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# The Response



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# Response to the Commentaries

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We are immensely grateful to the commentators for their careful reading of the Model ‘Fusion’ Law (ML). The level of support for our proposal from most of the commentators is encouraging as is the news that Northern Ireland intends to introduce legislation along similar lines. The aim of the ML is to eliminate the unwarranted discrimination against people with mental disorder that is inherent in current mental health legislation in England and Wales and in many other jurisdictions. We remain convinced that the principles underlying the enterprise are right and that they can be translated into a practical form. At the same time, excellent points have been raised by the commentators that have stimulated us to think further and to propose a number of revisions.

The editors have invited us to respond briefly to the commentaries. We should have liked to engage with each of the commentators on a number of specific issues, but in our response we must focus on the major themes that have emerged.

## **1 Difficulties in applying capacity criteria in mental disorder**

It has been questioned whether capacity criteria can be readily or reliably applied, especially in three sets of circumstances:

### **In emergencies**

It is argued that making an assessment that someone suffers from a mental disorder and presents a significant risk to themselves or others fits well with common understandings of ‘mental disorder’. Would capacity criteria be a practicable replacement? Our response is that one learns to apply the criteria that one is required to apply. In an emergency situation, the model law requires that the assessor determine whether there is a reasonable likelihood that the person lacks capacity (so that particular interventions might then follow). This assessment will often turn on whether a person behaving in an abnormal manner is able to give a coherent account of their reasons for doing so, whether they believe mental disturbance may be a cause (and why) and what kind of intervention (if any) might be appropriate. There is no reason to believe that this assessment is any more difficult than one that determines the person has a ‘mental disorder’ (with its ill-defined boundaries). Indeed one might claim that the assessment of capacity is focussed more precisely on what is of most interest when someone is acting strangely – what account could they give that would explain it?

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### Where there is a commonly held intuition that an intervention is justified but where capacity may not be judged to be impaired.

One type of situation that is cited concerns persons at risk of serious self-harm, perhaps presenting a risk of suicide in response to a major adverse event such as a rejection in love. A second situation is where there is a serious risk as a consequence of a disorder, but where a 'cognitive' bias in the criteria for capacity might lead to the conclusion that it is retained.

The former type of situation is likely to involve an acute disturbance. Similar risks to the safety of a person or to others may arise from intoxication, or from a loss of control due to rage. This type of case could be handled through a general law of justified intervention in an emergency situation where serious harm may befall a person (as under the common law when there is an imminent risk of harm to others). The intervention would not be based on whether a mental disorder is present or not, but on the need to prevent imminent serious harm. The allowed emergency intervention might involve taking the person to a 'place of safety' so that a further evaluation could take place.

The second kind of situation raises the question of what should be tested in a capacity assessment. It has been argued that the conventional type of assessment may not pay adequate regard to emotional influences and questions of 'value'.<sup>4</sup> We agree there is still work to be done on the meaning and assessment of capacity. Hence we propose that an 'appreciation' criterion be added to the definition (as in the Scottish Code of Practice on the *Adults with Incapacity (Scotland) Act 2000*). This would point to a need to examine the influence of 'pathological values'. Despite any current limitations, an assessment of capacity is not necessarily less reliable than that currently required in assessing whether the criteria for a compulsory order are met. Indeed the research evidence shows that high inter-rater reliability can be achieved for patients with psychoses and other disorders resulting in inpatient psychiatric care.<sup>5</sup>

### Fluctuating capacity

Some commentators hold that fluctuating capacity in 'mental disorders' may make capacity-based legislation problematic. In a series of studies of capacity in psychiatric patients recently admitted to hospital in which GS was an investigator this did not emerge as a significant observation.<sup>6,7,8</sup> Psychoses, unless caused by an acute, organic disturbance of brain function such as delirium, due to drug toxicity or withdrawal, do not fluctuate – recovery is generally progressive. Fluctuation of conscious level, even over the course of a day, is a well recognised clinical feature in acute disturbances of brain function and can be taken into account in determining when capacity is stably restored. An issue might arise in relation to the psychoses as to how long a period of restoration of capacity would be required before it could be judged 'stable'. One would not usually be thinking here in terms of hours, but of days or weeks, depending on the trajectory of recovery. This would involve the same kind of thinking as determining under the

4 Tam DJ, Hope PT, Stewart DA, & Fitzpatrick PR (2006), 'Competence to make treatment decisions in anorexia nervosa: thinking processes and values.', *Philosophy, Psychiatry and Psychology*, 13 (4), 267–82.

5 Cairns R, Maddock C, Buchanan A, David AS, Hayward P, Richardson G. et al. (2005), 'Reliability of mental capacity assessments in psychiatric in-patients.' *British Journal of Psychiatry*, 187 372–78.

6 Owen GS, Richardson G, David AS, Szukler G, Hayward P, & Hotojff M (2008a). 'Mental capacity to make decisions on treatment in people admitted to

psychiatric hospitals: cross sectional study'. *British Medical Journal*, 337, a448.

7 Owen GS, David AS, Richardson G, Szukler G, Hayward P, & Hotojff M (2008). 'Mental capacity, diagnosis and insight in psychiatric in-patients: a cross-sectional study'. *Psychological Medicine*, 21, 1–10.

8 Owen GS, Szukler G, Richardson G, David AS, Hayward P, Rucker J et al. (2009). 'Mental capacity and psychiatric in-patients: implications for the new mental health law in England and Wales'. *British Journal of Psychiatry*, 195(3), 257–263.

current MHA how long a person should no longer present an apparent risk to their health or safety for it to be judged that such a risk no longer exists.

## The ‘exceptionalism’ of mental disorder

Two major points have been raised questioning the applicability or value of capacity-based law in respect of mental disorder.

### 1 The associated risk of violence

Appelbaum, Buchanan and Gledhill suggest that the association of mental disorder with violence makes mental illness not comparable to physical illness. We address a number of points in the section below when we deal with specific forensic issues, but at this stage we wish to draw attention to a more general point.

Dangerousness is not a necessary condition of having a mental illness. It may be a consequence in a small minority of patients having a mental illness. The risk in the absence of alcohol or substance misuse, or of an antisocial personality, is modestly, if at all, raised – indeed two recent population-based studies have shown no increase in violence by people with a psychosis, in the absence of drug misuse or personality disorder.<sup>9,10</sup> We must avoid the damaging stereotype of mental illness as somehow necessarily entailing a risk to others. Dangerousness does not put those with a mental illness in a different place to other patients as Appelbaum maintains – it is an uncommon association.

### 2 Beneficence may be a higher value than autonomy

This claim is most strongly stated by Burns, but the idea is present in a muted form in some of the other commentaries. For example, both Gledhill and Buchanan state that since prison is a very non-therapeutic environment for persons with a mental disorder, they should be in a hospital, even if they have capacity and choose prison over hospital.

We cannot accept this proposition. It reinforces the stereotype of the person with mental illness being incapable of normal agency and is inconsistent with the respect for autonomy shown to all other patients in medical practice. A large measure of clinician discretion is introduced, as evidenced in the huge variability in rates of involuntary admissions across Europe (up to 30-fold), and changes in their rates over time (up 70% in England and Wales in the decade after 1995, down 40% in Sweden over the same period).<sup>11</sup> Doctors acting ‘beneficently’ in the past have subjected patients to damaging treatments – lobotomy, insulin coma therapy, removal of organs for ‘focal sepsis’. We cannot see why persons who are capable of making decisions for themselves should be denied that privilege. They are the best judges of what is in their best interests.

It should also be noted that the ‘best interests’ determination, engaged when capacity is absent, is primarily concerned with beneficence. In the ML as in the MCA it is an important advance on the notion that best interests should be based on what the doctor considers to be in the patient’s best interests. The decision-maker must take account of the medical, psychological and welfare aspects of an intervention.

9 Coid J, Yang M, Roberts A, Ullrich S, Moran P, Bebbington P et al. (2006), ‘Violence and psychiatric morbidity in a national household population – a report from the British Household Survey.’ *American Journal of Epidemiology*, 164 (12), 1199–208.

10 Elbogen, EB and SC Johnson (2009), ‘The intricate link between violence and mental disorder: results from the

*National Epidemiologic Survey on Alcohol and Related Conditions.*, *Archives of General Psychiatry*, 66 (2), 152–61.

11 Dressing, H and HJ Salize (2004), ‘Compulsory admission of mentally ill patients in European Union Member States.’, *Social Psychiatry and Psychiatric Epidemiology*, 39 (10), 797–803.

We consider that the two kinds of appeal to the ‘exceptionalism’ of mental disorder outlined above rest on negative stereotypes of the mentally ill – that they are dangerous and that they are not worthy of the respect we accord to full persons.

But perhaps whether mental illness is ‘different’ in principle to physical illness may not be the fundamental issue in relation to capacity. We need to see autonomy in a broader context. People in our society are given a right to self-determination, whether it relates to what can or cannot be done to their bodies, whether they can make a contract, whether they can make a will, and so on. The significance of what is a ‘mental disorder’ thus recedes in importance. The question is whether there is an impairment or disturbance in the functioning of mind and whether it renders the person incapable of acting autonomously.

Remember also that people with mental illness and physical illness are treated within the same health system, from the same budget, administered by the same department of health, and treated by the same professionals with the same codes of practice, ethical standards and regulatory bodies. The assessment of capacity is a skill that all doctors must have, and that they must exercise under the MCA. That patients with a mental disorder should be subject to a different set of rules when it comes to making decisions about their health is thus difficult to support.

We note also that in marked contrast to those supporting a stronger role for beneficence, Robinson presents a strongly negative view of the ‘paternalism’ it entails. He highlights the centrality of a loss of liberty that an involuntary treatment order imposes, and sees the Tribunal for example, as regulating a “conflict” between patient and clinician. Such opposite poles of opinion are difficult to reconcile, but we believe that capacity-based law offers the best solution.

## Forensic implications

A set of criticisms of the ML relate to our contention that conventional mental health law is discriminatory; to what are seen as inadequate protections of other people from dangerous persons with mental disorders; and to the implications of our exceptions in relation to fitness to plead (FP) and not guilty by reason of insanity (NGRI)

## Mental health legislation and discrimination

Gledhill argues that the ECHR permits the preventive detention of persons with a mental disorder as long as it is proportional to the risk. He argues that there is no discrimination against those with mental disorder. He points out another group of patients can also be lawfully detained if presenting a risk to others – those with infectious diseases.

Indeed there is legislation permitting the detention of persons with infectious disease (though used less than 10 times per annum in England).<sup>12</sup> We agree it is not discriminatory. This is because there is no category of persons within the population of those who present a risk to others by virtue of their infectiousness who are singled out for detention. All persons who present an equal risk due to their infectiousness are equally likely to be detained. There is no law that authorises detention only of a category of those who are infectious, for example those who are drug dependent or who are homeless. This is quite different to the situation in respect of people who present a danger to others by virtue of their potential for violence. Consider a population of people in the community who have reached a

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<sup>12</sup> Coker RJ (2001), ‘National survey of detention and TB.’, *Thorax*, 56(10) (10), 818.

particular threshold of risk of violence to others. Of this population it is only those with a mental disorder – not, for example, those who are habitually aggressive when drunk or who regularly assault their partners – who are subject to preventive detention (under the MHA), even when no offence has been committed. It is the unequal treatment of people who are equally ‘risky’ that constitutes the discrimination (and contrasts with the treatment of all people who are equally infectious).

Gledhill also argues that a preventive intervention for dangerous people with a mental disorder is not discriminatory because it is appropriate to allow autonomy to be restricted (proportionately) when someone presents a risk to others. However, he fails to use the right comparator. For a person with a mental disorder who has capacity and who presents a significant risk to others, the right comparator is a person who presents the same level of risk but who does not have a mental disorder (and presumably has capacity). If preventive interventions are restricted only to those who have a mental disorder, this is discriminatory.

We have argued elsewhere that non-discrimination in relation to risk of violence to others can only be ensured through generic dangerousness legislation, in which the level of risk determines that an intervention is required, rather than the category of person.<sup>13</sup> Two key questions can be asked in relation to risk, and it is the order in which they are asked that is crucial. The non-discriminatory order is: 1. Does this person’s behaviour pose an unacceptable risk to others; if so, then 2. If the risk is unacceptable, how should this be managed? This might be a mental health disposal if there a mental disorder and other criteria are met. The current order of the questions, that is – 1. Is there a mental disorder?; then 2. If so, is there an unacceptable risk to others? – is discriminatory.

A number of preventive sentence options have now been introduced into English law. These are sentences of life imprisonment, indeterminate ‘imprisonment for public protection’ and ‘extended sentences’ available for those convicted of specified categories of serious offence and who are deemed to pose a risk. There are thus means for protecting the public (in England at least) which are not discriminatory. We do not necessarily support preventive detention of this type, but at least it offers the possibility of non-discriminatory detention.

### **Protections from dangerous people with a mental disorder:**

Concern is expressed that there is no equivalent within the ML of a hospital order buttressed by a ‘restriction’ order to ensure that the person is supervised and treated as long as is necessary. This kind of medical disposal is seen as beneficent as it removes the ill person from the criminal justice system. It is claimed that ML shifts the locus, or at least the conceptual focus, too much in the direction of the criminal justice system.

Under the ML if a person has been convicted of a serious offence there are two major options:

1. a compulsory treatment order under the healthcare system, with no long-term option of a restriction order
2. a sentence, the duration of which is determined by the seriousness of the offence – not by the psychiatric assessment as claimed by Buchanan – with the option of:
  - a. involuntary hospital treatment for the person who lacks capacity until he or she regains it, when they might continue as a voluntary patient, or if they decide against treatment, a transfer to prison for the rest of the sentence; or

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13 Szukler G and F Holloway (1998), ‘Mental health legislation is now a harmful anachronism’, *Psychiatric Bulletin*, 22 662–65.

b. if the person has capacity but has a mental disorder which might benefit from treatment, voluntary treatment with consent.

These are the options under the ML. But that does not mean that a dangerous person with a mental disorder will be discharged with no further ado (apart from a likely referral to community mental health services). Under option 2, the sentence might be a life sentence or one of the extended sentences mentioned above. If so, the person will subsequently be under some form of supervision in the community following discharge: for example, on a licence for life following release from prison on a sentence of life imprisonment. Assuming that supervision does not compel treatment as one of its conditions, at the very least the person with capacity who might be a risk to others will be regularly monitored and appropriate action taken if there is a relapse of illness (this could be involuntary treatment if the conditions in Clause 21 are met) or a return to the court, and then perhaps prison. In effect this is a restriction order – but one which is non-discriminatory as it is applicable to all offenders with capacity, whether or not they have a mental disorder. Buchanan's objection that this form of restriction order uses the non-therapeutic framework of the criminal justice system must be set against the fact that restriction orders under the MHA are significantly under the control of the Ministry of Justice (MoJ), Mental Health Unit, which some would say in effect operates a form of tariff system, the order's duration being determined by the nature of the offence. The patient can appeal to a First-tier Tribunal (Health, Education and Social Care Chamber) (Mental Health), where the MoJ probably will present an argument for continuing the order. Thus the therapeutic framework may not be as therapeutic as appears at first sight, while its indeterminacy for persons with capacity is, we maintain, not justifiable.

The person with capacity, convicted of an offence, may of course agree to treatment in order to be released under supervision. Failure to comply with the treatment within the finite period of the sentence would result in recall to the court. This then becomes similar to Buchanan's proposal that a person may voluntarily submit to a kind of restriction order, but under the healthcare system. Under the ML the sentence is finite; it is not clear whether in Buchanan's proposal it would be finite or indeterminate.

A problem that might arise concerns the weight that might be given in the assessment of risk by the court to the mental disorder *per se*. It may be that the court will rate the risk as higher because the person has a mental disorder according to the stereotype of the mentally disordered as necessarily dangerous. This would need to be countered.

### **Fitness to Plead and Not Guilty by Reason of Insanity**

These are the two exceptions to the governing role of capacity in the ML in which we allow involuntary treatment of people with capacity under certain conditions. However, rather than representing a flaw in the fabric of the ML as Appelbaum implies, we believe that it is almost inevitable that at some points of intersection, the different perspectives on human conduct from healthcare and criminal justice viewpoints will not allow tidy reconciliation. The problem resides just as much with the criminal law as health law.

The main problem that arises currently concerns the person with mental disorder, who is deemed dangerous, and who has capacity and who therefore cannot be subject under the ML to an involuntary order – but who, at the same time cannot also be under a sentence under the criminal justice system (because not convicted), even if found to have committed a serious offence on a trial of the facts. Under English law a Supervision Order can now be made, possibly with a condition of treatment or a requirement to see a psychiatrist, but it is non-punitive and our understanding is that there is no sanction



for non-compliance. Our exception is there until this problem can be resolved. But we expect this to be rarely necessary – unless reform of FP greatly expands the numbers of people who are found to be unfit to plead yet to have treatment decision-making capacity.

The problem with NGRI is similar. How does one deal with a person who was ‘insane’ at the time of the offence, but now has capacity, refuses treatment, but is deemed dangerous. Again a Supervision Order with uncertain powers can be made. And again this occurrence is likely to be rare.

If some kind of enforceable supervision order for FP and NGRI (which however, did not allow involuntary treatment) could be created under a ‘third way’, there would be no need to retain the ML exceptions.

### **Implications for tribunals**

Robinson poses the important question of how the ML would affect the proceedings of tribunals. Matters currently considered by Tribunals are relatively well understood by all parties, and these would necessarily change.

Robinson is right that capacity would need to be established prior to any further considerations. Whether this will involve a more complex and longer determination is not clear. We do not see why the nature of the evidence relating to this would be qualitatively different to the evaluation of evidence currently considered by tribunals – whether there is a mental disorder, whether it represents a sufficient risk to the health or safety of the patient, or to others, etc. The idea of capacity has a long history in the law and we do not see why ordinary people should find the idea difficult to understand. Everyone believes they have a basic right, within limits, to self-determination. Insight is a closely related concept and tribunals regularly discuss it. Whether patients knowing the law will be able to ‘feign’ capacity is unknown, but we assume that sufficient evidence will be placed before the tribunal by the clinical team to allow this to be tested. Similarly the consideration of best interests is unlikely to be qualitatively different to the current discussions about the value of treatment, risks, the influence of social support and so on. There will be differences in content and emphasis, but we do not see why they should not be able to be determined as readily as matters are determined currently. Even if they should turn out to be more complex, they are, as we have argued from an ethical standpoint, the right questions, and it will be necessary for tribunals to learn how best to deal with them.

### **Advance statements**

There has been a misunderstanding by some of the commentators of our intention in saying that advance decisions may be overridden “when treatment without the consent of the person is *expressly authorised* by the Act”. There are only two circumstances in which such treatment is *authorised* without consent – in relation to fitness to plead and NGRI.

### **The burden imposed by the ML on informal patients and those on general hospital wards**

Holland and Appelbaum argue that the ML imposes a set of burdensome regulations governing informal patients who lack capacity, especially those on general hospital wards, some of whom will now require an involuntary treatment order. As a result we have rethought these matters and propose some amendments.

We remain convinced that the ML recognises the relevant domains that should be covered for all patients, wherever they are treated, and establishes the right principles. However, we agree that in the real world

there are resource limitations that unfortunately need to be taken into account. The challenge is to formulate a law that is practicable so that all cases with impaired capacity can be covered by the principles.

The domains covered in Parts III, IV and V can be governed by variations in requirements for a range of elements – second opinions, consultation with a range of others, advocacy, reviews, appeals and time intervals for their implementation. We believe that a combination of these requirements can be found that will be applicable across the whole range of services. A ‘lighter touch’ can be adopted at many points in the ML. A relevant moderating contextual factor to be considered is the accreditation and inspection of health and social care institutions and our confidence in these procedures.

In most places the ML has followed the MCA and we do not wish to reopen a debate about its provisions, established after a long period of consultation and generally welcomed.

Our proposed amendments<sup>14</sup> are influenced by the following:

1. The scope of the ‘General Authority’ (clause 6) is of central importance; for example, it could cover all routine interventions (including intravenous fluids and mineral replacement – and perhaps standard antibiotic regimes), blood transfusion, emergency treatments, and restraint of patients when there is an immediate risk to their health or safety.
2. What comprises ‘serious medical treatment’ can be specified in regulations following further debate.
3. Protection for those in long-term care homes could be dropped as a statutory requirement in favour of ‘good practice’ and accreditation and inspection of homes.
4. ‘Deprivation of Liberty’ safeguards are at present only required in countries under the jurisdiction of the ECHR. But, despite difficulties in defining loss of liberty, we believe there is a strong case for establishing safeguards for non-objecting persons without capacity who are not free to leave an institution. Our amendments to Part IV of the ML propose a lighter touch, especially during the first 28 days.
5. Involuntary treatment: The boundary with the General Authority is hugely important. A clear and consistent objection to treatment outside routine care would lead to the initiation of involuntary treatment. Our amendments to Part V of the ML make significant changes. In the original version of the ML we accepted the general structure of recommendations and tribunals as in the MHA, first established in 1959. However, mental health practice has changed substantially over the ensuing five decades. Patients are no longer confined for long periods, hidden, in large mental hospitals. Practice is more open to scrutiny and is now largely in the community. Our amendments propose a lighter touch in keeping with such changes, and which would make the application of involuntary treatment feasible in general hospitals. Thought might be given to a less than ‘three-person’ tribunal to authorise an order (but retained for appeals).

We also note the comments of Atkinson and Patrick who draw attention to the often neglected position of patients with learning disabilities. We fear that these patients are sometimes incorrectly regarded as having capacity in order to avoid the uncertainties around the use of force that would be necessary in providing medical or surgical interventions.

In conclusion, we see the ML as a beginning. We aimed to show that practical expression could be given to the concept of a single statute governing the treatment of all persons who lack decision-making capacity, wherever they are treated or cared for. Whilst many details remain to be resolved, we believe we have succeeded in our aim.

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14 The proposed amendments are presented in an Addendum at the end of the Model Law