
The Proposal

A model law fusing incapacity and mental health legislation

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An outline for a model law is presented here that would govern the non-consensual treatment of people who lack the capacity (or competence) to consent due to mental impairment⁴, whether this is due to ‘mental disorder’ or ‘psychiatric disorder’ as conventionally conceived, or due to a ‘physical disorder’. Our aim in drafting this model law is to give coherent and practical expression to the case, previously made by two of the current authors, that separate legislation authorising the civil commitment of ‘mentally disordered’ persons is unnecessary, and discriminatory, and should be replaced by new, comprehensive legislation that would govern the non-consensual treatment of both ‘mental’ and ‘physical’ conditions⁵. This new scheme – which we have described as the ‘fusion’ proposal – would be based squarely on incapacity principles: that is, on the impaired capacity of a person to make decisions about treatment, from whatever cause – whether this is due to schizophrenia, Alzheimer’s Disease, a learning disability, a confusional state due to infection, a cerebrovascular accident, a head injury, or any other mental impairment.

A model statute of this kind, drafted largely by Rowena Daw, is presented here in skeleton form.

Justifications for the ‘fusion’ proposal

In the UK, as in most jurisdictions, treatment for ‘mental disorder’ is largely governed by mental health legislation. Under that legislation, the usual criteria for intervention – by way of both detention and involuntary treatment – are that the person concerned is ‘mentally disordered’ (or ‘mentally ill’) in the necessary sense and that they present a serious risk to themselves or others. If a person meets those complex criteria, the legislation will usually authorise their certification by medical practitioners, their emergency detention and transportation to a hospital or clinic, their compulsory assessment, their

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4 The term ‘mental impairment’ is used in its broad sense here and is not limited to the legal definition of the term which was to be found in section 1(2) Mental Health Act 1983 prior to the Mental Health Act 2007 amendments

5 Dawson J, Szmukler G (2006). ‘Fusion of mental health and incapacity legislation’. *Br J Psychiatry*, 188:504–509.

involuntary psychiatric treatment, and their compulsory community care, provided the person's involuntary status as a whole is kept under regular, continuing review by a court or tribunal. Patients who retain, or regain, their capacity to consent may still receive psychiatric treatment without their consent as long as they remain involuntary patients under the scheme.

When it comes to the treatment without consent of non-psychiatric medical conditions, on the other hand, different criteria and different procedures are followed that are grounded in different sources of law. Treatment without consent is not permitted for those with capacity; for those who lack capacity reliance is placed on common law powers (or justifications) for intervention whose origins lie in the defence of necessity in the law of crime and tort, or we act under adult guardianship (or incapacity) legislation, such as the *Mental Capacity Act 2005* (MCA 2005). Under these regimes the fundamental criterion for intervention is not the presence of any specific disorder or the imminent threat of harm. Instead, the test for intervention is the incapacity of the person to make necessary treatment decisions. If the person lacks that capacity, treatment that is in their 'best interests' may generally be provided without their consent.

We have argued that the maintenance of these separate regimes is no longer acceptable. In particular, this 'two-track' approach is inconsistent with general principles of health care ethics and with basic notions of human rights, particularly the right of people with mental disorders to be free of unnecessary discrimination in the law. Mental disorder is *not* always associated with incapacity to consent, and the capacity of mentally disordered people is already assessed for many other legal purposes. Furthermore, there is good research evidence that the assessment of capacity in people with a 'mental disorder' is as reliable as for those with a 'physical disorder'⁶.

The 'fusion' framework

The alternative approach that we advocate is to abandon the two-track approach, and, instead, to fuse the two together into a single comprehensive involuntary treatment scheme, which preserves the strengths of each. A major strength of non-consensual treatment schemes that are based on incapacity principles is the respect shown for the autonomy of those patients who retain their capacity; but these schemes are, nevertheless, often weak on the regulation of emergency treatment powers, detention in hospital, and forced treatment. These are the areas, in contrast, in which civil commitment schemes are strong. The use of force, and the detention and involuntary treatment of objecting patients, is clearly authorised and regulated by mental health legislation. We therefore advocate a legal regime that retains the strengths of both, but still relies squarely on the incapacity of the person to make necessary care or treatment decisions as the primary justification for intervention in their life.

Our proposed 'fusion' legislation deals with all persons who lack capacity who may require treatment or care; compulsory powers will only affect a subset of those covered. Provisions for the treatment and care of informal patients include safeguards for those requiring 'serious medical treatment', protections for informal patients in residential care, and requirements for informal patients lacking capacity who need to be 'deprived of their liberty' in their best interests. A single regime is thus provided that specifies the conditions for both treatment under compulsion and treatment under circumstances amounting to a 'deprivation of liberty'.

This paper demonstrates how we may fuse the central elements of these two distinct schemes into one comprehensive piece of legislation. The basic criterion for intervention under 'fused' legislation is

6 Cairns R, Maddock C, Buchanan A, David AS, Hayward P, Richardson G, Szmulker G, Hotopf M. (2005) 'Reliability of mental capacity assessments in psychiatric in-patients'. *British Journal of Psychiatry* 187: 372–8.

incapacity to make necessary treatment decisions. The usual meaning of ‘incapacity’ applies: that is, inability to understand, recall, process, use or weigh relevant information; inability to communicate a decision; or inability to reach a decision that is sufficiently stable for it to be followed. This incapacity test must be defined in a manner that is sufficiently flexible to cover the complex and subtle forms of incapacity found in some mental disorders. The test is not linked to any specific disabling condition, even if it is linked in a general manner to an impairment or disturbance in the function of the mind, as in section 2(1) MCA 2005 for England and Wales. In addition, for intervention under this test to occur, no less restrictive resolution of the apparent problems should be available.

In emergency circumstances, a ‘reasonable belief’ that the patient lacks capacity in this sense is sufficient to authorise intervention. Suitably qualified professionals could then intervene, using similar powers to those provided by a civil commitment scheme: that is, powers of entry, detention of the person, transportation to assessment, use of reasonable force, and so on.

The patient then enters a staggered compulsory assessment process, during which immediately necessary treatment can be authorised. A more structured assessment of the patient’s capacity can then take place. If the patient’s involuntary treatment is to continue, further downstream decisions about the details of their treatment are required: decisions, for instance, concerning the need for their detention for treatment purposes, the appropriate place of treatment – which includes the community – the contents of the treatment plan, and the value of any continuing care.

Comprehensive review and accountability mechanisms also apply. All involuntary patients must have ready access to rights advice and to independent review of their status before a court or tribunal. A substitute decision-maker for treatment is appointed (and parameters for the patient’s treatment set). Serious treatments require special regulation, through mandatory peer review of treatment, for instance. But this kind of requirement does not apply only to psychiatric treatment; it should apply to all treatments of a similarly controversial or intrusive kind.

In our proposed scheme, with some minor exceptions (see below), involuntary treatment is restricted to patients who lack capacity. This does not preclude involuntary treatment for the protection of others, which is permitted in two sets of circumstances – first, where treatment for the protection of others is in the patient’s best interests, and second, where in the course of providing treatment in the best interests of the patient, there arises a risk of harm to others.

Note that we are not advocating the intermediate (or hybrid) legal position now followed in many parts of North America and continental Europe that involves the application of different legal criteria to the detention and involuntary treatment decisions⁷. Under that approach, mental disorder and threat of harm criteria may be applied to a person’s detention, while incapacity criteria may be applied to their treatment. That approach has the significant disadvantage that it can lead to a position wherein a person may be lawfully detained in a psychiatric facility on the basis of their mental disorder, but cannot then be treated if they retain or regain their capacity to consent to psychiatric treatment. Instead, we argue that the test of incapacity to consent should be applied to both a person’s detention and their involuntary treatment.

⁷ Dawson J, Kampf A (2006). ‘Incapacity principles in mental health laws in Europe’. *Psychology, Public Policy and Law*, 12, 310–331.

Forensic care in the ‘fusion’ framework

The consequences of applying capacity principles to forensic care may appear problematic. The matter is complicated by the existence of different categories of forensic patient – some on remand, some convicted of criminal offences, some found not guilty by reason of insanity, or unfit to plead. The matter is also complicated by the fact that some forensic patients can be returned to prison if they regain their capacity and refuse treatment, while others cannot be returned to prison, because they are not currently subject to a prison sentence. If the detention of a person in that latter group was no longer authorized, they would have to be immediately released, which is an outcome that may not be politically or socially acceptable if the person concerned is deemed to still present a serious risk of harm.

This points to the fact that protecting the autonomy over treatment of patients with capacity is not the only important ethical principle in this field. Another important principle concerns the need to protect other people from serious harm. So some modification of pure capacity principles may be required in the forensic field.

Nevertheless, most of the difficulties in the forensic area can be overcome if the following principles are applied. First, any mentally disordered offender with capacity who consents to their treatment could be treated in an appropriate facility (and any sentence they were under could continue to run). Secondly, any mentally disordered offender who lacks capacity could be treated involuntarily like any other incapacitated patient. Thirdly, any criminal defendant found unfit to plead or not guilty due to insanity might still be treated without their consent, even if they retain or regain their capacity, if certain conditions apply:

- the person has committed acts or omissions constituting a serious offence; and
- a serious mental impairment or disturbance has contributed significantly to that conduct; and
- an effective treatment can be offered that could be expected to reduce the risk of that disorder’s reoccurrence.

This compromises pure incapacity principles, in narrowly defined circumstances, in order to prevent harm to others. It may also be the most humane disposal, as the option of prison would be inappropriate for a person with a mental impairment of such severity, and indeed would be impossible without a conviction. However, we believe that the number of persons likely to fall into this category who retain capacity is extremely small.

Further we propose that a mentally impaired offender who has been convicted of a serious criminal offence could be sentenced to the usual period of imprisonment, but if they were found to lack capacity and need treatment, they could be transferred to hospital for necessary care. If capacity is regained in hospital, the person has the choice of continuing treatment with consent; if not, the person would be transferred to prison for the remainder of their sentence. An alternative position, which we are not proposing in our draft statute, is that a convicted person could be placed under a hospital order on disposition from the criminal court, and be directed immediately to psychiatric treatment for a limited term, proportionate to the seriousness of their offence. During that limited term involuntary treatment could proceed on the same conditions, specified above, as would apply to those found not guilty by reason of insanity or unfit to plead; that is, treatment could be given involuntarily even for someone who has capacity, under the specified conditions. This would be a pragmatic response to society’s demand that a person who has committed a serious offence – even with a mental disorder, and even one that might respond rapidly to treatment – should be detained for a proportionate time. We have proposed the former

option to preserve as far as possible the centrality of incapacity as the justification for involuntary treatment. But we also retain the option of disposal to a compulsory treatment order without a concurrent sentence, which would deem the person to be subject to an equivalent civil order, and which would be terminated by the responsible clinician when the necessary conditions were no longer met.

In the manner outlined above, capacity principles can be followed in most forms of forensic care, subject to some limited modifications that would be required to respect the competing ethical principle of preventing serious harm to others.

The Northern Ireland Bamford Review (2007)⁸, with which our proposals share much in common, took an uncompromising approach to the forensic aspects, recommending that only people who lack capacity should be subject to a statute that authorises treatment without consent. We might favour the Bamford position, if their suggestion were adopted that there should be a “new legislative framework to incorporate future measures in relation to the risks posed by people suffering from an impairment or dysfunction of mind within a wider and independent risk management framework that addresses the full range of people who pose a risk of serious harm to the public” (p 79); that is, within a framework that does not discriminate against those with mental disorders. Whether such a scheme would be politically acceptable in England and Wales, or, in the absence of an offence, would be compatible with the European Convention on Human Rights, is questionable.

Our precedents

It is not possible in a paper of this type to present a fully drafted statute, but we have attempted to provide sufficient detail in key areas to show that the concept of fused legislation can be given coherent expression. We take as our base *the Mental Capacity Act 2005* (MCA 2005) for England and Wales. The recommendations of the Richardson Committee (1999)⁹ established to review the *Mental Health Act 1983* for England and Wales (MHA 1983) have also been influential, as has the *Mental Health (Care and Treatment) (Scotland) Act 2003*, which incorporates an ‘impaired decision making’ criterion into a civil commitment regime. Other concepts are drawn from the MHA 1983, from proposals of the Mental Health Alliance for new mental health legislation¹⁰, and from the draft mental health bills of 2002 and 2004¹¹, which appeared during the law reform process. In the event, these drafts met with substantial resistance and a different *Mental Health Act 2007* was eventually passed for England and Wales (MHA 2007). This act substantially amends the MHA 1983 but is not based on incapacity principles. In addition, we have drawn on the report of the Bamford Review of Mental Health and Learning Disability for Northern Ireland¹², which recommended the adoption of a ‘comprehensive legislative framework’ for non-consensual treatment that is very similar to our fusion proposal.

8 Bamford Review of Mental Health and Learning Disability (Northern Ireland) (2007). ‘A comprehensive legislative framework’. www.rmhdni.gov.uk/legal-issue-comprehensive-framework.pdf.

9 Department of Health (1999). *Report of the Expert Committee (Richardson Report): Review of the Mental Health Act*. HMSO: London.

10 Daw R, Cobb A, Spencer-Lane T, (2005) ‘Towards a

Better Mental Health Act’, Mental Health Alliance, <http://www.mentalhealthalliance.org.uk/policy/policyagenda.html>

11 Department of Health (2002). *Draft Mental Health Bill*. HMSO: London. Department of Health (2004). *Draft Mental Health Bill*. HMSO: London.

12 See n.8 above.

Some outstanding issues

Many other contentious matters besides those relating to patients' capacity arise, of course, in the design of non-consensual treatment legislation. Many of these matters were extensively debated during the law reform processes that preceded the passage of the MCA 2005 and the MHA 2007. Should a 'treatability' or a 'best interests' test be included? Should compulsory treatment in the community be authorised? Should the 'responsible clinician' always be a medical practitioner (except where the expertise of a medical practitioner is clearly required, to comply for example with requirements of the European Convention on Human Rights). What is the right structure and frequency for the process of independent review? Should elected politicians continue to exercise statutory powers over the release of forensic patients?

Some position must be taken on such issues when a model statute is designed. In our model statute, we have included both a treatability and a best interests test as preconditions for intervention; our statute would authorise compulsory community treatment; and we have given tribunals the power to direct the release of some forensic patients. Some contentious positions have therefore been taken that go beyond the capacity issue and each would require extended justification. Regrettably, due to the constraints of space, we do not have the opportunity to present those justifications here.

This omission is not fatal to our current purposes, however. Our current aim is not to convince readers of the correctness of our model law on every point of detail. It is to demonstrate that our fusion proposal could be turned from concept to reality. The draft model law we present here is sufficient, we believe, to make this point: that our fusion proposal can proceed from drawing board to prototype. This prototype needs to be located in a particular jurisdiction, with whose wider laws it must be integrated. We have chosen for this purpose the jurisdiction of England and Wales.

We accept that some details of our model law will be contentious for some readers. If they would only want to change the details, however, we would have succeeded in our primary task: making a case that a comprehensive statute giving effect to our fusion proposal could be satisfactorily drafted, with only arguments of detail to remain. We hope we have convinced readers of this and have shown that a non-consensual treatment statute, applicable to both 'physical' and 'mental' disorders, could be constructed satisfactorily on the foundation of an incapacity test.

An outline of the Model Statute

We now discuss the general principles behind each major aspect of the model statute. It is in eight parts.

I THE PRINCIPLES

We have included an opening statement of principles because these are helpful to practitioners in exercising their powers and duties, to courts in interpreting the law and to individuals who may be affected by the provisions in giving them confidence in the purpose of the law.

The '**best interests**' principle applies to any act done, or decision made, under the Act for or on behalf of a person who lacks capacity, *unless* different principles are applied by specific provisions of the Act. The specific provisions cover exceptional instances where contrary actions may be justified by the competing ethical requirement for the **protection of others**. This occurs in the forensic section (Part VI; Clause 45) where a person found 'not guilty by reason of insanity' or 'unfit to plead', but who has capacity, may be detained in hospital if a number of further conditions are met.

The protection of others is also addressed in Clause 4 (10). When a patient's treatment is authorised in his or her best interests, but during the course of such treatment a serious threat of harm is posed to another person, the patient may be provided with such treatment as is immediately necessary to prevent such harm occurring and is proportionate to the likely seriousness of that harm.

In many cases where a person lacking capacity may present a danger to others, it will, of course, be in that person's best interests that this harm be prevented.

II GENERAL PROVISIONS

This part of the Act provides definitions for the terms and concepts that underpin the main provisions.

The definition of **capacity** generally follows that of the MCA, but is broader in referring to the ability of a person to 'appreciate' the necessary information. This will give clearer recognition of the fact that a person may be able to use information for some purposes but still not be able appreciate the manner in which the information pertains to their own situation.

Further elaboration of the concept of capacity could be provided in an accompanying Code of Practice which would make it clear that a person is to be regarded as able to understand the information relevant to a decision if he or she can understand an explanation provided in a way that is appropriate to the circumstances (for instance, by using simple language or visual aids or any other means). It should also make clear that relevant information includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision.

The concept of **best interests** is a central concept underpinning the Act and requires full elucidation. The formulation of best interests follows that in the MCA. It makes the person's wishes, feelings and values a primary consideration. Nevertheless, a decision may be in a person's best interests although it is not in accordance with the person's present wishes, and although the person objects to the treatment.

The general **requirement to consult** relevant people with respect to a person's best interests applies throughout the Act but this is supplemented in different clauses by additional consultation requirements.

The '**general authority**' permits people caring for a person who lacks capacity to do certain routine acts without requiring specific authority under other provisions. A proportionate degree of **restraint** of the person in their best interests is permitted under this section. The general authority covers such routine acts for all patients lacking capacity, including those receiving care or treatment under Part IV, V or VI of the Act. A similar form of authority was previously provided by the justification of 'necessity' under the common law.

Generally, where **medication** is to be administered over the person's objection, or to prevent harm to others, the compulsory treatment process under Part V should be initiated. Medication may only be administered using force under the 'general authority' if it is immediately necessary to prevent serious harm to the patient. In the case of persons treated under Parts IV, V, or VI it applies to medication that is not authorised under an approved care plan.

III SERIOUS MEDICAL TREATMENT

This Part is intended to ensure protections for the patient who lacks capacity who is to receive **treatment that is 'serious'** because it is particularly invasive, irreversible or likely to carry special risks. Some treatments of this kind are listed – ECT or medication under the Act lasting beyond three months; others may be specified in Regulations.

Before treatment is provided it is important to seek the agreement of the **substitute decision maker (SDM)** for the person. In the absence of such a person, or the ability to appoint such a person, an **advocate** must be appointed so that the person's interests are independently represented. The person's **primary carer** should also be consulted.

It is not considered appropriate that serious medical treatment should go ahead immediately if there is a disagreement between the clinician and the substitute decision maker or primary carer. Here the opinion of a **second opinion approved doctor** must be sought. The clause also gives a SDM, advocate or primary carer the right to seek a second opinion.

IV PROTECTIONS FOR INFORMAL PATIENTS LACKING CAPACITY AND NEEDING CARE AND TREATMENT¹³

This Part applies to people who **lack capacity** in relation to their care and treatment and who are **in hospital or a care home** (or are going to be admitted to residential care). In addition, they must be in residential care for a period of at least 28 days. They should not be people for whom the compulsory assessment and treatment process should be initiated under Part V.

If these conditions are satisfied following examination by an **approved clinician**, a **responsible clinician** must be appointed, a **care plan** provided and the person **registered** with an appropriate authority (for instance, the local authority). Before completing the care plan the responsible clinician must **consult** the persons's SDM or primary carer. The care plan must be regularly reviewed.

If the person needs to be **deprived of liberty** in his or her best interests, extra conditions apply. The person must be **examined** by a **medical practitioner and another health or social care practitioner** to decide if the conditions are met, including that the person has an impairment or disturbance in the functioning of mind and that deprivation of liberty is a proportionate response to the harm the person is likely to suffer if not so deprived. A right of **appeal** to the Mental Capacity Tribunal is included. These conditions should satisfy the ECHR's requirements resulting from the case of *HL* (2004).¹⁴

V COMPULSORY PROVISION OF CARE AND TREATMENT¹⁵

Before a person is placed under compulsory care and treatment a set of conditions must be met. These provide a proper legal basis for a person to be treated involuntarily and to be detained, if necessary, for treatment to occur.

Illustrating the value of the 'fusion' approach, impaired capacity is a necessary condition, but the processes of emergency assessment and treatment, detention, the use of force, and compulsory treatment are clearly regulated.

The **conditions** are: 1. the person has an impairment or dysfunction of the mind; 2. the person lacks capacity to make a decision about his or her care or treatment; 3. the person needs care or treatment in his or her best interests; 4. the person objects to the decision or act that is proposed in relation to his or her care or treatment and that decision or act is not authorised by the 'general authority'; 5. the proposed

¹³ Following a consideration of the commentaries on the statute, we propose a number of amendments that simplify Part IV. These are presented in the Addendum at the end of the Model Law

¹⁴ *HL v UK* (2005) EHRR 32.

¹⁵ We also propose possible amendments to Part V that simplify the process of compulsory treatment, also presented in the Addendum at the end of the Model Law.

objective cannot be achieved in a less restrictive fashion; 6. treatment is available that is likely to alleviate or prevent a deterioration in the person's condition; and, 7. the exercise of compulsory powers is a necessary and proportionate response to the risk of harm posed to the person or any other person, and to the seriousness of that harm, if the care or treatment is not provided.

Compulsory treatment follows a staggered set of phases, although not every patient will pass through all of them: 1. Preliminary Examination (up to 24 hours); 2. Initial Assessment (up to 7 days); 3. Assessment Order (up to 28 days); and, 4. Compulsory Treatment Order (up to 6 months). The assessments and compulsory treatment order can apply either in hospital or, if it is judged safe and effective, in the community.

1 Preliminary Examination

If there is a reasonable request for a person to be assessed and a medical practitioner, after examining the person, considers the necessary conditions appear to be met, the person may be detained in hospital for **up to 24 hours** and urgent treatment provided. Appointment of a **responsible clinician** and **consultation** with the primary carer or SDM are provided for, along with the need to advise of the availability of **advocates**.

There are also **powers for the Police to take a person to a place of safety**, if necessary, by **entering private premises**. The conditions for the latter are that the person appears to lack capacity; and is being, ill treated or neglected, or kept otherwise than under proper control, or, while living alone, is unable to care for himself or herself and is in need of care and attention. The phrase 'under proper control' could cover concern about the risk to another person in the household. A warrant must be issued by a justice for such entry. There is also a **power to convey** the person to hospital.

2 Initial Assessment

After 24 hours of Preliminary Examination, the person must be discharged unless a **second mental health professional** examines the person and determines that the conditions for Initial Assessment are met. The person can then be **assessed and given urgent treatment** for a further **7 days**. This can take place either in hospital or in the community to which the person can be returned.

During the Preliminary Assessment and Initial Assessment, **treatment** to which the patient objects may be given to save life or prevent serious and immediate deterioration in the person's health or to protect another person from harm. (Treatment under the General Authority may also be given, and if 'serious treatment' is to be given it is subject to the conditions noted above (Part III)).

3 Assessment Order

In order for a person to be assessed and treated for longer than a total of 8 days it will be necessary for a **Tribunal** to authorise a further period of detention. A **single person Tribunal** can authorise a period of detention for **up to 28 days**. Before applying for such an order the **responsible clinician** must prepare a **preliminary care plan** in **consultation** with the SDM or primary carer. The Assessment Order shall state the length of the assessment period and the treatment proposed. It also includes the **appointment of the SDM** if there is not one already.

If assessment is to take place in the **community** this shall include a limited set of **conditions** that will need to be placed on the person in order for treatment to take place or to protect the health and safety

of the patient or other persons. There is a requirement for consultation with the person (unless inappropriate or impractical), the SDM and any person who will have care of the patient in the community. The responsible clinician has a power of recall to hospital.

Treatment may be given without the consent of the patient if it is included in the approved care plan, is covered by the General Authority, or needs to be provided as a matter of urgency in order to save the patient's life or to prevent a serious and imminent deterioration in the patient's health.

In some circumstances such a period of further assessment under an Assessment Order will be unnecessary and it will be appropriate to **apply directly for a Compulsory Treatment Order** (see below). In that case the hearing must be before a full Tribunal. There are restrictions on the right to apply directly for a compulsory treatment order. It may only be made where the SDM agrees or the patient is an existing patient of the relevant health service.

4 Compulsory Treatment Order

A Compulsory Treatment Order is made by a **Full Tribunal**, consisting of a legal, medical and lay member, and may last for **up to 6 months**. The order will be based on the **recommendations of a medical practitioner and another health or social care professional** that the conditions are met. If the order is to take place in the **community** the order will include conditions, possibly including proportionate restrictions on the person's conduct and freedom of movement. Before deciding that a person shall be a compulsory patient in the community the responsible clinician must be satisfied that this would be compatible with safe and effective care, and that appropriate treatment is available. The patient's views must be considered, as well as that of the SDM and carer.

Before applying for the order a written **care plan** shall be drafted, in consultation with the SDM and the primary carer. The **Tribunal must authorise the care plan**, and may make amendments to it, but if these include changes to the treatment regime they should be approved by the Responsible Clinician and the medical member of the Tribunal. Copies of the care plan must be provided to the patient and the SDM.

Subsequent **changes** may be made to the care plan with the **agreement of the SDM**. Any changes to the compulsory treatment provisions or to the conditions attached to the patient's treatment in the community, or a change in the location of treatment, must have the agreement of the SDM. If the SDM does not agree it is necessary to obtain the approval of a doctor appointed to give a **second opinion**.

Treatment may be given without the consent of the patient if it is included in the approved care plan, or is covered by the General Authority, or needs to be provided as a matter of urgency in order to save the patient's life or to prevent a serious and imminent deterioration in the patient's health.

A Compulsory Treatment Order can be renewed or discharged by the Tribunal.

VI FORENSIC PROVISIONS

The Forensic provisions deal with a situation in which a person with an apparent impairment or dysfunction of mind comes before a criminal court charged with an offence and is then remanded for assessment or treatment, or convicted of the offence. These provisions also cover situations in which an accused person is found unfit to stand trial or 'not guilty by reason of insanity'.

1 Remand for report on mental condition or for treatment

A person who is charged with an offence may be sent to hospital for a report on his or her mental condition or be remanded to hospital for treatment at any time before the conclusion of their trial. Such assessment or treatment may also take place on bail. If the person has capacity, this must occur with their consent; if the person lacks capacity, it must be in the person's best interests.

The duration of an order for treatment in these circumstances is limited to 6 months. The person or their SDM may request a second medical opinion as to whether the conditions are met.

During a remand to hospital, treatment may be provided to a person with their consent; or, in urgent circumstances (where it is necessary to save life or prevent serious and immediate deterioration in the person's health, or to protect another person from harm) when there are reasonable grounds to believe the person lacks the capacity to consent. For the incapable patient the General Authority applies. The Tribunal, as the authority on capacity, best interests and definitions of impairment or dysfunction of mind, has the power to discharge a remand order and the person has the right to seek a second medical opinion.

2 Persons convicted of an offence

A person convicted of an offence may be put on a hospital order with a concurrent criminal sentence, with that sentence continuing to run while the person is treated in hospital. Where the person lacks capacity, he or she may be treated under this regime without consent. However, for the person who retains capacity, the regime is consensual; the person must agree to the treatment order being made and to any treatment provided. If that agreement is withdrawn, the person will be transferred to prison, or released into the community, to serve the remainder of their sentence. The Tribunal has the power to discharge from this treatment order but the person would then be required to serve the remainder of his or her criminal sentence.

The court may also decide to impose a hospital order alone, without a concurrent sentence, if that is considered a satisfactory disposition of the case. The effect of this order is to deem the person to be subject to a Compulsory Treatment Order under Part V. Treatment could then take place in hospital or the community. The person would have to be released from that order by the responsible clinician or Tribunal in the usual way, if the necessary conditions ceased to apply, and that possibility should be taken into account by the criminal court when deciding to impose an order under this clause.

3 Persons found not guilty by reason of insanity or unfit to plead

The court may order the person's detention in hospital if it considers it in the interests of the person or to protect the safety of other persons. Where the court orders detention in hospital, treatment can be given in the patient's best interests, if the patient lacks capacity. However, for this group of patients, an exception is made concerning involuntary treatment for a person who has capacity. Treatment may be given to such a person where the responsible clinician is satisfied that: the person needs treatment in his or her own interests or for the protection of others; and the person is suffering from an impairment or dysfunction of mind that contributed significantly to the offence; and, that treatment is available that is likely to reduce the risk of recurrence of such an offence.

Alternatively, for such persons, a Compulsory Treatment Order can be made deeming them to subject to compulsory treatment under Part V, as a civil patient, provided the conditions are met.

4 Transfer from prison to hospital

A person may be **transferred from prison to hospital** where he or she has an impairment or disturbance of mind and requires treatment and where, having capacity, the person consents to the treatment, or where, lacking capacity, the treatment is in the person's best interests.

A person who is accused or convicted of an offence and becomes subject to the provisions of this Part should have the same rights to a SDM, a care plan and an advocate as those who are subject to Parts III, IV and V. More detail on such matters would be included in a full statute.

VII MENTAL CAPACITY TRIBUNAL

The Act establishes a Mental Capacity Tribunal with both original and appellate jurisdiction. The Primary Division will hear most cases at first instance and will sit as a 3 person Tribunal except when otherwise provided. The Appeal Division will hear appeals from the Primary Division.

VIII PATIENT SAFEGUARDS

This Part of the Act deals with an essential patient safeguard, the **substitute decision maker (SDM)**. An adult with capacity may appoint an SDM to take decisions about his or her care or treatment in the event of loss of capacity. An SDM may also be appointed by the Tribunal.

Advocates play a key role under the Act and must be made available to people who are subject to its provisions. The Act specifies the functions of advocates and places responsibilities on authorities to ensure they are appointed.

Advance decisions to refuse treatment must be signed and witnessed by a person when the person has capacity. They apply when the person has lost capacity but have effect as if the person had capacity to make the decision over any health care issue to which the advance decision applies. So long it is clearly applicable to the circumstances the advance decision has effect as if the person had the capacity to make such a decision at the later time. Such decisions may still be overridden when treatment without the consent of the person is expressly authorised by the Act. A clause should be added concerning a process for replacing a SDM should that be required.

The full model statute we have drafted to illustrate the viability of the fusion proposal, is produced towards the end of this issue.