reversed, by the Court of Appeal

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1 See N. Eastman (1994), *Mental health law: civil liberties and the principle of reciprocity* 308 *British Medical Journal* 43-45; G. Thornicroft (1996), *Review British Medical Journal* 312, 786

2 Department of Health and Home Office (2000), *Reforming the Mental Health Act*. The Stationary Office: London.

3 G. Szmulker and F. Holloway (1998), *Mental health legislation is now a harmful anachronism* 22 *Psychiatric Bulletin* 662-665

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

in *Bournewood*⁵ which suggested that capacity-based criteria were already required at common law. The government's legislative proposals, published in 2000, revealed that these views had not prevailed.⁶ This paper asks whether they should have been allowed to do so.

Even to ask what are the proper criteria for detention and compulsory treatment is to ignore two possibilities, possibilities which will not be discussed further here. These are what might be termed an extreme libertarian position, that no-one should ever be coerced unless convicted, and an extreme paternalist position, that everyone should be liable to coercion if their behaviour deviates from that which is in their own best interests. It will be assumed also that what is required is a dichotomous classification, into those deemed able and unable to manage their own affairs, and that there can be no equivalent, in civil legislation, of the criminal law's "diminished", or partial, responsibility. In addressing these questions, the remit of this paper is limited to civil procedures and does not include the admission and treatment of patients from prison and the courts under Part III of the Mental Health Act 1983.

The approach adopted here parallels one used by Herbert Hart.⁷ In *Punishment and Responsibility* Hart is concerned with a different question, namely, why does the criminal law usually require, as a condition of punishment, the presence of mental states such as intention and recklessness? Why do we excuse, partially or completely, those who were provoked, insane or simply mistaken as to what they were doing? He examines a number of possibilities and by answering the question, "Why does the law require certain mental states?", suggests how we might assess the adequacy of the defences available, at law, to those whose mental state is different.

Hart's analysis

The first possibility which Hart discusses is that the requirement for excuses stems from a more fundamental requirement that, in order for criminal responsibility to be present, there must be moral responsibility. By this argument we recognise excuses because we wish to ensure, before a prosecution can be successful, not only that the person intended to act as he did, but that he intended to do wrong. This view, that the law exists to punish, not acts which are simply forbidden, but acts which are morally wrong, has been expressed on both sides of the Atlantic.⁸ Hart argues that it is incorrect and points out that the law defines as offences numerous forms of behaviour whose moral wrongness is, at best, in doubt.⁹

The second possible reason, which Hart examines, for our desire to convict only the "mentally responsible" relates to what he calls Jeremy Bentham's "economy of threats". Bentham thought that it was wrong to punish where the threat of punishment could not deter a potential offender from indulging in criminal behaviour in general or the act for which he was being tried in particular.¹⁰

5 *L. v Bournewood Community and Mental Health Trust ex parte L* [1998] 1 All ER 634.

6 Department of Health and Home Office (2000), *Reforming the Mental Health Act*. The Stationary Office: London.

7 H. Hart (1968), *Punishment and Responsibility*. Oxford: Clarendon Press.

8 In England Lord Denning said that, "In order for an act to be punishable, it must be morally blameworthy. It must be a sin" (see A. Denning (1953), *The Changing Law*. Stevens and Sons: London, p.112). In the United States

Professor Jerome Hall has argued that the general principle of liability is that, for conviction, there be proved the, "voluntary doing of a morally wrong act" (see J. Hall (1947), *General Principles of Criminal Law*. Second edition. Bobbs-Merrill Co.: Indianapolis, p.103).

9 Hart cites as an example legislation intended to give effect to a state monopoly of road or rail transport.

10 Bentham (1823), *Introduction to the Principles of Morals and Legislation*, Volume Two. Second edition. Pickering: London, pp. 1-13.

Punishment in such cases was wasteful because suffering was caused to the accused in circumstances where it could do no good. Hart's argument in reply is that it is far from clear that making punishment dependent on responsibility is, in fact, the most efficient way of persuading people to observe the law. Doing away with "accident" as an excuse, for instance, might make everybody more careful. We recognise excuses despite the possibility that suffering would be reduced by our not doing so.

Instead, Hart argues, the criminal law is best seen as a "choosing system"¹¹ in which individuals are aware of the costs and benefits of various courses of action. He points out the similarities between conditions which excuse under the criminal law and those which invalidate marriages, contracts and wills. In the absence of such invalidating conditions as accident, mistake and insanity, contracts entered into without the individual making a real choice would remain in force and the individual would suffer a corresponding loss of control over his or her future. Similarly, by attaching excusing conditions to criminal responsibility we maximise the chances of an individual successfully predicting whether sanctions will be applied to him and choice becomes one of the factors which determines whether such sanctions will be applied.

An analysis for civil legislation

Hart's arguments concerned the criminal law. This paper addresses civil provision. Why do we have a law that permits the detention of some people when they present a risk to themselves or others? In particular, why does this risk justify the detention of mentally disordered people but not others? One possibility is that we have utilitarian motives. Left to their own devices, perhaps, an unacceptable number of those we detain would harm themselves or others. In support of this being our motivation is the stress laid on harm done to others in press criticism of some decisions to release detained psychiatric patients. But even those who consider the mentally disordered, as a group, no more dangerous than the population at large are content for compulsory detention to continue. And we do not detain in hospital those non-disordered people who are, sometimes by their own descriptions, dangerous. Our behaviour cannot be wholly explained in terms of utilitarian motives.

A second possibility is that we regard it as a moral necessity that sick people receive medical attention. Certainly the Mental Health Act requires that someone be placed, not simply out of the way or under supervision, but in hospital. Again, however, this explanation of our current practice seems, on its own, inadequate. First, even when treatment has begun, things are sometimes done which are not in the best interests of health. Where the diagnosis or prognosis is uncertain, patients are routinely subjected to two operations, the first exploratory, so that informed consent can be obtained for the second.

11 H. Hart (1968), *Punishment and Responsibility*.
Oxford: Clarendon Press, p.31.

Second, many people fail to seek help or refuse it without our seeking to compel them. Those, such as Jehovah's Witnesses, who refuse blood transfusions on religious grounds are dramatic examples. But it is easy to think of more mundane instances of people failing to act in their own best interests where we see no reason to intervene. The value of medical treatment for diabetes and high blood pressure is seldom questioned, yet research into how best to improve the uptake of such treatment does not conclude that compliance should be compulsory.¹² And even when a disease is infectious and an effective treatment is available, proposals for improving compliance make no mention of coercion.¹³

It seems more reasonable to suggest that we detain those we believe incapable of making proper choices. This incapacity applies to choices regarding the way they treat others, their care of themselves and their willingness to seek medical treatment. Hart thought it no coincidence that the range of conditions which reduce criminal responsibility, duress, accident and so on, are the same conditions which invalidate contracts and wills. I think it is no coincidence that the mental conditions used to justify detention in hospital, mental disorder, mental illness and so on, are the same mental conditions which invalidate contracts and which permit the management of one's financial affairs by the Court of Protection.¹⁴ To the extent that we can control our futures, we do so by making choices. When we can no longer make choices properly we allow, and perhaps even expect, others to attempt to control the future for us.

The language employed by the common law and, in particular, the law's repeated use of the word "choice", offers some support for this explanation of why we remove autonomy from some people but not from others. Where no mental disorder has been held to be present, the courts have wished to respect the patient's "rational choice"¹⁵ and "absolute right to choose".¹⁶ When allowing treatment against the express wishes of the mentally disordered they have been, if anything, even more explicit in their use of choice as a criterion. Hoffman L.J. doubted that,

"someone who acknowledges that in refusing food at the critical time she did not appreciate the extent to which she was hazarding her life ... could be said to be capable of making a true choice."¹⁷

The right of a man with schizophrenia to refuse surgery hinged on his, "comprehending and retaining treatment information, ... believing it ... and ... weighing it in the balance to arrive at choice."¹⁸ One authority concludes that a "true choice criterion" for the right to refuse treatment

12 See D. Sackett, R. Haynes, E. Gibson, B. Hackett, D. Taylor, R. Roberts and A. Johnson (1975), *Randomized clinical trial of strategies for improving medication compliance in primary hypertension* i *Lancet* 1205-7; R. Haynes, D. Taylor and D. Sackett eds. (1979), *Compliance in Health Care*, Johns Hopkins University Press: Baltimore.

13 See, for example, J. Volmink and P. Garner (1997), *Systematic review of randomised controlled trials of strategies to promote adherence to tuberculosis treatment* 315 *British Medical Journal* 1403-1406

14 See the frequent references to mental disorder in A. Guest (ed.) (1994), *Chitty on Contracts*. 27th edition. Sweet and Maxwell: London, 8-064 - 8-073. Of particular relevance to the present argument, however, is that the presence of mental disorder alone is

insufficient to render most contracts invalid. There must be a consequent inability to manage one's affairs (at 8-071). Similarly, the *Matrimonial Causes Act 1973*, while identifying mental disorder (as defined by the *Mental Health Act*) as one of the grounds for voiding a marriage, also requires that the disorder be "of such a kind or to such an extent as to be unfitted for marriage".

15 *Sidaway v. Governors of Bethlem Royal Hospital* [1985] 2 W.L.R. 480 at 505.

16 *Re T* [1992] 3 Med. L. R. 306 at 307.

17 *B v. Croydon Health Authority* [1995] 2 W.L.R. 294 at 300.

18 *Re C* [1994] 1 All E.R. 819 at 824.

has become entrenched in common law.¹⁹ The Law Commission included the phrase “true choice” in their proposals to change the law relating to mental incapacity.²⁰

If choice is the criterion which determines whether someone’s stated wishes should be respected then choice is the criterion which should appear in the legislation which governs the circumstances in which those wishes can be ignored. This is not to argue that difficult cases would cease to be difficult. It is to argue that difficult cases would be decided according to the appropriate criteria. Several other issues would arise, however, if a “choice test” were included in any new Mental Health Act.

The first concerns the term “mental disorder”. Should this, or similar, wording be retained such that detention and treatment would be dependent on, for instance, “the inability, by reason of mental disorder, to make a proper choice as to one’s need for treatment”? It could be argued that “mental disorder” should be omitted. If someone is, for whatever reason, unable to choose, why should their access to medical services be dependent on something as difficult to define as mental disorder?²¹ There are, however, many non-psychiatric causes of an inability to make a proper choice: physical threats, for instance. Retention of the term “mental disorder” would achieve the uncontroversial objective of restricting the use of the Mental Health Act to cases where the inability to choose stemmed from mental ill-health.

A second is whether any of the other elements should be changed. The Mental Health Act 1983 contains a number of criteria in addition to the requirement that mental disorder be present. Among these are that there be a risk of harm to the patient himself or to others, that treatment is necessary and that it be impossible to provide treatment by other means. These criteria, which seek to ensure only that compulsory measures will be invoked where they will be of some benefit and where there is no other way of achieving this benefit, seem unexceptionable.

Third, it has not been suggested here that any future legislation should expand on the term “proper” or, perhaps, “true” choice”. In *Re C*²² the court seems to be describing the royal road to choice in its reference, previously described, to, “comprehending and retaining treatment information, ... believing it ... and ... weighing it in the balance”. Whether this route is the only one seems an open question.

19 Fennell (1995), *Treatment Without Consent*. Routledge: London, p.267.

20 See Law Commission (1993), *Consultation Paper No. 128. Mentally Incapacitated Adults and Decision Making*. H.M.S.O.: London, p.32. The proposal was dropped from the final report, which made reference instead to the ability to “make a decision”. See Law Commission (1995) *Mental Incapacity*. Law Commission No. 231 H.M.S.O.: London, p.39.

21 See the reviews by Hoggett (1990), *Mental Health Law*. Third edition. Sweet and Maxwell: London, and Jones (1994), *Mental Health Act Manual*. Fourth edition. Sweet and Maxwell: London. Hoggett considers the definition of mental illness, one of the forms of mental disorder named in the Act, so vague as to do no more than describe instances where a layman would say, “the man must be mad” (p.48).

22 *Re C* (1994) 1 All E.R. 819.

It is suggested that it may be more appropriate to describe, in each case, the reasons why someone's choosing might be defective than to attempt to provide a definition of proper choice which will be universally applicable. The situation is analogous to that which obtains in respect of s.2 of the Homicide Act 1957. No definition of responsibility is available to assist the court. Instead, it is open to the defence to introduce evidence to the effect that, in this case, responsibility was diminished. The procedure is able to operate because the initial presumption, that the defendant is responsible, holds until the contrary is shown to be the case. Given that the same presumption made by the common law in respect of capacity is widely seen as satisfactory,²³ further definition may not be required.

Finally, legislation would have to take account of the fact that a person's ability to make a proper choice will vary over the course of their illness. People who are made subject to coercion need to be able to make plans for the future and those plans need to be made in the knowledge of whether or not they will continue to be coerced. The plans made by professionals and services need to take this into account also. In cases where someone's condition fluctuates rapidly, ensuring that every clinical decision is made after an assessment of that person's ability to choose is unlikely to be practicable. A compromise would have to be reached between the requirements of consistency and predictability for patients and staff and the need for a patient's legal status to reflect their ability to choose.

Conclusion

Fennell²⁴ has argued that the primary purpose of legislation is to regulate what the common law permits, and in some cases expects, doctors to do anyway. Eastman²⁵ has suggested that the law should be there, in part, to insist that where autonomy is removed, something is given in return. If part of the task of mental health legislation is also to define the criteria for detention and compulsory treatment, however, it has been suggested here that those criteria should be based on a person's ability to make a proper choice. It is this ability, or capacity, on which the courts have based their decisions as to who should, and who should not, be permitted to act autonomously in other respects and there seem to be good reasons why the same principles should be applied in respect of those with mental disorders.

The report of the government's Expert Committee²⁶ suggested that the presence or absence of capacity was an appropriate criterion by which to identify a group of people who could properly be made subject to compulsory measures and psychiatrists have argued that capacity would represent a sound basis for a reformed Mental Health Act.²⁷ The government's most recent legislative proposals²⁸ would permit the detention and compulsory treatment of patients with capacity who

23 See Lord Chancellor's Department (1997), *Who Decides. Making Decisions on Behalf of Mentally Incapacitated Adults*. Cm 3803. Stationery Office: London., p.11; Law Commission (1995) *Mental Incapacity*. Law Commission No. 231 H.M.S.O.: London.

24 Fennell (1995), *Treatment Without Consent*. Routledge: London.

25 N. Eastman (1994), *Mental health law: civil liberties and the principle of reciprocity* 308 *British Medical Journal* 43-45.

26 Department of Health (1999), *Report of the Expert*

Committee. *Review of the Mental Health Act 1983*, Department of Health: London.

27 For a psychiatric advocacy of this position, see G. Szukler and F. Holloway (1998), *Mental health legislation is now a harmful anachronism* 22 *Psychiatric Bulletin* 662-665; G. Szukler and F. Holloway (2000), *Reform of the Mental Health Act: health or safety* 177 *British Journal of Psychiatry* 196-200.

28 Department of Health and Home Office (2000), *Reforming the Mental Health Act*. The Stationery Office: London.

present a risk to others. If the argument presented here is accepted, the justification for measures to detain such patients will be couched in terms different from those employed to justify the coercion of people whose mental disorders render them incapable of making a proper choice.

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