

# The treatment of mentally disordered offenders under capacity-based mental health legislation

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I agree that someone's lack of mental capacity, or their inability to make proper choices, as I would prefer, has an intuitive moral force as a criterion for coercing them to accept care.<sup>2</sup> The authors of "A Model Law Fusing Incapacity and Mental Health Legislation" (henceforth AML) are right also, I think, when they suggest that this moral force is reflected in the law's widespread use of "choice based" criteria to determine when and to what degree a medical patient's stated wishes will be respected. I also agree that bad legislation can contribute to the stigmatization of the mentally ill.

As AML points out, mental health legislation has to incorporate many principles, some of which are in tension with each other. AML uses, as an example, the balance that has to be achieved between maximizing patient autonomy, on the one hand, and ensuring their safety and that of others, on the other. An essential principle in mental health legislation is that mentally disordered offenders need treatment and that the law should seek to ensure that they get it. As would be the case for any law, other principles will need to be respected too; but this one seems crucial. I am not convinced that the need to ensure treatment receives sufficient attention in AML. I also have some concerns over the details of what is proposed.

## Definitions and details

### Definitions of capacity

The Introduction to AML states that the proposals use the "usual" definition of incapacity, one that includes, "the inability to reach a decision that is sufficiently stable for it to be followed". This definition may be usual in other jurisdictions, but it is not the one employed in England and Wales. *The Mental Capacity Act 2005* provides a test with four elements: understanding information, retaining that information, using or weighing information, and communicating a decision. In this respect the Act is consistent with an earlier literature that includes the Law Commission's "Mental Incapacity"<sup>3</sup> and the

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<sup>2</sup> Buchanan A (2002) 'Psychiatric detention and treatment: a suggested criterion'. *Journal of Mental Health Law* 35-41.

<sup>3</sup> Law Commission (1995) *Mental Incapacity*. Law Commission No. 231 HMSO: London.

green and white papers, “Who Decides”<sup>4</sup> and “Making Decisions”.<sup>5</sup>

The difference is important because capacity fluctuates. More specifically, the illnesses that interfere with the ability to make a proper choice do so by virtue of symptoms and signs and those symptoms and signs vary over time, both in nature and intensity. Other legislative approaches to the problems of mental ill health, as the authors point out, make coercion contingent on the presence of “mental disorder” and a “risk of harm”. While these terms carry their own problems of definition, and while “mental disorder” and “risk” each have their quantitative aspects, as currently interpreted they do not seem to fluctuate to the same extent as any legally defined “capacity”. One still has schizophrenia even after one’s symptoms have resolved with treatment. As a result, patients and services can make their plans in the knowledge of what the patient’s legal status is likely to be and some consistency in treatment becomes possible.

By contrast, intuitive moral forces notwithstanding and as one of the authors of AML has pointed out elsewhere,

“Respecting immediately the right to refuse treatment of patients who regain their capacity to consent after initial medication may mean that patients whose capacity fluctuates never receive the sustained treatment that they need.”<sup>6</sup>

The implications of this for capacity-based approaches to mental health law are substantial. The problem is not solved by simply including, “the inability to reach a decision that is sufficiently stable for it to be followed,” in the definition of incapacity because the hard question then becomes what is “sufficiently stable”. In any case, AML is arguing that it is not the stability of the decision that is morally important, but the quality of the process by which the decision is made.

Nor do usual definitions of capacity include the requirement that appears here under clause 3 (1) (c), that in order to have capacity a patient must, not just “understand”, but “appreciate” the information relevant to a decision. The change in wording may have important consequences. The substitution of “appreciate” for “know” probably increased the availability of the insanity defense in the United States.<sup>7</sup> Here, as AML points out, it would restrict the number of people found to have capacity. The change seems also to be a potential source of argument. Those advocating detention will presumably suggest that a patient’s willingness to ignore medical advice is, in and of itself, evidence that they are unable to appreciate fully the implications of their decisions.

### **Details of the proposed provision**

Clause 45 (2) of AML makes provision for those found insane or unfit to plead to be treated compulsorily even when they have capacity. Surprisingly, given the importance that the proposals attach to patient choice, an order to permit this can be made even if the offence is not serious. Clause 45 requires the offence to be punishable by imprisonment, but this would cover a large number of crimes including “threatening behavior” and “failing to answer bail”.

Clause 45 (4) requires that the same patients be released where the order is either a) no longer necessary for the protection of others or b) has become “disproportionate to the seriousness of the offence with

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4 Lord Chancellor’s Department (1997) *Who Decides*. Cm 3803 HMSO: London.

5 Lord Chancellor’s Department (1999) *Making Decisions*. Cm4465 HMSO: London.

6 Dawson J and Kämpf A (2006) ‘Incapacity principles in mental health laws in Europe’. *Psychology, Public Policy and Law* 12, 310-331, at 312

7 American Bar Association (1989) *Criminal Justice Mental Health Standards* American Bar Association: Washington DC, U.S, pp. 321–347.

which P was charged". It is not unusual for someone charged with a minor offence to be regarded, clinically and by courts, as presenting a substantial risk: half of Imprisonment for Public Protection (IPP) sentences have had a tariff of less than 20 months.<sup>8</sup> In such a case the Tribunal will be faced with what amounts to a sentencing decision, deciding what is "proportionate", without having available the information which a court has when it passes a sentence. Where the patient has regained capacity and a Compulsory Treatment Order under clause 34 is, therefore, not available, the Tribunal will have to make this decision in circumstances where only by declaring the order "proportionate" can it protect the public.

Numerically, the most important question is what would happen to the 750 – 800 cases who are admitted annually to hospital under s.37 of the *Mental Health Act 1983* (MHA 1983).<sup>9</sup> The answer seems to be that they would either a) receive a prison sentence and then go to hospital (clause 43 of AML) under arrangements similar to the present "hospital direction" under s.45 A of the MHA 1983 or b) receive a treatment order (under clause 44 of AML) which could be discharged either by the responsible clinician or by the Tribunal. Under an "alternative position", described in the Introduction but not in the draft statute, the convicted mentally disordered could, again, be made subject to a hospital order for a period, "proportionate to the seriousness of their offence" provided that their mental condition had "contributed significantly" to what they did.

Since the "alternative position" is not included in the draft statute I will not dwell on it here. I would note, however, that establishing when a mental disorder does or does not "contribute" to the commission of a criminal offence has occupied U.S. criminal jurisprudence for many years, with little sign of resolution.<sup>10</sup> I would note also that keeping people in hospital, irrespective of their clinical condition, for a period proportionate to the seriousness of an offence is bound to distort clinical care and that many clinicians will be concerned about the ethics of recommending an order that formalizes such an arrangement.

The option of a treatment order that can be discharged by the responsible clinician (clause 44) is unlikely to interest the criminal courts when the offence is a serious one. Simply put, they will worry that the defendant could shortly be back on the street, untreated and unsupervised. This means that for mentally disordered offenders convicted on serious charges the consequences of AML would be similar to the making of a "hospital direction" under current provision. I discuss the implications in the next section.

The model statute makes no provision for people with capacity to receive supervised treatment in the community, as is presently provided for in the *Mental Health Act 1983* by community treatment orders (s. 17A) and orders for the conditional discharge of restricted patients (s. 42(2) & s. 73(2)) A patient who regained capacity would have to be discharged from compulsion. Nor is there provision for increasing the level of scrutiny in serious cases, as happens elsewhere in medicine.<sup>11</sup> At present, Mental Health Tribunals in restricted cases are chaired by Queen's Counsel or a circuit judge as a, "safeguard for the public interest".<sup>12</sup> Clause 48 of AML describes two-level tribunals but the upper level, like the Upper Tribunal created by the *Tribunal, Courts and Enforcement Act 2007*, seems to deal primarily with appeals.

8 'In the Dark. The Mental Health Implications of Imprisonment for Public Protection', Sainsbury Centre for Mental Health, London (2008).

9 Health and Social Care Information Centre (2008) *In-patients Formally Detained in Hospitals under the Mental Health Act 1983 and other Legislation, England: 1997–98 to 2007–08* NHS Information Centre: Leeds.

10 Buchanan A and Zonana H (2009) 'Mental disorder as the cause of a crime'. *International Journal of Law and Psychiatry* 32, 142–146

11 Buchanan A (2004) 'Mental capacity, legal competence and consent to treatment'. *Journal of the Royal Society of Medicine* 97, 415–20.

12 Fennell P (2007), 'Mental Health. The New Law', *Jordans*, p224

## General considerations

### Imprisonment is not treatment

Any mental health law has to choose its “legislative posture” with respect to the criminal law. AML suggests that difficulties will be minimized if mental health legislation adopts some of the principles of criminal justice. The justification offered for allowing the seriousness of the offence to govern how long someone should spend in hospital, for example, is that this would represent, “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.”

IPP sentences under the *Criminal Justice Act 2003* seem to move criminal justice away from this ‘just desserts’ approach to proportionality. But I am not sure that it is necessary to invoke criminal justice principles in any case. With respect to mentally ill people who have committed serious offences, the primary concern of politicians and of the public is the same as the primary concern of clinicians. Sick people should receive the treatment they need and not leave hospital without arrangements to ensure first, that they can continue to receive it and, second, that risk has been addressed. If this does not happen, and someone re-offends, I cannot see that society will be comforted to be told that, at some earlier point, that person had been detained for a proportionate period.

The Butler Committee described what it thought was the correct legislative posture. Where a hospital order is made, the Committee wrote, the patient,

“is being removed from the penal process; it is being decided not to punish him. The possibility of his early discharge must be taken into account by the court. If necessary for the protection of the public a restriction order should also be imposed ... or a prison sentence may be indicated,”<sup>13</sup>

The Committee emphasized also the need for the receiving hospital to agree to whatever order was being made. This is an important and complicated area that would ideally be addressed in any review of forensic provision. It may be that present provision has allowed clinicians inappropriately to “gate-keep”,<sup>14</sup> thereby reducing the number of mentally disordered offenders being admitted.

Two aspects of the Butler Committee’s analysis seem particularly relevant to the suggestions contained in AML. First, as the Mental Health Act Commission has since reiterated,<sup>15</sup> there is value in making a clear distinction between treatment and punishment. The Butler Committee considered whether, in making a hospital order, the sentencing court might, “simultaneously impose a prison sentence as an alternative, to be served if the offender proved unresponsive to treatment or not to need treatment” (at 188). The possibility they were considering was very similar to clause 43 of AML and its “hospital order with a concurrent sentence”. The Committee concluded that: “It seems to us undesirable that the court should not clearly decide, in so important a matter as the loss of a man’s liberty, between a punitive sentence and an order for medical treatment” (at 189). The Committee noted also that it seemed “illogical and inappropriate” to send a patient to prison if he improved with treatment and that the prospect was unlikely to encourage anyone to cooperate.

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13 *Home Office and Department of Health and Social Security (1975) Report of the Committee on Mentally Abnormal Offenders*. Cmnd. 6244 HMSO: London (at 189).

14 Grounds A (2008) ‘The end of faith in forensic psychiatry’. *Criminal Behaviour and Mental Health* 18, 1–13.

15 *Mental Health Act Commission (2006) In Place of Fear. Eleventh Biennial Report 2003 – 2005 The Stationery Office: London*.

Experience of the “hospital direction” under s.45 (A) of the MHA 1983 suggests that these concerns persist. Only 30 such orders were made in the six years to the end of 2008, as against 3,999 orders under s.37 over the same period.<sup>16</sup> Part of the reason for the discrepancy may be unfamiliarity on the part of courts, lawyers and psychiatrists with legislation that is relatively recent. It is also possible that use of s. 45 (A) will increase following its amendment in 2007; hospital directions can now be applied to anyone with a “disorder or disability of mind”, and not just the “psychopathically disordered”. But psychiatrists were concerned at the prospect of such an amendment when the order was introduced,<sup>17</sup> and the change may not affect the number of orders made.

Second, the criminal courts are more likely to allow mentally disordered offenders who have committed serious crimes to go to hospital where those courts are confident that the public is being protected. In over half of the cases where a hospital order was made in 2007–8 the courts chose to add a restriction order.<sup>18</sup> Hospital is not the only alternative open to the courts. Where they do not see any other means of ensuring public safety they can send mentally disordered offenders to prison.

In addition to adopting an appropriate posture towards the criminal law, mental health statutes should foster the ethical practice of medicine. At present, at the sentencing stage of a criminal proceeding a doctor can testify to the clinical needs of the patient, and whether treatment in a hospital is appropriate. The court can then impose a restriction order if it feels that this is necessary to ensure the protection of the public. Lawyers can still ask a psychiatrist whether this would be a good thing, but the distinction in roles, between doctor and court, means that the doctor can answer in clinical terms and the court can reach a legal conclusion.

The situation envisioned by AML is likely to be more difficult for the psychiatrist. If the offence is minor, he or she might reasonably offer treatment on a treatment order under clause 44. If the offence is serious, however, the only option under AML that the court would be likely to accept would be that of the “hospital order with concurrent sentence” under clause 43. The psychiatrist would, presumably, be asked about prognosis and risk. The answers would be used by the court to set the length of the sentence. The psychiatrist would then be in a predicament, the prospect of which may have contributed to the lack of enthusiasm for s.45 A. He or she will effectively be recommending not just a prison sentence, but its length.<sup>19</sup>

### Risk is not exclusively forensic

The commentary to AML states that different principles need to be applied in the forensic field in order to protect the public. The model statute itself reflects this belief, drawing a clear line between forensic patients, in respect of whom “some modification of pure capacity principles may be required”, and other clients of psychiatric services. The modification will apply to four groups: those on remand facing criminal charges, found unfit to plead, found legally “insane” or convicted of a criminal offence. All other patients will require to be released if they regain capacity, irrespective of whether they present a risk to themselves or others.

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16 Health and Social Care Information Centre (2008) *In-patients Formally Detained in Hospitals under the Mental Health Act 1983 and other Legislation, England: 1997–98 to 2007–08* NHS Information Centre: Leeds.

17 Eastman N (1996) ‘Hybrid orders: an analysis of their likely effects on sentencing practice and on forensic psychiatric practice and services’. *Journal of Forensic Psychiatry* 7, 481–494.

18 Health and Social Care Information Centre (2008) *In-patients Formally Detained in Hospitals under the Mental Health Act 1983 and other Legislation, England: 1997–98 to 2007–08* NHS Information Centre: Leeds.

19 Walker N (1996) ‘Hybrid orders’. *Journal of Forensic Psychiatry* 7, 469–472.

Whether this will be acceptable to lawmakers must be open to doubt. From the perspective of a commentary on the forensic aspects of the proposals I would point out only that risk of harm to others is not restricted to forensic populations as defined by AML. Nine percent of the high secure hospital population in England and Wales are detained on non-forensic treatment orders under s.3 of the MHA 1983.<sup>20</sup> For the medium secure population, the figure rises to over 20%.<sup>21</sup> There will be many other “risky” non-forensic patients who will be excluded by these criteria. In London, 10% of detained psychiatric patients appear to have sufficient capacity to make other medical decisions<sup>22</sup> and would presumably require to be released.

Also importantly, a group of psychiatric patients will be made subject to different criteria for coercion for reasons that are unrelated to their clinical condition. This happens to some extent at present, of course: the criteria for a hospital order under s.37 are not identical to those for admission under s.3. But the differences are much more marked under AML. This aspect of the proposals seems to be at odds with the “non-discriminatory” thrust of the Introduction. I am not sure that the problems of stigma, as they apply to psychiatric patients as a whole, can be addressed by hiving off some of those who are seen as presenting a risk to others. And I would be concerned that attempting to do so in the way that is proposed by AML could create an even more stigmatized forensic population.

## Alternatives

These difficulties in fitting forensic provision into an overarching theory need not prevent the application of capacity principles in particular contexts. The Richardson Committee, while advocating an incapacity criterion for compulsion under the MHA, included an exception for those presenting “substantial risk of serious harm”.<sup>23</sup> Other European jurisdictions also apply capacity and other principles simultaneously.<sup>24</sup> In England and Wales, the making of a hospital order, with or without restrictions, on a defendant with capacity could be made to require the defendant’s consent.<sup>25</sup>

The rights of a defendant with capacity would then be respected because he would be able to choose whether or not to accept treatment. Public safety concerns would be respected because the defendant would be making the choice at the sentencing stage of the proceedings when the court could make an alternative disposal, including imprisonment, if the defendant did not want to be admitted to hospital. The law would then need to permit re-sentencing if the convicted defendant subsequently changed his mind. The Butler Committee considered reference back to the sentencing court or to the Court of Appeal where a hospital order had been made but where it subsequently became apparent that the patient did not intend to cooperate. The Committee rejected this course because they thought that the interim hospital order would address the problem. It may not have.<sup>26,27</sup>

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- 20 Harty M, Shaw J, Thomas S, Dolan M, Davies L, Thornicroft G, Carlisle J, Moreno M, Leese M, Appleby L, Jones P (2004) ‘The security, clinical and social needs of patients in high security psychiatric hospital in England’. *Journal of Forensic Psychiatry and Psychology* 15, 208–221.
- 21 Coid J, Kahtan N, Gault S, Cook A and Jarman B (2001) ‘Medium secure forensic psychiatry services. Comparison of seven English health regions’. *British Journal of Psychiatry* 178, 55–61.
- 22 Cairns R, Maddock C, Buchanan A, David A, Hayward P, Richardson G, Szumukler G, Hotopf M. (2005)

‘Prevalence and predictors of mental incapacity in psychiatric in-patients’. *British Journal of Psychiatry* 187, 379–385.

- 23 Department of Health (1999) *Report of the Expert Committee: Review of the Mental Health Act* HMSO: London.
- 24 Dawson J and Kämpf A (2006) ‘Incapacity principles in mental health laws in Europe’. *Psychology, Public Policy and Law* 12, 310–331, at 312
- 25 Buchanan A (2007) ‘Correspondence. Mental health and incapacity legislation’. *British Journal of Psychiatry* 190, 176–177.

Catering for patients changing their minds is more laborious than failing to do so, but it is an inevitable consequence of respecting their choices. If capacity principles are to be introduced into forensic psychiatric practice the issue will have to be addressed more generally. Forensic care can be long-term and involve several changes of service. It is one thing to agree to treatment in one's local regional secure unit but quite another to agree to live in a high-secure hospital. Clinicians are not going to be able to guarantee what lies in store. Some provision for review and reconsideration will be required.

Because compliance is often partial, there would still be cases under such a "hospital order with consent" where the doctor's subsequent decision, that a failure to participate in treatment amounted to withdrawal of that consent, would be seen as declaring the patient "fit for punishment".<sup>28</sup> Such a scheme would also have to overcome objections that s.37 of the Act already provides an efficient way of getting treatment to people who need it, resources permitting. But by making the court-ordered treatment of a defendant who has capacity dependent on that defendant's willingness to accept treatment the scheme would bring care of the mentally disordered more into line with that of patients elsewhere in medicine while addressing some of the additional discrimination that forensic patients seem otherwise likely to suffer under AML's capacity umbrella.

## Conclusion

Two aspects of current provision that are not contained in AML seem particularly important and should be preserved in any new legal framework. First, the MHA 1983 has a clinical emphasis. The Act contains no reference to detention proportionate to the seriousness of an offence, no reference to whether a mental condition contributed significantly to what happened and no requirement that a court pass a sentence that will determine what happens when the patient leaves hospital. Instead, it permits the passing of a hospital order where it is appropriate for the patient to be in a hospital, where treatment is available and where such an order is the most suitable way of dealing with the case. This embodies a level of judicial and medical discretion. Most importantly, it emphasises clinical need.

Second, the MHA 1983 offers an alternative to a court that is considering sending a mentally disordered offender to prison. It offers this alternative while allowing additional steps to be taken to protect the public if the court chooses to send the offender to hospital. These steps include a restriction order that allows judicial scrutiny (but not judicial criteria) at tribunal hearings and recall to hospital if community treatment proves unsafe. They also include an increased level of scrutiny in serious cases. Mental health legislation should encourage courts to permit mentally disordered offenders to receive treatment. By adopting the correct legislative posture, it can do this without compromising the medical principles essential to the proper provision of care.

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26 Mawson D (1983) 'Psychopaths in special hospitals'. *Bulletin of the Royal College of Psychiatrists* 7, 178–181.

27 Grounds A (1987) 'Detention of 'Psychopathic Disorder' patients in special hospitals. *Critical issues*'. *British Journal of Psychiatry* 151, 474–478.

28 Mullen P, Briggs S, Dalton T, Burt M (2000) 'Forensic mental health services in Australia'. *International Journal of Law and Psychiatry* 23, 433–452.