An Overview

The role of capacity in mental health laws – recent reviews and legislation

Kris Gledhill[1]

The context in which the Szmukler et al proposal is put forward is the several reviews in the different jurisdictions in the United Kingdom and in Ireland, which have led to capacity becoming a central feature in relation to civil detention in Scotland and in Ireland, and which may well lead to it becoming a central feature in Northern Ireland, though efforts to achieve the same in England and Wales were rejected.

For forensic patients, however, capacity is not prominent, and the proposal made goes further than recent legislative amendments and debates have contemplated. These are set out in the order in which they occurred: the Richardson Committee review of the English statute, then the amendments in Scotland, followed by those in Ireland (which pre-dated those in Scotland but came into effect later); next was the action that was eventually taken in relation to the English statute, and finally there are the proposals as to what to do in Northern Ireland. The latter is the only one that comes close to the proposals of Szmukler and others, which they acknowledge in their paper.

(i) The Richardson Committee

The first review was that by the Expert Committee appointed to advise the Secretary of State for Health on the *Mental Health Act 1983* for England and Wales (also known as the Richardson Committee), which reported in November 1999[2]. It suggested, in a chapter on underlying principles[3], that treatment for mental ill-health should be governed by principles similar to those relevant to physical ill-health, where patients with capacity decide whether or not to accept treatment: providing similar respect for autonomy in the mental health field was necessary to avoid discrimination on the basis of mental disorder. The logic of this would be that only those without capacity could be compelled to accept treatment. However, a consultation exercise carried out by the Committee revealed that only a small minority of respondents suggested that capacity to make decisions should be the only test: the larger body of opinion favoured overriding decisions to refuse treatment by those with capacity when to do so was necessary for public

1 *Barrister; Senior Lecturer, Law School, University of Auckland; Editor, Mental Health Law Reports.*

2 *Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009576 (last accessed 29 August 2009)*

3 *Chapter 2*

safety. The Committee supported this approach[4], and so suggested that the criteria for an order for compulsory treatment[5] be phrased so that it could be met in alternative circumstances: either when the patient was without capacity and compulsory care and treatment was necessary for his or her health or safety, or to protect the patient from serious exploitation, or to protect others from serious harm; or, if the patient had capacity, when there was a substantial risk of serious harm to other persons , or possibly to the health or safety of the patient or to the safety of other persons if the patient was untreated[6].

In relation to patients involved in the criminal justice system, the Committee noted[7] that it had made little progress in deciding the extent to which principles applicable to civil patients should be adjusted when carried across to those in the criminal justice system. This was largely for pragmatic reasons: the complexity of the panoply of existing regimes, and the lack of internal coherence; the uncertainty of government policy in relation to those with severe personality disorders[8]; and the lack of time available to it to consider the issues involved or to discuss them with the government department most involved, the Home Office[9]. The Committee did, nevertheless, make several recommendations, including that offenders who lacked capacity and met the criteria for a compulsory order should be dealt with primarily according to their health needs[10], that transfers be used when offenders met the civil criteria[11], and that the criminal courts should be able to make a health order if the offender met the criteria for a civil order and lacked capacity[12]. The Committee did not conclude that those who retained capacity should be excluded from treatment, noting that "to leave in prison offenders who could benefit from treatment would not be productive of public safety"[13]; however, there was the contrary point that hospitals and health professionals "should not be required to detain offenders who are persistently unwilling to engage in treatment or who are untreatable"[14]. The belief the Committee expressed was that mentally disordered offenders who retained capacity would probably be personality disordered and subject to a mental health order only if there was the possibility of benefit to the patient: since this would invariably depend on

4 *Para 2.7. The Committee noted that there was a "more intractable dilemma", namely what to do when the harm involved is not to others but to the patient; the consultation process did not produce any consensus on this. Arguments as to whether to intervene to prevent self-harm or to respect autonomous choices to self-harm "reflect a difference in fundamental philosophy which can only be resolved by according preference to one approach over the other. We have set out the alternative views as best we can and invite politicians to make the moral choice between them" (para 2.11).*

5 *This was in the civil setting; it would be a judicial order, made by a Tribunal.*

6 *Paras 5.94 and 5.95. There were other criteria for the compulsory order: the presence of a mental disorder of such seriousness as to require care and treatment under specialist services; the proposed care and treatment be the least restrictive alternative and be in the patient's best interests; treatment be available that was likely to prevent a deterioration or secure an improvement.*

7 *Chapter 15*

8 *A consultation paper, 'Managing Dangerous People with Severe Personality Disorder', was issued by the Department of Health and the Home Office, in July 1999 (just days after the Richardson Committee report was delivered to the Department of Health); available at http://www.homeoffice.gov.uk/documents/cons-1999-personality-disorder (last accessed 29 August 2009)*

9 *This was before the reorganisation of central government that saw the creation of the Ministry of Justice, which took some of the Home Office's functions in relation to mental health matters.*

10 *Para 15.9. They also suggested at para 15.15 that those with a learning disability should be placed under the framework for those with long-term capacity problems that was being developed (and became the Mental Capacity Act 2005); courts should be able to make an appropriate order under the incapacity framework instead of imposing a criminal sentence.*

11 *Para 15.16: the Committee noted that offenders could not be denied appropriate healthcare without discrimination; in Ch 16, the Committee recommended that, since the poor quality of mental health services in prisons meant that compulsory treatment in prison was inappropriate, arrangements should be in place whereby prisoners could be transferred to hospital for an assessment of their needs and whether there should be a formal transfer to hospital.*

12 *Para 15.13.*

13 *Para 15.14.*

14 *Para 15.11.*

cooperation, it could be tested by the greater use of interim orders[15]. The Committee supported the retention of the Restriction Order regime[16], which was described as "an essential safeguard" in the identification of "high risk cases": however, it should rest on a special risk assessment so that those dealing with the offender subsequently could know the basis for its imposition[17].

It was some time before new legislation was forthcoming for England and Wales: it did not incorporate capacity principles and is discussed below: a more speedy process was followed in Scotland, which did put capacity as a central feature, but only on relation to civil detention.

(ii) The MacLean Committee and the Millan Committee

The Scottish Executive also established a review of its legislation, the *Mental Health (Scotland) Act 1984*, by the Millan Committee, which was appointed in February 1999 and reported in January 2001[18]. There was also the MacLean Committee, more officially the Committee on Serious Violent and Sexual Offenders, which reported in June 2000[19]; its recommendations were subject to comment by the Millan Committee. The MacLean Committee had concluded that the range of sentences available to the criminal courts in Scotland was suitable except in relation to a small number of offenders who posed a high and continuing risk to the public, for whom there should be a new sentence, the Order for Lifelong Restriction[20]. It felt that a small number of such offenders might have a mental disorder[21] as well, most likely a complex combination of forms of disorder, and suggested that such offenders should receive an OLR together with a hospital direction: this would mean that they would be detained in the high secure setting of the State Hospital and could be transferred to prison if treatment was no longer appropriate[22].

The Millan Committee believed that capacity should be a central component of the process for authorising civil detention on the ground of mental disorder: its formulation was to require that the judgment of the patient be significantly impaired as a result of mental disorder[23]. It also gave

15 *Para 15.14. Naturally, a penal sentence could be imposed in the event of non-cooperation.*

16 *Para 15.17.*

17 *The Committee also suggested that the role of the Secretary of State be replaced by an extended role for the Tribunal to approve leave and transfer decisions, since it was more appropriate that such important decisions be taken by a judicial body rather than by central government as they were essential precursors to release and so relevant to the human rights standard that release should be governed by a judicial body: paras 15.19ff. The Secretary of State would be a party to the Tribunal. The Committee also recommended that the conditional discharge regime be continued, though this would be to provide for recall to hospital since the Committee recommended that the effect of a detention order would be to allow in-patient or out-patient treatment and so there would be no need for a conditional discharge for that purpose: paras 15.24ff.*

18 *New Directions, SE/2001/56.*

19 *SE/2000/68*

20 *Chapters 5 and 6; this would be available if the offender had committed a violent or sexual offence or another offense showing a propensity to such offending, and there were reasonable grounds for believing that there was a substantial and continuing risk to the public (which would require a formal risk assessment) such as to require such an order.*

21 *Defined in the Mental Health (Scotland) Act 1984 as amended by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 as 'mental illness (including personality disorder) or mental handicap however caused or manifested'. The replacement for the 1984 Act, the Mental Health (Care and Treatment) (Scotland) Act 2003, maintained a similar definition: s328 provides that "(1) … "mental disorder" means any – (a) mental illness; (b) personality disorder; or (c) learning disability, however caused or manifested …" This followed the recommendations if the Millan Committee, see ch 4 of New Directions.*

22 *Chapter 7*

23 *Chapter 5, paras 40ff. At para 41, it noted "We propose that it should not be possible for a compulsory intervention to be made under mental health law unless there is evidence that the person's judgment is significantly impaired, as a result of mental disorder, so as to justify the intervention. This expresses a broadly similar concept to incapacity, but is felt to be a less legalistic formulation, and one which may be easier to apply in practice. It may also be a term which is easier for service users to accept than the term 'incapable'."*

consideration to the question of the approach to be taken in relation to offenders with mental disorder[24], concluded that protecting the public from risk was a proper legislative object and identified the need for a framework that provided for "the range of legislative needs, including … protection of the public from those who may pose a risk to others"[25], but it recommended that the criteria for detention through the criminal process should be the same as for civil detention[26].

In relation to high risk offenders, the Millan Committee agreed with the MacLean Committee that some such offenders would have complex disorders, but also set out its view that others might have an untreated mental illness and would not pose a high risk after appropriate treatment, and so could be dealt with by way of the existing hospital order regime without any need for anything such as an OLR[27]. As had been the view of the Richardson Committee, the Millan Committee was content for the Restriction Order regime to continue[28]. It was also able to give brief consideration[29] to those who were unfit to stand trial because of their mental disorder – 'insanity in bar of trial'[30] – and found to have committed the actus reus of the charge[31]; and also those found fit to stand trial but to have been insane at the time of the offence and so not guilty by reason of insanity[32]. Such findings allowed the court to impose an appropriate order for either hospital or community care. The Committee noted that various practical problems had arisen, namely a lack of fit between the legal questions posed and the clinical understanding of these constructs, and delays in dealing with the cases in court because of difficulties in arranging the necessary medical evidence in a timely fashion. Their main conclusion was that the whole area, and the question of diminished responsibility as a partial defence to murder, should be subject to a full review by the Scottish Law Commission[33].

24 *The statutory regime then in place in Scotland had the power to impose mental health disposals in one statute (the Criminal Procedure (Scotland) Act 1995, whereas the effects of the disposals were set out in the Mental Health (Scotland) Act 1984. The Committee noted that some people saw advantages to this, both from the point of view of having a comprehensive code for the criminal justice system, which might also encourage an integrated response to mentally disordered offenders from the system which tends to have to deal with them, namely the criminal justice system. However, their view was that it was better to have all provisions relating to mental disorder in one statute: ch 24.*

25 *Chapter 2, para 22.*

26 *Chapter 26, para 15. The Committee had been concerned about facilities in prisons and had concluded that compulsory treatment in a prison setting would not be right: ch 26, paras 59ff. This led it to reject the idea of having the conditions of a community treatment order relating to treatment continuing to have effect in prison. The Committee did also note that the more important question in the criminal context might well be ensuring access to treatment: at para 1 of ch 26, the Committee noted that there were some problems in relation to the availability of facilities, particularly for young people and female offenders with self-harming behaviour.*

27 *Chapter 27, para 9.*

28 *Chapter 27, paras 15ff discuss the Restriction Order: there is no suggestion that they be abolished. The Committee suggested that the discharge of such patients – who at that time could appeal to the Sheriff (s63 of the 1984 Act) or be discharged by the Scottish Ministers – become a matter for the Parole Board (sitting as the Restricted Patients Review Board): ch 27, paras 41ff; though it also suggested that the Mental Health Tribunal it proposed in relation to civil patients should also have jurisdiction over restricted patients: ch 27, para 49.*

29 *Chapter 29*

30 *The test – set out in MH Advocate v Wilson 1942 JC 75 – involves a mental disorder preventing the giving of instructions or following the evidence; English law has a similar test, in R v Pritchard (1836) 7 C&P 303.*

31 *This process is carried out pursuant to the Criminal Procedure (Scotland) Act 1995; there is a similar process in England and Wales, introduced by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991.*

32 *The test in Scotland is whether mental disorder prevented a defendant from controlling his conduct: HM Advocate v Kidd 1960 JC 61. This is wider than the M'Naghten Rules (based on M'Naghten's Case (1843) 10 Cl&F 200) applicable in England and Wales, which require that the defendant's delusions cause him not to know the nature or quality of the act or that it was unlawful.*

33 *This was done: the Scottish Law Commission issued a Discussion Paper in January 2003 and its Report in July 2004 (SE/2004/92), which proposed that there be a defence of lack of criminal responsibility if mental disorder means that the person cannot appreciate the nature or wrongfulness of conduct (but excluding from this a personality disorder characterised by abnormally aggressive or seriously irresponsible conduct); and that a person be unfit for trial if a mental or physical disorder means that effective participation is not possible.*

One additional feature of the regime, which had recently proved controversial, had to be considered, the need to be satisfied as to the "treatability" of patients with personality disorders[34]. An order for discharge in a highly-publicised case where there was felt to be an ongoing risk to the public but the treatability requirement was not met[35] led to the *Mental Health (Public Safety and Appeals) (Scotland) Act 1999*, which required the detention of a restricted patient who did not meet the treatability test if detention was necessary to protect the public from serious harm[36]. The Millan Committee suggested that this test be removed, since the hospital system should be used only for those who could be treated: this approach allows the hospital system to be used where protecting the public coincides with the treatment of mental disorder, but protecting the public in other situations is a matter for the criminal justice system[37].

(iii) *The Mental Health (Care and Treatment) (Scotland) Act 2003*

The Scottish Parliament, which had been the first UK legislature to put in place a comprehensive framework in relation to adults without capacity – the *Adults with Incapacity (Scotland) Act 2000* – soon enacted legislation based to a significant extent on the recommendations of the Millan Committee. The *Mental Health (Care and Treatment) (Scotland) Act 2003* – the main provisions of which were brought into effect in October 2005[38] – made long term compulsion in the civil setting dependent on the making of a Compulsory Treatment Order by the new Mental Health Tribunal[39]: the test for this order, which can be on an in-patient or out-patient basis, is set out in s64 and requires various findings, including that the patient's mental disorder leads to a significant impairment in the making of decisions about treatment and that treatment is necessary to avoid a significant risk to the patient or other others[40]. In other words, the Scottish Parliament has engaged with the principles that (i) capacity should be central, which means that those who retain the ability to make true decisions cannot be compelled, at least not in the civil setting; a decision is not a true one under the statutory test if there is a significant impairment to decision-making caused by the disorder; and (ii) danger posed to others is also a basis for intervention in the civil setting, but not as an alternative to the impaired capacity test, which has to be met in any event.

In the criminal justice setting, however, the changes introduced were less radical and did not go as far as the Millan Committee had recommended. Parts 8 and following of the 2003 Act provide for orders that can be made by the criminal courts, by adding sections to the Criminal Procedure (Scotland) Act 1995[41].

34 *Section 17 of the 1984 Act; there was an equivalent requirement in ss3 and 37 of the English Act of 1983.*

35 *See Ruddle v Secretary of State for Scotland [1999] Mental Health Law Reports 159. This led to an inquiry for the Scottish Parliament conducted by the Mental Welfare Commission for Scotland: see Report of the Inquiry into the Care and Treatment of Noel Ruddle, available at http://www.scottish.parliament.uk/business/bills/billsPassed/rudr-01.htm (last accessed 29 August 2009)*

36 *This was upheld, subsequently to the Millan Report, in a challenge in the European Court of Human Rights: Reid v UK [2003] Mental Health Law Reports 226, the Court rejecting a suggestion that detention was only possible if the disorder was treatable.*

37 *Chapter 28, para 18ff:*

38 *See Scottish Statutory Instrument 2005 No 161, The Mental Health (Care and Treatment) (Scotland) Act 2003 (Commencement No 4) Order 2005*

39 *Sections 57ff; only the new Mental Health Tribunal can make the order.*

40 *A short-term detention certificate may be made under s44 if an approved medical practitioner (s22 – a medical practitioner having suitable expertise) certifies the likelihood of, inter alia, mental disorder (ie mental illness, personality disorder or learning disability: s328), significant impairment of ability to make decisions as to medical treatment and significant risk to the health, safety or welfare of the patient or to the safety of others in the absence of treatment.*

41 *The Millan Committee's recommendation that the criteria for the making of criminal orders be part of the same legislation as the civil regime was not followed.*

The main order that can be made after conviction, the Compulsion Order, differs from a civil order in that there is no requirement that the defendant have any impaired capacity: what is needed [42] is that there is mental disorder, that treatment for the disorder is available, that the absence of treatment would result in a significant risk to the health, safety or welfare of the offender or the safety of another, and that the order is necessary. Of course, in determining whether an order is "necessary", a relevant factor might be whether or not the defendant has the capacity to make treatment decisions, since its absence might be a factor in favour of making the order. The Millan Committee's view that the criteria for a hospital order should be the same as those for a civil order, noted above, was rejected by the Scottish Executive, which stated in the Policy Memorandum accompanying the Bill that became the 2003 Act[43]:

> "191. The civil criteria are designed to ensure that a patient is only placed under compulsion and deprived of their liberty when there are grounds for over-ruling the patient's autonomy. The forensic criteria are directed at ensuring that a court disposal and any continuing compulsion are appropriate, given all the circumstances of the offender's mental disorder and offence. We believe this difference is justified in the context of criminal disposals, where the alternative to a mental health order may be prison. The aim is to place the emphasis on the patient's need for appropriate care and treatment rather than on a person's willingness to accept the care and treatment. The intention is also that the criteria should not preclude voluntary transfer of prisoners to hospital under the Bill, when that is the most appropriate course of action.

The proposal to remove the effect of the *Mental Health (Public Safety and Appeals) (Scotland) Act 1999* was also rejected: the legislation had by then been upheld by the Privy Council (and subsequently was upheld by the European Court of Human Rights)[44].

(iv) *The Mental Health Act 2001 and Criminal Law (Insanity) Act 2006 – Ireland*[45]

In response to an admissibility decision in the European Court of Human Rights challenging the absence of an effective court review of detention[46], the Oireachtas in Ireland passed the *Mental Health Act 2001*, which came into effect in 2006[47]. The Act's definition of "mental disorder"[48], which is the key to the use of compulsion, requires "mental illness, severe dementia or significant intellectual disability" which (a) causes " … a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons", or (b) is of a degree such that "the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that

42 *Section 133 of the 2003 Act, inserting s57A into the 1995 Act. The order can be renewed by a Tribunal after 6 months if the criteria still apply, and then for 12 months at a time: see s139ff of the 2003 Act.*

43 *Mental Health (Scotland) Bill (SP Bill 64), 16 September 2002, Policy Memorandum, available at http://www.scottish.parliament.uk/business/bills/billsnotInProgress/index.htm#64 (last accessed 29 August 2009)*

44 *See Policy Memorandum paras 181ff; the case law is Anderson, Docherty and Reid v Scottish Ministers [2001] Mental Health Law Reports 192 and Reid v UK [2003] Mental Health Law Reports 226.*

45 *For a more comprehensive account of the Irish legislation, see Prof Anselm Eldergill's two-part article, 'The Best is the Enemy of the Good: The Mental Health Act 2001', Journal of Mental Health Law, May 2008, pp21–37, and Spring 2009, pp7–18.*

46 *Croke v Ireland [1999] Mental Health Law Reports 118; the friendly settlement of the case, on 21 December 2000, involved its withdrawal on the basis that what was then the Mental Health Bill 1999 would pass into law. There had been previous proposed Bills, but they had not progressed.*

47 *The Mental Health Act 2001 (Commencement) Order 2006, SI No 411 of 2006 brought the act into force from 1 November 2006.*

48 *Section 3 of the Act.*

could be given only by such admission", and admission would be beneficial[49]. Again, the legislature involved has placed lack of capacity as a central feature in the justification for detention, whilst also making harm to others an important matter. The 2001 Act does not have any provisions relating to orders made by the criminal courts in relation to mentally disordered offenders, though it does provide that a Tribunal must authorise the transfer of a civil patient to the secure Central Hospital (s21(2)).

Further legislation was passed to deal with the criminal justice sector, the *Criminal Law (Insanity) Act 2006*. This statute deals with fitness to stand trial, findings of not guilty by reason of insanity and also transfers of prisoners to hospital. Section 4, which sets the test for fitness to stand trial, allows an order for treatment in a designated centre[50], but this requires a finding of "mental disorder" as defined in the 2001 Act; s5, relating to findings of insanity, is similar[51]. In relation to the transfer of prisoners – sentenced or remand prisoners[52] – the provisions are, however, somewhat different[53]: the first relevant question is whether the prisoner has a "mental disorder for which he or she cannot be afforded appropriate care or treatment within the prison"; transfer is then possible if the prisoner "voluntarily consents" or if two or more doctors certify that the transfer should occur because the treatment cannot be provided. That allows the transfer to be effectuated "notwithstanding that the prisoner is unwilling or unable to voluntarily consent to the transfer". In summary, a patient found unfit to stand trial or not guilty by reason of insanity is treated as though he or she were a civil patient, with impaired judgment being a basis for detention; but a serving prisoner requires either agreement to transfer or two medical opinions in the absence of capacity or agreement if the prisoner has capacity.

(v) *The Mental Health Act 2007*

By the time, then, that the Westminster Parliament came to decide on the reform to the *Mental Health Act 1983* for England and Wales, it had an expert committee recommendation on making capacity central, and further expert reports and models of legislation from other parts of the UK and from Ireland that suggested the importance in modern legislation of capacity. In addition, the Westminster Parliament had also put in place a framework to regulate the approach to adults with limited or no capacity, the *Mental Capacity Act 2005*, though not in relation to those placed under the Mental Health Act 1983[54]. There was a significant time period between the Richardson Committee's recommendations and the *Mental Health Act 2007*, which was marked by a number of false starts towards legislation[55], but a

49 *In MR v Sligo Mental Health Services [2007] IEHC 73, 2 March 2007, O'Neill J commented that the language of the statute provides two bases for detention, but that "they are not alternative to each other" and that they are likely to overlap. It is difficult to know precisely what His Honour means, namely whether or not both of the two bases have to be met on the facts.*

50 *This includes the Central Mental Hospital; other "psychiatric centres" may be designated (s3 of the Act), and s13 indicates that they might well be prisons.*

51 *It requires "mental disorder", but does not tie it to mental disorder for the purposes of the 2001 Act; s1 of 2006 act provides that ""mental disorder" includes mental illness, mental disability, dementia or any disease of the mind but does not include intoxication"; the mental disorder has to be "such that the accused person ought not to be held responsible for the act alleged by reason of the fact that he or she – (i) did not know the nature and quality of the act, or (ii) did not know that what he or she was doing was wrong, or (iii) was unable to refrain from committing the act". However, the disposal on such a finding may involve compulsory treatment if there is a finding of mental disorder as defined in the 2001 Act.*

52 *Defined in s1 of the Act*

53 *See s15 of the Act.*

54 *Section 28 of the 2005 Act effectively gives priority to the provisions in the 1983 Act relating to treatment.*

55 *There was a Green Paper (Cmnd 4480, November 1999), a White Paper Cm 5016-I, December 2000), a Draft Bill 2002 (Cm 5538-I) and a further Draft Bill of 2004 (Cm 6305-I), which was subject to pre-legislative scrutiny by the Joint Committee on the Mental Health Bill (Session 2004–5, HL Paper 79-I, HC 95-I), to which the government responded (Cm 6624, July 2005); eventually, the Mental Health Bill 2006 was introduced to the House of Lords in November 2006 (HL Bill 1, Session 2006–7).*

consistent line from the Government was that capacity would not be made part of the test for detention and efforts to make it part of the test were rebuffed. Rather, the emphasis was on public safety or preventing self-harm. A few extracts from the lengthy process leading to reform give a flavour of the approach adopted.

The Green Paper of November 1999 that was published along with the Richardson Committee report called for views to be expressed on the recommendation that capacity be made central to the test for detention: but the Green Paper indicated[56] that

> "The principal concern about this approach is that it introduces a notion of capacity, which, in practice, may not be relevant to the final decision on whether a patient should be made subject to a compulsory order. It is the *degree of risk* that patients with mental disorder pose, to themselves or others, that is crucial to this decision. In the presence of such risk, questions of capacity – while still relevant to the plan of care and treatment – may be largely irrelevant to the question of whether or not a compulsory order should be made."

When the Draft Bill of 2004 was subject to pre-legislative scrutiny, the Joint Committee of both Houses of Parliament recommended the adoption of the Scottish Parliament's approach of including impaired capacity as a precondition for detention[57]. The Government position had been set out to the Joint Committee, the reasons for objecting to capacity as a central component being[58]:

– it would not prevent harm to patients and others;

– professionals would have a very flexible approach to the test in order to ensure that people were treated;

– people with fluctuating capacity would receive inconsistent treatment and have periods of relapse and recovery;

– it would be impossible to treat under compulsion many people with personality disorders.

However, the Joint Committee felt that these difficulties could be overcome in practice and did not justify the position adopted by the Government[59]: put shortly

> – it was a necessary addition to ensure that the legislation covered only psychiatric conditions, in light of the very broad definition of mental disorder[60], namely "an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain"; since this could cover many physical and neurological disorders[61]; the use of an impaired capacity test would answer concerns about the breadth of the proposed new regime;

56 *Page 32, ch 5, para 6*

57 *Para 71 of its report; it heard submissions and evidence, printed as HL Paper 79-II and HC 95-II for Session 2004–5.*

58 *Paragraph 152.*

59 *Paragraphs 153–156.*

60 *Clause 2.5 of the Draft Bill, a definition that was supported by the Joint Committee but on the basis that it would be accompanied by a set of exclusions – as to substance misuse, sexual orientation and cultural and political beliefs and behaviours – that the Government was not proposing should be included. See paragraphs 87–114.*

61 *At para 88, the Joint Committee noted of the extended definition of mental disorder that "Many experts told the Committee that the proposed definition would result in people suffering from a wide range of physical conditions not covered by the current Act being brought within the ambit of the new Bill. It was suggested that those with epilepsy, people who have suffered traumatic brain damage, and those suffering from neurological disorders such as multiple sclerosis, Parkinson's disease or metabolic disorders would be covered by the new definition because of the psychological and behavioural symptoms of their conditions.*

– it would approximate the test for best interests in what became the Mental Capacity Act 2005, and reduce the emphasis on risk (since the test for capacity takes into account the consequences of the decision) whilst allowing intervention without a discriminatory regime that makes a special case of mentally-ill people;

– it was inconsistent to ignore capacity and autonomy in relation to the criteria for detention but make it central in relation to other areas, such as ECT[62] or psychosurgery[63].

The Government issued a formal response to the Joint Committee's Report[64], and rejected most of its recommendations, including those in relation to the impaired capacity test, noting "it is not safe to assume that there is a link between the severity of a condition – and therefore the need for treatment – and the person's ability to make decisions"[65].

When a Bill was finally introduced into Parliament in 2006, the House of Lords did add a clause making it a precondition for civil detention (either for assessment under s2 or treatment under s3 of the 1983 Act) that "because of his mental disorder, his ability to make decisions about the provision of medical treatment is significantly impaired"[66]. The central arguments in favour that featured in the debate were: (i) decision-making capacity was central in relation to other forms of medical treatment, and should be central in relation to mental health because there was no great contrast in terms of ability to participate[67]; it was part of good professional practice in any event, including in mental health work, was part of the test as to detention in Scotland (where it did not seem to be causing a problem), and in the English legislation was already relevant in relation to decisions about medication beyond three months and ECT[68] and psychosurgery[69]; (ii) allowing people to retain some decision-making capacity about their treatment would make them more likely to present themselves; and for those placed in the mental health system, there would be more compliance because the loss of the ability to make decisions was a source of frustration and could lead to non-compliance and a position of opposition to the clinicians who were viewed as having an "upper hand" in a relationship and not taking the views of patients seriously; in other words, it would promote confidence in the system by users[70], which would raise the prospects of it being successful; (iii) assessment of capacity was to become a matter required on a daily basis with the introduction of the *Mental Capacity Act 2005*, and making it a necessary focus for mental health clinicians would enable them to identify patients who did not recognise their own illness, who might present the most serious risk.

62 *Clause 179 of the Draft Bill indicated that ECT would require the consent of an adult patient with capacity. This became law: see s27 Mental Health Act 2007, adding s58A Mental Health Act 1983.*

63 *See s57 Mental Health Act 1983.*

64 *July 2005, Department of Health, Cm 6624*

65 *Page 16.*

66 *Moved and adopted at the Committee Stage: HL Hansard, 10 January 2007, Vol 688, col 228ff. Specifically referred to in the debate was a study conducted by Prof Szmuckler that indicated that 85% of those assessed just after admission under compulsory powers at The Maudsley Hospital in London did not have capacity, and so a higher proportion would meet the lower test of impaired decision-making: col 235.*

67 *Baroness Barker, who moved the relevant amendment stated at col 230 "In mental health, as in all other aspects of healthcare, there is a growing recognition that the involvement and compliance of patients in their treatment, and in maintaining their treatment regimes, rests on their ability to be part of the decision-making about it."*

68 *Section 58 of the 1983 Act required consent from a patient with capacity or the authority of a second opinion doctor.*

69 *Section 57 of the 1983 Act required consent from a patient with capacity and the authority of a second opinion doctor.*

70 *Baroness Murphy, who made some points in favour of this proposition noted that this might in particular be of assistance to populations that were statistically overrepresented in the system, in particular black communities: see col 236.*

The only opposition to this amendment in the debate came from the Government minister in charge of taking the Bill through the House of Lords, Lord Hunt[71], who commented that "[t]he primary purpose of the legislation is to protect people from the harm that may be caused by mental disorder" and as such was to be contrasted with the Mental Capacity Act 2005, which was designed "to provide a way of intervening where people cannot make their own decisions". The question of compulsion turned on "the needs of patients and the risk that their disorder poses to themselves and to others, not their decision-making ability" and an impaired decision-making test "could result in some patients going untreated and thereby harming themselves or others"[72]; this – leaving people to harm themselves or commit a crime they would not otherwise commit – was not something that promoted autonomy, whereas treating people so that they could recover from serious mental disorder would allow them better to operate autonomously. He restated the previously-indicated position that medical professionals would misreport impaired capacity in order to ensure treatment, and that the test would cause the premature discharge of patients who regained their capacity before their treatment was complete and who would then have to be discharged to deteriorate again. Moreover, he did not accept that reluctant patients would be more likely to comply if the pre-conditions for compulsion included an impaired decision-making clause. The Government majority in the House of Commons reversed the impaired capacity clause inserted by the House of Lords: this was done at the Committee stage of the Bill. Though the issue took up one and a half of the 12 sittings of the Committee, the arguments were along the same lines as those presented in the Lords, with one side emphasising risk and the other emphasising autonomy and the need to avoid discrimination as between physical and mental illness. The vote was along party lines[73].

Accordingly, the question of capacity is not relevant to the test for detention under the civil provisions for England and Wales, except in an indirect fashion: the White Paper of December 2000, for example, noted that the question of whether the nature and degree of the disorder required detention would include consideration of the question of the patient's capacity to make relevant decisions[74]. With no apparent realisation as to the juxtaposition, capacity was however central in another element of the new regime. Consent to treatment for a 16–18 year old could be given by his or her parents. The White Paper suggested that, in part because of "the increasing recognition of the capacity of a developing young person to take decisions", it should be made clear that the absence of consent from that group would require the use of compulsory powers rather than any reliance on parental powers to consent[75]: this became law under the 2007 Act[76]. In other words, questions of capacity are of vital importance in determining who could give consent for an informal admission, but in a non-consensual admission capacity was only of tangential relevance in light of its potential to affect the assessment of the nature or degree of the disorder.

At no stage in the process of reform did capacity on the part of those in the criminal justice system become a central feature. There were, rather, a number of reasons given as to why those who entered the mental health system via the criminal courts should be subject to differential treatment involving less stringent conditions. For example, when the Joint Committee was considering the Draft Bill of 2004, it recommended that the criteria for detention include a requirement that the disorder be of a nature or

71 *Starting at col 243.*

72 *He acknowledged the research of Prof Szmuckler, but noted that as some people would escape compulsion, this would be an "unacceptable gap".*

73 *See the Third and Fourth sittings of the Public Bill Committee, 26 April 2007, cols 79–120. Available at http://www.publications.parliament.uk//pa/cm200607/cmpublic/cmpbment.htm (last accessed 25 August 2009)*

74 *Paragraph 3.24.*

75 *Paragraphs 3.70ff.*

76 *Section 43 of the 2007 Act, amending s131 of the 1983 statute.*

degree to make treatment appropriate irrespective of whether the defendant would consent to treatment[77]. The Government position was that the civil criterion that voluntary treatment was not possible had to be omitted because otherwise a patient willing to attend hospital voluntarily would have to be subject to a prison sentence[78]. Also missing was any requirement that treatment be necessary to protect the patient or others from harm: the Government position was that this pre-condition was justified in relation to a civil patient as the basis for depriving the patient of his or her liberty, whereas in the criminal setting the justification arose from the fact that a court order was made; and the danger of including a criterion reflecting the need to protect someone from themselves was that this could be met by a prison sentence[79].

(vi) The Bamford Review – Northern Ireland

Reporting in August 2007, the Bamford Review of Mental Health and Learning Disability[80] provided a suggested framework to replace the *Mental Health (Northern Ireland) Order 1986*. Article 3 of the 1986 Order defines mental disorder as "mental illness, mental handicap and any other disorder or disability of mind" but expressly excludes those whose only diagnosis is of a "personality disorder". The criteria for detention for treatment, as set in Art 12, require an opinion that the absence of detention involves "a substantial likelihood of serious physical harm to himself or to other persons". In relation to detention ordered by the criminal courts, Art 44(2) allows a hospital order if there is "mental illness or severe mental impairment of a nature or degree which warrants his detention in hospital for medical treatment" and the order is the more suitable disposal.

The message of the Bamford Review was that the 1986 Order had significant gaps, and it suggested that the opportunity be taken to provide a comprehensive legislative framework based on a number of central principles. The Committee set out four over-arching principles that provided a "sound ethical basis for legislation" and "recognise and support the dignity of the person", namely[81]:

> "i. – Autonomy – respecting the person's capacity to decide and act on his own and his right not to be subject to restraint by others.
>
> ii. – Justice – applying the law fairly and equally.
>
> iii. – Benefit – promoting the health, welfare and safety of the person, while having regard to the safety of others.
>
> iv. – Least Harm – acting in a way that minimises the likelihood of harm to the person."

The Committee's preference was for one legal framework that dealt with all issues arising in relation to capacity and mental health which "should apply in a non-discriminatory way to both physical and mental health decisions, as well as to welfare and financial needs"[82]. In other words, the separate area of law relating to mental health law should become a sub-set of the law relating to what happens when someone has a loss of capacity to act autonomously. Capacity law should develop and incorporate mental health

77 *Paragraphs 272–3.*

78 *Paragraphs 267–268. This was a position similar to that adopted by the Scottish Executive (and Parliament, given that the 2003 Act passed as it did) in relation to why impaired judgment should not be part of the test for a detention order in the criminal setting: see infra.*

79 *Paragraphs 267 and 269. The Joint Committee also rejected this viewpoint in its recommendations.*

80 *Its extensive collection of papers can be found at http://www.rmhldni.gov.uk/index.htm (last accessed 29 August 2009). References here are to the report entitled 'A Comprehensive Legislative Framework'.*

81 *See para 1.8; the consequences of the principles were expanded upon in chapter 5 of the report.*

82 *Para 5.3.*

law "whilst ensuring appropriate protections"[83]; practical arrangements would be put in place for the assessment of capacity. However, the Committee noted that it would then be necessary to consider how this intersected with legislation relating to children and also "the consequence of adopting such an approach for forensic patients and the interface with the Criminal Justice System"[84]. Its starting point in relation to the latter was that the principles-based approach it adopted meant that those who had capacity and made decisions to commit crime would have to be dealt with through the criminal justice system[85]. Of course, it would be possible to have an intervention that was based both on the need to protect the patient and to protect others if the patient's autonomy was compromised so as to prevent a decision with respect to the particular risks in issue.

The Northern Ireland Government has been broadly supportive of the suggestions of the Bamford Review. Its initial response was entitled "Delivering the Bamford Vision"[86]: after discussions between interested departments within the Northern Ireland Government, it was accepted that there was a need for a new framework for mental health and capacity law, but it was proposed[87] that there should be two pieces of legislation, the first amending the 1986 Order because of the "urgent need" for that – though the timescale was given as it being enacted only in 2011 – and then new mental capacity legislation was to follow. The suggestion made was that putting both together in a single statute "would lead to a very complex piece of legislation which may be difficult to implement"; unfortunately, no reason is given for this assertion[88]. The Government response is also far from clear as to what would be the interface with the criminal justice system: the chapter dealing with forensic matters[89] notes the need for service provision, including for people with personality disorders and those detained in prison, but does not give any details on what is proposed in this area.

After the consultation on this initial position, the Northern Ireland Government has produced an updated proposal, entitled "Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland"[90], which retains the idea that there will be separate legislation on mental health and questions of capacity but proposes that the two relevant bills should be introduced at the same time. It is also noted that the legislation relating to mental health matters, which may be in the form of an amendment to the 1986 Order or be a new statute, will be harmonised with the mental capacity legislation "to form a coherent framework"[91]. The timeframe envisages new legislation by April 2011. The mental health law will adopt the Scottish approach: so, it is noted that the proposed criteria for detention for assessment or treatment will include as a pre-requisite that the patient is found to have a "significantly impaired decision-making ability in relation to treatment" because of mental disorder[92]. How this applies to people in the criminal justice system is not clarified.

83 *So at paras 5.57ff the Committee comments on the need to ensure public protection when a person with impaired capacity poses a threat to others (which it notes is not a frequent occurrence).*

84 *Paras 5.5. and 5.6. The Committee noted at para 5.55 that there was a need to ensure that the law relating to criminal responsibility and matters such as unfitness to stand trial, and also the law relating to matters such as transfers from prison to hospital, was amended to comply with the principles-based approach. The "equivalence" requirement means that those in the criminal justice system have the equivalent access to services: para 5.56.*

85 *Para 5.53.*

86 *Available at http://www.dhsspsni.gov.uk/showconsultations?txtid=30219 (last accessed 19 October 2009).*

87 *Ibid pp 25ff*

88 *The Northern Ireland Executive's proposals were put out for consultation, and the responses were collated in 'Summary of Key Points Arising from Consultation', March 2009, available at the same website. One of the points made – on page 7 of the document – was that there was "strong opposition to the proposal for two pieces of legislation".*

89 *Ibid pp 68ff*

90 *Available at www.dhsspsni.gov.uk/legislative-framework-for-mental-capacity.pdf (last accessed 19 October 2009)*

91 *Paragraph 6.1.*

92 *Paragraphs 8.5 and 8.6.*