
The mental capacity tribunal under the model law: what are we arguing about?

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The nature of mental health law

It would be a mistake to think of mental health law as a generic form of law directed at a particular class of people, those described as suffering from mental disorders. If a person who has a mental disorder will accept treatment, whether or not they have the capacity to consent to it, there is in general no need to have recourse to mental health law. *The Mental Health Act 1983* ('MHA') exists for the specific purpose of regulating, and ultimately adjudicating upon, the conflict between a person who objects to receiving psychiatric treatment and the professionals on whom the law confers powers of compulsion. But, as advocates of a capacity-based legal framework would surely agree, it is not the existence of mental health law that gives rise to this conflict. That we have a Mental Health Act but not, say, a Dental Health Act is explained by features characteristic of serious mental illnesses which are not, by and large, found in other medical conditions. Psychiatrists are routinely faced with patients who not only deny they are mentally ill, but whose denial can best be understood as an aspect of the illness which, in the doctor's opinion, merits treatment. And as they do not believe they have an illness, or at least not the illness described by the doctor, such patients may well object, sometimes forcefully, to being admitted to hospital for treatment. An analysis of this situation in terms of the patient's lack of capacity to consent to treatment obscures what is emblematic: that the features which lead to a finding of incapacity are at the same time symptoms of the illness which demands treatment. There are, moreover, two matters of wider public concern pertaining to mental disorder which any developed legal system has to accommodate. First, among those with mental disorders there is a significantly increased risk of suicide and self-neglect which arises both from the individual's experience of mental distress, for example severe depression, and from pervasive features of some chronic mental illnesses. Second, for a small minority, there is an association between the presence of the symptoms of a mental illness, such as delusions or hallucinations, and a risk of violence towards others. While these characteristics may not of themselves preclude a capacity-based mental health law, they do at the very least indicate that in the psychiatric field, to a much greater extent than in other areas of medicine, the law has to concern itself with the possibility of a

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conflict between doctor and patient, and to provide for circumstances where the justification for clinical intervention is not limited to the alleviation of the patient's suffering.

If the primary purpose of mental health law is to regulate the conflict between an individual and those who would detain and treat him against his will, the judicial forum in which that conflict is fought out is the tribunal. The territory over which the parties clash is that in which the psychiatrist is a recognised expert, but the justification for compulsion does not lie solely within the domain of medicine.² The matters in dispute may include whether or not the person has a mental disorder, whether hospital admission is necessary, whether treatment is likely to be effective, and the nature of the risks arising from an individual's mental disorder. It may also be in issue whether, regardless of his capacity to consent to it, the person would accept some or all of the proposed treatment if not subject to compulsion, thus obviating the need for MHA powers. At the heart of the conflict is an individual's assertion of his right to make his own choices as an autonomous being, regardless of the views of professionals about his mental capacity or what they consider to be in his best interests, against those who would seek to justify taking away his liberty and subjecting him to unwanted medical treatment. A comparison of traditional mental health law and any proposed capacity-based model needs to consider which legal framework is best suited to regulating this conflict. In relation to the role of the mental health tribunal the questions to be considered are those affecting the adjudication of the claims of the disputing parties, specifically whether the tribunal is satisfied that the patient's condition is sufficiently serious to warrant loss of liberty and compulsory treatment.

The tribunal's role under the *Mental Health Act 1983*

Case law (both domestic and European) offers a multiplicity of judicial statements about what tribunals do under the current law. First, the tribunal carries out a substantive and independent review of the patient's condition at the time of the hearing:

"[The tribunal is] a *body charged with reviewing the operative decisions of the responsible authorities to detain the patient, and its functions are to reappraise the patient's condition at the time of the hearing and in the light of its findings to do one of three things – to direct discharge as of right, to direct discharge in the exercise of its discretion, or to do neither.*"³

Second, the review requires the tribunal to look into the future and to assess the risks should the patient cease to be detained:

"*The question that then has to be asked is whether the nature of that illness is such as to make it appropriate for him to be liable to be detained in hospital for medical treatment. Whether it is appropriate or not will depend upon an assessment of the probability that he will relapse in the near future if he were free in the community.*"⁴

Third, if it is to uphold a patient's detention the tribunal must be satisfied that this is a proportionate response to the risks, bearing in mind also the impact on the patient of deprivation of liberty:

2 "Why should a doctor decide on the level of risk that is acceptable to an individual, or to a group? Medical training does not enable one to answer a question of this type, and it could never do so, because it is not that sort of question." Anthony Maden *Treating Violence* (OUP 2007) page 70. See also, for example, the judgment in *R (on the application of Warren) v Mental Health Review Tribunal (London and North East Region)* [2002] EWHC 811 (Admin) where, at paragraph 16, Jack Beatson QC

referred to "the diagnostic question of whether there is a mental disorder and the policy question of whether it is safe to discharge".

3 *R v Canons Park Mental Health Review Tribunal ex parte A* [1994] 1 All ER 481, at 490, per Sedley J.

4 *R v London and South West Region Mental Health Review Tribunal Ex p. Moyle* [1999] MHLR 195, at para 36, per Latham J.

*“The appropriate response should depend upon the result of weighing the interests of the patient against those of the public having regard to the particular facts. Continued detention can be justified if, but only if, it is a proportionate response having regard to the risks that would be involved in discharge.”*⁵

Proportionality also requires the tribunal to satisfy itself that the risks could not be managed in a less restrictive way:

*“The detention of an individual is such a serious measure that it is only justified where other, less severe measures have been considered and found to be insufficient to safeguard the individual or public interest which might require the person concerned to be detained.”*⁶

Fourth, in considering the impact on the patient of a deprivation of liberty, the tribunal must also take account of the treatment which it enables:

*“Thus the MHA provides for an integral package of detention and treatment and imposes restrictions designed to ensure that individual treatment is justified. It is not logical to consider the latter question in isolation from the overall objective of the package. The most important question is whether the package is justified, and that is a question that falls within the remit of the Mental Health Review Tribunal under Part V of the MHA.”*⁷

But medical treatment in this context is not always benign, or at least may not be regarded as such by its recipient. A relevant factor for the tribunal may be the impact on the patient’s human rights of medical treatment given without consent. The most important consideration here is whether the patient objects to the treatment:

*“when considering the severity of the treatment the fact that it is imposed by compulsion is more significant than the question whether the patient has or has not capacity.”*⁸

A capacity-based legal framework

If judicial statements are an accurate guide to the role of the tribunal under the MHA, there is no comparable source for understanding how tribunals would function under the Model Law which is proposed. The criteria which the tribunal would have to apply in deciding whether to uphold the treatment of a person’s mental disorder without his consent, which might also include detention in hospital for the purpose of treatment, are to be found in clause 21(a) of the Model Law. The tribunal would have to be satisfied of the following:

- (1) *P has an impairment or dysfunction of the mind.*
- (2) *P lacks capacity to make a decision about his or her care or treatment.*
- (3) *P needs care and treatment in his or her best interests.*
- (4) *P objects to the decision or act that is proposed in relation to his or her care or treatment ...*
- (5) *The proposed objective cannot be achieved in an alternative less restrictive fashion.*

5 *R (on the application of H) v Mental Health Review Tribunal, North and North East London Region [2001] EWCA Civ 415, at para 33, per Lord Phillips MR.*

6 *Litwa v Poland (2001) 33 EHRR 53, at para 78.*

7 *R (on the application of B) v Dr SS (Responsible Medical Officer), Second Opinion Appointed Doctor and the Secretary of State for Health [2006] EWCA Civ 28, at para 47, per Lord Phillips CJ.*

8 *Ibid, at para 50.*

(6) Treatment is available that is likely to alleviate or prevent a deterioration in P's condition.

(7) The exercise of compulsory powers is a necessary and proportionate response to the risk of harm posed to P or any other person, and to the seriousness of that harm, if the care or treatment is not provided.

Clause 21 (b) says that: "If any of these conditions are no longer met P shall be discharged from compulsory powers."

Apart from the most obvious difference, that the patient's mental capacity forms part of the criteria for compulsion, two other points stand out. First, the Model Law, unlike the MHA, does not link compulsory treatment to the requirement that the patient be detained, or liable to be detained, in a hospital. This is not, however, of fundamental importance because compulsion in the community is neither a necessary feature of a capacity-based law nor is it incompatible with traditional mental health law. Second, clause 21 of the Model Law goes beyond a bare best interests test for authorising treatment given to a person who lacks capacity to consent. It requires the tribunal, when the patient objects to admission or treatment, to consider a wider range of matters such as risk to other people and proportionality.

On further inspection, clause 21 of the Model Law can be seen to bear some resemblance to section 6 of the *Mental Capacity Act 2005* ('MCA') which requires, in relation to a person who lacks capacity to consent, that where restraint is used it is not enough that it is in the person's best interests, it must also be a proportionate response to the likelihood and seriousness of that person suffering harm. However, it should be noted that clause 21 takes us still further beyond a best interests standard to something which reflects features of traditional mental health law, including the power to compel the patient to accept treatment (which could include detention in hospital) for the protection of others. This is quite different from section 6 of the MCA which authorises restraint only where it is necessary for the incapacitated person's own safety. It is also somewhat disconcerting, although consistent with a concern for the protection of other people, that in relation to medical treatment that satisfies the criteria in clause 21 the Model Law abrogates a fundamental feature of a capacity-based framework by allowing what would otherwise be a valid and applicable advance refusal of treatment to be overridden.⁹ It seems that the proponents of reform do not envisage a radically different role for mental health law but they appear to believe that by changing the legal framework they will get rid of what they regard as a form of discrimination against people who suffer from mental disorders. The contrary view is that the inclusion of non-consensual psychiatric treatment would cause any capacity-based statute to burst at the seams.

How a capacity-based law would change what tribunals do

Returning to the role of the tribunal, its function under any system of law is to adjudicate between the person subject to compulsion and those who would use the law to compel treatment. Two aspects of the tribunal process under a reformed law would be critical to all parties. First, whether it will be more difficult (or easier) to compel treatment against a person's wishes; and second, whether the law provides a clear framework in which the matters that are important to the parties will be given due weight by the tribunal in balancing the competing claims on which it has to adjudicate. A third consideration is that

⁹ This is stated in the authors' paper: "So long as 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." It is not, however, incorporated into the Model Law, clauses 53 and 54 of which make no reference to advance decisions being overridden in these circumstances. Neither the paper nor the Model Law says whether the decision of a person's substitute decision maker (SDM) could be overridden where the clause 21 criteria are satisfied.

where compulsory treatment involves deprivation of liberty there needs to be a speedy hearing to determine the lawfulness of the patient's detention.¹⁰

With regard to the first aspect, advocates of a capacity-based law do not argue that current mental health law, which they consider to be discriminatory, results in a greater use of powers of compulsion than is necessary or that the incidence of non-consensual treatment of those diagnosed as suffering from mental disorders could be expected to fall under their preferred legal framework. Their proposal does not proceed from a criticism of psychiatric power and certainly not from an anti-psychiatry stance. Their unstated assumption is that much the same people in much the same circumstances would be subject to compulsory psychiatric treatment. What would change are the formal legal grounds which tribunals and mental health professionals invoke when justifying their decisions.

As to the decision-making framework, tribunals under the MHA are required to consider the seriousness of the patient's mental disorder ("of a nature or degree which makes it appropriate for him to be liable to be detained") and the risks to which it gives rise ("necessary for the health or safety of the patient or for the protection of other persons").¹¹ Judicial decisions of tribunals about detention and compulsion are necessarily expressed in these terms, the so-called statutory criteria, but in any particular case the decision maker has a broad discretion which in reality is little constrained by the language of the statute. The decision whether to impose compulsion on a person because he has a mental disorder requires a consideration of a variety of factors. These may include: "his state of health, his need for continuing treatment, his ability to take care of himself in the community and the threat that he might pose to the public, the availability of facilities in the community to give him any necessary care, treatment or supervision, and the support he would receive from family and friends"¹² – all matters on which a person with a mental disorder is likely to have his own views, just like anyone else. The tribunal hearing is the occasion when, in theory at least, such views are to be taken seriously. One matter which may be of particular concern is whether the person who seeks to be discharged from MHA powers can be relied upon to do what he says. This is a distinct issue from the question whether he has capacity to consent to the proposed treatment and it requires the tribunal to consider different kinds of evidence, such as the individual's past history of psychiatric treatment. A decision to override the patient's autonomy is by its nature paternalistic but its foundation is that the tribunal concludes that the risks associated with the patient's mental disorder are sufficiently serious to justify compulsion. The experience of tribunals under the current law is that this exercise can be conducted without an assessment of the person's capacity to consent to any or all of the proposed treatment.

The breadth of the discretion and the wide range of potentially relevant factors make it especially important that the framework within which competing views are weighed and adjudicated upon encompasses how the various participants think about the issues in dispute. Traditional mental health law is clearly directed towards matters of substance which despite the opacity of the statutory language can be readily understood by the participants, including the person subject to compulsion. That the current law fits with psychiatric thinking and practice is hardly surprising, but it also reflects how people with no medical training intuitively think about these issues. This can be seen when friends and relatives of a detained patient give evidence at a tribunal hearing. The way in which they express their views generally

10 This is required by Article 5(4) of the European Convention on Human Rights.

11 In describing the legal test under the MHA I have deliberately omitted the appropriate treatment criterion ("that appropriate medical treatment is available for him") which was introduced by the Mental Health Act 2007.

12 Taken from: 'Mental Health: Tribunal Procedure', Gostin and Fennell Longman, 2nd edition., 1992 page 4.

accords with the current legal framework, though not necessarily with the findings of the tribunal in any given case. That the law is directed to what professionals and lay people regard as relevant and important is the best guarantee, together with an effective and fair procedure, that people will not be unnecessarily – and therefore unlawfully – detained.

In contrast to the current law, a capacity-based statute would have as its starting point the question of capacity. The mental capacity tribunal would of necessity have to decide in every case whether or not P, who objects to receiving treatment, has capacity to consent to it. Having disposed of the issue of capacity, and if the finding is that P lacks capacity, the tribunal would under clause 21 then determine whether P is entitled to refuse that to which he objects. It does this with reference to the following test: that it is in P's best interests and the objective cannot be achieved in a less restrictive fashion, and that the use of compulsion is both necessary and proportionate.¹³ A question that should concern us is as to P's input into this process.

Deciding whether P has capacity

A fundamental criticism that can be made of a law which allows compulsory psychiatric treatment only where the patient lacks capacity to consent is that a tribunal hearing is not the best setting in which to assess an individual's mental capacity. It will no doubt be pointed out that courts, in a wide variety of situations, are used to deciding whether someone has, or had, mental capacity to make a particular decision. However, where the issue of capacity is linked to non-consensual psychiatric treatment, it is not difficult to envisage cases in which the person subject to compulsion, knowing the law, will answer questions about their understanding of their illness with the legal test for capacity in mind. In such a case the tribunal may see its inquisitorial function as requiring it, through questioning the patient, to demonstrate to its own satisfaction his lack of capacity. As one has sometimes seen at tribunal hearings under the present law, something similar can happen when questions are directed towards exposing the patient's lack of insight into his condition. But while mental capacity is a binary concept – a person either does, or does not, have the capacity to make this decision at this time – insight is a matter of degree. Moreover, a finding that the patient's insight is impaired does not form part of the foundational criteria for compulsory treatment, though it may be relevant to an assessment of the likelihood that the patient would accept treatment if he were free to decide for himself, a question that can be answered without reference to the concept of mental capacity. The MCA rightly demands that findings of incapacity are made only after every practicable step has been taken to enable the person concerned to make the decision for himself. It is difficult to see how this could readily be achieved in a tribunal hearing. If the hearing was not considered to be a suitable occasion for assessing the patient's capacity, tribunals would instead have to rely on expert evidence. In most cases this would come from the treating clinician who will have been in a position to carry out a capacity assessment in circumstances sanctioned by the MCA. Where, however, the patient disputed the treating clinician's account of the interview at which capacity was assessed, or claimed that the position has changed since that interview, the tribunal would, unavoidably, have to make its own assessment of capacity. That a task could prove difficult is not, of course, a reason for its not being attempted, but it is a ground for questioning its utility.

¹³ I have omitted the treatment criterion, "that the treatment is likely to alleviate or prevent a deterioration in the patient's condition". Although this is different from the MHA appropriate treatment criterion (see footnote 11 above) either formulation is compatible with either traditional mental health law or a capacity-based law.

Deciding what is in P's best interests

Having dealt with the issue of capacity, and assuming it finds that the patient lacks capacity to consent to the treatment, the tribunal would then have to decide whether the treatment, possibly involving deprivation of liberty, is in the patient's best interests. The answer will be found by applying the principles of section 4 of the MCA and going through the items that are listed there. These include P's "past and present wishes and feelings" and "the beliefs and values that would be likely to influence his decision if he had capacity". Put simply, P's own views are among the factors the decision maker weighs in coming to a conclusion on what is in his best interests. Given that clause 21 of the Model Law is concerned only with cases where P is objecting to treatment, one must allow that among P's views is likely to be a strong wish not to have things done to him against his will.¹⁴ This takes us back, by a different route, to the essential point in mental health law which is the justification for imposing compulsion on a person who has a mental disorder. If this is indeed the fundamental issue, we might wish to ask which route we prefer and how P is most likely to be able effectively to participate in the process. Although the distinction is blurred by the breadth of a best interests inquiry under section 4 of the MCA, there is an essential difference between a rights-based approach (people have rights which in certain circumstances society is entitled to override) and a paternalistic approach (P lacks capacity to make this decision so we must make it in P's best interests, taking account of P's wishes and feelings).

A related concern is how the change to a mental capacity and 'best interests' jurisdiction would affect the work of tribunals. That tribunals under the present law are able to get through the current volume of cases without breaching the detained patient's right to a speedy hearing is due to the narrowness of the inquiry. A typical tribunal hearing, with oral evidence, lasts about two hours. Experience of the High Court's former inherent jurisdiction and of the Court of Protection's jurisdiction under the MCA is that cases take many weeks, if not months, and that the Court depends heavily on expert evidence in its determination of both capacity and best interests. While it is true that in every case involving compulsory psychiatric treatment there is, in the person of the responsible clinician, a suitably qualified expert readily to hand, the responsible clinician is not a court-appointed expert but comes to the tribunal on behalf of a party to the proceedings to put forward evidence which is intended to show that the criteria for compulsion are made out. Given the different nature of the tribunal's inquiry under a capacity-based law, where the patient's capacity and best interests are in issue, the question arises whether the tribunal would routinely need independent expert evidence on these matters. If independent expert evidence were not available, one wonders how the tribunal would satisfy itself of the matters comprehended by section 4 of the MCA.

The problem of paternalism

Seen from the point of view of a person who is diagnosed as suffering from mental disorder, there is one potential advantage of a capacity-based law which needs to be faced. A person who has capacity will be entitled to refuse psychiatric treatment, just as he can refuse all other types of medical treatment, regardless of the views of professionals or members of mental health tribunals about the likely consequences of a refusal. It could be argued by its proponents that if a change to a capacity-based mental health law were to bring this about for only a small number of people it would be a vindication of their

¹⁴ This point was articulated by Judge Marshall QC, sitting as a nominated judge of the Court of Protection, in *Re S and S (Protected Persons)*, cases 11475121 and 11475138, Judgment given on 25th November 2008. The judge said that "having his views and wishes taken into account and respected is a very significant aspect of P's best interests". The converse of this is "the sense of frustration, impotence, anger and lack of self-worth" that P might experience in having his expressed wishes overruled.

position. The tribunal would perform the necessary and important role of making principled decisions about capacity, unsullied by pragmatic concerns about risk. To put the case for a capacity-based law in this way, with its appeal to principle over pragmatism, would be disingenuous because it avoids what is fundamentally at stake in any system of law for compelling people with mental disorders to accept treatment. The subject matter of mental health law necessarily gives rise to questions about whether, either generally or in particular cases, we are detaining people unnecessarily or for excessive periods of time, and whether clinical arguments in favour of treatment provide justification for denying personal autonomy to the individual concerned. The elevation of mental capacity would do nothing to enhance the judicial consideration of these and related issues which, as we have seen, are at the heart of decision-making under the existing law.

One matter that should concern us when considering any proposal for reform is the tendency in the field of mental health law towards benign paternalism: the wish to do what is best for a person who is disadvantaged. This is compounded by an understandable aversion to taking risks with other people's health and safety, including risks that we ourselves might be willing to bear where our own health is concerned. If, as seems likely, the vast majority of those who are detainable under the MHA could be expected at the point of detention to fail a capacity test in relation to treatment of their mental disorder, a best interests approach would inevitably tend towards increased paternalism which in this field means less, not more, liberty. While, as we have seen, mental health law must necessarily allow a broad discretion, the application of legal standards which direct the decision-maker to what is essential in balancing risks and rights is a necessary discipline for us all.