

Reform of the Mental Health Act 1983: The Relevance of Capacity to Make Decisions¹

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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 authorise⁴ 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

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.”⁷⁷ 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.”⁷⁸ 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.”⁷⁹ 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

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 problem¹³ 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,

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 Geneva 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;

and

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;

and

iii. that the proposed care and treatment is in the patient’s best interests;

and, either

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

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.