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THE TEST OF COMPULSION IN MENTAL HEALTH LAW: CAPACITY, THERAPEUTIC BENEFIT, AND DANGEROUSNESS AS CRITERIA FOR COMPULSION.

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I. INTRODUCTION

In June 2002, the Department of Health published its draft mental health bill.[2] This was the latest stage in processes commencing in 1998, and consolidating two different agendas of reform. The first was based in the Fallon report into conditions at Ashworth special hospital. That report considered a broader mandate than the specifics at that hospital however, and proposed that 'dangerous persons with personality disorders' be able to be detained indefinitely, whether or not they were treatable.[3] This recommendation was largely accepted by the Department of Health and Home Office in a green paper in 1999.[4] Mental health reform more generally also commenced in 1998, with the appointment of an expert panel chaired by Professor Genevra Richardson.[5] It too proceeded to a green paper in 1999,[6] although one which challenged many of the conclusions and proposals of the expert panel. Mental

health and personality disorder reforms were then consolidated, and a joint white paper issued in 2000.[7]

Through this process, the government managed to achieve a consensus rarely seen in mental health politics. Sadly, the consensus was negative: virtually no one supported the draft bill.[8]

Such antagonism is not without justification, as the bill is certainly badly flawed. The consensus view however avoids the different question of how mental law ought to be reformed, and on this there is no obvious consensus. This paper begins to address this question, considering capacity, a rights-informed therapeutic criterion and dangerousness as alternative possible standards.

II. PSYCHIATRY AS SOCIAL CONTROL

Much of the resistance to the government bill seems to be based on the removal of the existing treatability test for people with psychopathic disorders. The perception is that such persons might be maintained in psychiatric facilities if treatment were not available. Along with the perceived re-focussing of the bill onto dangerousness from treatment, the fear is that it will turn psychiatrists into agents of social control.

These concerns are problematic for several reasons. Admittedly, the government has done itself no favours by highlighting particular issues relating to personality disorder and the protection of the public from danger during reform

process. That focus during the consultation process makes it unsurprising that the issues have arisen in public discussion. It is less obvious how far the proposals change the status quo. While the government's draft bill does include a new clause concerning confinement of persons 'at substantial risk of causing serious harm to other persons',[9] it is not obvious how far this extends the powers to confine 'with a view to the protection of others' in the 1983 statute and repeated in the draft bill.[10]

The draft bill does, certainly, remove the requirement under the 1983 Act that 'psychopaths' and persons with (non-severe) 'mental impairment' may only be detained beyond twenty-eight days if treatment is available to alleviate or prevent a deterioration of their condition.[11] This largely brings them into conformity with other mental disorders, and specifically persons classified as having 'mental illness', a diagnosis accounting for roughly 97 per cent of psychiatric admissions. The objection appears to be coherent only if viewed as a specific concern relating to personality disorder, since there has been no objection to the removal of the requirement as it applies to people with mental impairment. On that basis, it seems reasonable to suggest that the argument ought to be whether personality disorders ought to be excluded from the bill entirely, rather than to argue for the maintenance of an enhanced treatability standard. This seems a particularly convincing question, since predicted treatability of a given psychopath seems to a significant degree dependent on the psychiatrist engaged in diagnosis. This risks turning the compulsion of psychopaths into a lottery.

The concerns are also problematic on theoretical grounds, insofar as they suggest that psychiatry can avoid social control. The reality is that psychiatric

treatment in any situation other than by free and competent consent of the patient is by its nature about social control. The vast bulk of people currently confined in psychiatric facilities are categorised as 'mentally ill', and for them there is no requirement of treatability. Most of them are treatable of course, but that does not remove the social control function. They tend to be admitted when their behaviour becomes socially unacceptable; and they are treated until it is no longer unacceptable. Alternatively, they are admitted when they are perceived to be unable to cope or function in society, and treated until they can be discharged, able to do so. When such behavioural features are significant factors in clinical decision-making, doctors are acting as agents of social control.

This is not of course necessarily an undesirable outcome. One need only peruse the published accounts of former patients to realise how much better life gets for many people after psychiatric treatment, but that does not change the fact that it remains the imposition of social control. This is not just a function of law, as such; it is what psychiatry does. It changes who people are, one hopes usually in desirable ways.

To abolish the social control function of psychiatry, we would need to prohibit psychiatric treatment on any but competent and freely consenting patients. This would, obviously, be an undesirable restriction, since those who lack capacity and might be in particular need of psychiatric services would nonetheless be precluded from receiving them. The intrusiveness of the interventions, along with their socially controlling nature, do mean that the level of standards must not simply be left to medical discretion. The interests at stake are also both political and social, and

therefore must be articulated in a clear and binding legal framework. The intrinsic argument to that effect is buttressed by our international commitments: a clear legally binding structure is required by the European Convention on Human Rights.[12] In practice, that means a standard contained in a statute. The current fetish for Codes of Practice must be viewed with scepticism here. Including the substantive standards for compulsion in such a code in a mental health context makes no more sense than legislating in a criminal context that police officers may arrest people who do bad things, and providing illustrative or non-binding 'guidance' in a code of practice as to what bad things might be. It is not good enough. It must be clear from the statute itself what the standards of intervention are.

The proper question is therefore not how psychiatrists can cease to be agents of social control: they cannot. The better question, to be asked bluntly, is when the social control is justified. The squeamishness of critics of the government bill to engage with that question does not help. The reality is that we need mental health legislation, and we must therefore choose from a set of criteria of administration, all of which are problematic. The acknowledgement that mental health law is about social control allows that choice to be made in a fashion which acknowledges the individual and social interests at stake, in a way which acknowledges appropriate policy concerns and the need for a system which will actually function in practice.

III. THE STATUS QUO AND THE NEED FOR REFORM

There can be little doubt that reform of mental health law is desirable. It is now twenty years since the last comprehensive revisions, introduced as amendments

to an act passed in 1959. That act in turn constituted a synthesis of statutes reaching back to the beginning of the nineteenth century. Since 1983, there has been additional piecemeal reform, in particular the introduction of aftercare under supervision in 1995.[13] The Mental Health Act 1983 is thus a scrappy and sometimes incoherent result of two centuries of cut and paste.

Much has changed since the 1983 amendments. Key in theses changes are the increasing acknowledgment that patients, be they formally or informally admitted, have a role in their treatment. The patient user movement, still a novelty in 1983, has grown in maturity and is now an accepted part of the policy landscape, and individual patient-doctor relations have changed to reflect this. Under the 1983 Act, for example, the patient has no right to information during the first three months of confinement as to the treatment being performed on him or her.[14] It is difficult to imagine any clinician supporting such an approach now. In the academic and policy literature more broadly, there is now discussion of rights to determine psychiatric treatment in advance, choice of decision-makers in the event of subsequent incapacity, substitute judgment tests in preference to clinical best interests tests, and other similar mechanisms to ensure that the patient's views are reflected in psychiatric treatment. The culture of psychiatric practice is still in a process of change, and may not have changed as much as some would wish, but change in the last twenty years is undeniable.

Non-discrimination on the basis of disability, including mental disability, has entered the public, legal and academic consciousness in a way which could not have been anticipated twenty years ago. This broader acceptance is reflected at the

legislative level in the Disability Discrimination Act 1995, the Treaty of Amsterdam 1997, and European charter signed at Nice,[15] and, potentially most importantly, in the proposed new European constitution.[16]

There are further structural changes. The 1959 Act had been drafted on the expectation that treatment would be provided increasingly, indeed predominantly, in the community. Numbers of psychiatric in-patient beds were already falling at that time, a process that has continued unabated since. At the same time, numbers of admissions have continued to rise on an annual basis, and lengths of individual stays have correspondingly fallen dramatically.

In policy terms, it is often said that risk has been introduced onto the policy agenda in this period. This claim is somewhat difficult to make out in any simplistic way, since dangerousness has been a part of the English landscape of legal psychiatry for some four hundred years, and numbers of homicides by persons with mental disorder have been falling fairly steadily for decades.[17] It is tempting to speculate that what has changed is that tabloids more than ever before have discovered that dangerous people with mental disorder sell newspapers, and certainly the obsession of news media in modern times with associating dangerousness and mental disorder has been documented.[18] Nonetheless, there has been a revival in academic and political interest about risk analyses of persons with mental disorder.

To a modern eye, the standards provided by the Act are exceptionally loose. Under section 2 of the Act, for example, a person can be admitted under compulsion for periods up to twenty-eight days if suffering from a ‘mental disorder of a nature or

degree which warrants the detention of the patient in hospital for assessment' and 'he ought to be so detained in the interests of his own health or safety or with a view to the protection of others.' This provides little guidance to professionals as to who should, and who should not be admitted. In practice, standards have for some time been a function of professional culture rather than law,[19] coupled with continued chronic under-funding. This latter has placed considerable restrictions on the number of persons confined at a given time, introducing standards indirectly by way of rationing.

Such an approach is not appropriate. Current mental health law allows not only forcible confinement of the individual, but also their treatment with exceptionally powerful chemicals and sometimes electricity. The methods used to effect the cures are extremely intrusive, and have as their objective fundamental changes to the individual. Medical discourse may distinguish between individuals and their conditions, but treatments for depression may result in astonishing mood changes accompanied by corresponding changes to attitudes to self, and removal of psychosis changes the phenomenal world in which the individual lives. This is not merely social control, but social control of a particularly invasive kind, causing fundamental change to individuals' experience of day-to-day life. The frequent beneficial effects of psychiatric treatments are to be acknowledged, but in legal terms, current English mental health law claims powers more sweeping in their effect on the individual than any other area of law. Not even criminal law, after all, allows compulsory treatment without consent of persons with capacity. As a matter of basic civil rights, the law must establish clear and appropriate standards. It is difficult to see that a standard that allows confinement and enforced medication on the basis of a

mental disorder which 'warrants detention' of the individual for his or her 'health' meets such a threshold. The world has moved on since this standard was introduced in the 1950s.[20]

If reform is required, and a meaningful standard of compulsion introduced, what should it look like? In the sections which follow, it will be argued that capacity should form a cornerstone to the standard regarding enforced treatment – indeed, that this is becoming a norm expected under European human rights law, with which England should be expected to comply. That leaves the problem of criteria for admission to psychiatric facilities. Here, some commentators have also suggested a role for capacity, and that will be considered. In addition, a therapeutic model will be discussed, as well as a standard of dangerousness.

IV. CAPACITY AND TREATMENT DECISIONS

The use of capacity to determine the rights of persons with mental disorder has the advantage of emphasising a non-discriminatory approach: in the same way that we may treat without further consent people who lack capacity to consent to somatic disorders,[21] so psychiatric decisions could be made for those lacking capacity. The social control implications of compulsions, unpopular with psychiatric professionals, are similarly minimised. In the best tradition of anti-discrimination law, the disability is acknowledged insofar as it is relevant to decision-making, but left outside the equation otherwise.

The use of mental capacity as a gateway concept for compulsion is gaining popularity in the academic literature in Britain.[22] The Richardson Committee further used it as one part of compulsion criteria, although it would not in itself have been sufficient to justify compulsion.[23] The government however retreated from that recommendation, and it is nowhere to be found in the white paper or draft bill. The substantive issue in the next sections of this paper is how far capacity may be used as a gateway for compulsion in a mental health context.

English mental health law already recognises the authority of the competent voluntary patient to make treatment decisions. Indeed, the Code of Practice under the Mental Health Act 1983 provides specific guidance on the determination of capacity and its use in a treatment context.[24] It is only when competent patients are subject to involuntary admission that they lose their right to consent to treatment under the 1983 Act.[25] For the first three months in which treatment is provided to them, these patients have no right to refuse treatment at all; after this period, their refusal to consent may be overridden by their responsible medical officer, with the agreement of a second doctor, specially appointed for the purpose by the Mental Health Act Commission.

Other jurisdictions have gone considerably further, however. In Ontario, for example, the rule has been established that no patients with capacity may be treated without his or her informed consent.[26] This applies equally to somatic or psychiatric treatment, whether or not the person is in hospital or in the community, and if in hospital, whether formally or informally admitted. This standard was introduced under threat of constitutional litigation under the Canadian Charter of Rights and

Freedoms in 1986, much to the chagrin of the province's psychiatrists. It appears now to have been accepted into the professional culture however, and there are few if any serious suggestions that it should be changed.

The usual objection to separating enforced treatment from enforced admission is the possibility that individuals will be admitted involuntarily, but refuse treatment once admitted. Their health, according to the concern, would not improve; the hospital would become a warehouse for such patients, and psychiatrists little better than gaolers. Whatever the theoretical possibilities the system presents, there is no indication that this is happening to any marked degree in Ontario. While statistics on those refusing all treatment do not appear to be kept, anecdotal evidence suggests these patients number few indeed. Certainly, some patients consent to medication which is not considered by their psychiatrist to be optimal, but in practice what seems to happen is that psychiatrist and patient negotiate a solution that both can live with. This seems to be a desirable approach. Indeed, it is a reasonable speculation that it leads to a greater personal commitment to the treatment programme by patients, and accordingly better treatment concordance in the long term.[27]

Given the appropriate political will, there would be no obvious reason that this approach could not be implemented in England. It is submitted that this would be appropriate. The violation of autonomy consequent on enforced treatment of a person with capacity is considerable. The introduction of psychiatric medication into an individual's body results in fundamental and substantial changes to the person's self. These changes are, of course, the objective of the treatment, and have social benefits. Many patients will also willingly consent to them, as they are perceived to have

benefits to them too. That in no way alters the extraordinary nature of the intervention, however, and it is difficult to see that it should be provided on a patient with capacity who refuses it.

This is also, increasingly, the view of the Committee for the Prevention of Torture, the body established by the Council of Europe to police the right in Article 3 of the ECHR to be free of torture or (as at issue for current purposes) inhuman or degrading treatment. The words of their guidance phrase the matter as follows:

> Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.[28]

It seems reasonable to expect England to conform to this norm. The matter has already had an initial airing before the Court of Appeal, with an inconclusive result. In *R (Wilkinson) v. RMO Broadmoor*,[29] the Article 3 point was put directly to the court. Simon Brown LJ was broadly sympathetic:

> If in truth this appellant has the capacity to refuse consent to the treatment proposed here, it is difficult to suppose that he should nevertheless be forcibly

> subjected to it. True, Dr Horne appears to regard it as his only hope of eventual return to the community. That said, however, its impact on the appellant's rights above all to autonomy and bodily inviolability is immense and its prospective benefits (not least given his extreme opposition) appear decidedly speculative.[30]

Brooke LJ took no position on the point. Hale LJ took a contrary view:

> I do not take the view that detained patients who have the capacity to decide for themselves can never be treated against their will. Our threshold of capacity is rightly a low one. It is better to keep it that way and allow some non-consensual treatment of those who have capacity than to set such a high threshold for capacity that many would never qualify.[31]

The difficulty with the view of Hale L.J. is that the threshold of capacity in England is not low at all. Indeed, it is exceptionally high. The individual is not merely required to have the ability to understand the information given, but also to appreciate it, that is, to be able to identify 'relevant' information, and to 'weigh it in the balance as part of the process of arriving at a decision.'[32] The reported case law further suggests a marked hesitancy of courts to affirm a patient's capacity when treatment is refused.[33] There are no obvious moves afoot to lower this standard of capacity. On this basis, the view of Hale LJ seems unconvincing.

The adoption of a standard allowing competent patients control of their treatment of course has considerable ramifications for the nature of community

treatment orders. For patients lacking capacity, such orders would seem to add little, as existing incapacity law already allows the treatment of such patients. For patients with capacity, it is not obvious that there would be room for such an order, since if it is not justified to treat a such patient in a psychiatric facility without consent, it would be manifestly unjustified to do so outside the facility. Such a loss is not necessarily a problem even in therapeutic terms, for it is debatable whether such treatment orders are effective.

V. CAPACITY AND ADMISSIONS

While the use of capacity rather than confinement status as the arbiter of treatment rights appears to be becoming best legal practice, a similar movement does not seem to have occurred in the area of confinement. While persons without capacity may often be able to be admitted without resort to formal compulsion, I am aware of no system that adopts an incapacity standard to the exclusion of another standard of formal admission. Ontario uses a dangerousness standard, for example, and for the Richardson Committee, capacity formed only one part of a more complex set of standards of compulsion. The question for this section of the paper is whether a capacity standard can apply here too.

Issues relating to the psychiatric institutionalisation of people lacking capacity have been litigated before both the Supreme Court of the United States[34] and the House of Lords[35] in recent years. The cases concerned similar points: was it legal to admit informally a patient who lacked the capacity to consent to psychiatric admission. The House of Lords in the *Bournewood* decision held that such

admissions were legal, albeit for unconvincing reasons.[36] The case is currently on appeal to the European Court of Human Rights. The core of the American decision in *Zinermon* turned on the wording of the relevant state statute, which the court held did require capacity prior to admission. Blackmun J writing for the majority went further, however, holding that the informal admission of persons lacking capacity to consent to admission was unconstitutional.[37]

Such intensive litigation makes it surprising that there are few articles examining what precisely capacity to consent to psychiatric admission entails.[38] This is not an abstract question, for capacity in common law jurisdictions is a functional concept. Capacity always has an object: one is capable of doing or engaging in a specific task, relationship or decision, and capacity or not to consent to treatment will be established on a different set of criteria than to consent to psychiatric admission. What exactly, therefore, ought one be capable of knowing in order to have capacity to consent to psychiatric admission?[39]

The American literature includes a range of proposed tests. Appelbaum and Bateman's 1979 paper proposes a high threshold:

1. Does the patient appreciate the nature of his condition?
    a. Does he recognise that he has a mental illness?
    b. Does he think that he requires treatment?
    c. Does he know of a reasonable alternative to hospitalisation?

2. Does the patient understand the nature of hospitalization?

a. Does he understand the role of his doctor?

b. Does he understand the role of medication, if indicated?

c. Does he understand the nature of an inpatient setting, such as an understanding that there will be closed and open wards, and activities and programmes available?

3. Is the patient able to comprehend the basis for the doctor's recommendations concerning admission?

4. Is the patient able to make a decision to co-operate with his doctor's recommendations?

5. Can the patient act affirmatively to protect himself in the hospital environment? For example, if the patient were experiencing adverse effects, would he know to approach a member of staff?

6. Is the patient aware of rights as voluntary patient, including

   a. right to file request for discharge;

   b. right to refuse medication;

   c. right to legal representation;

   d. aware of existence of civil rights advisor in hospital.

7. Is the patient aware of adverse consequences that might result from admission? This would include an awareness of potential of involuntary detention if he requests discharge?

At the other extreme, the test favoured by the American Psychiatric Association and most authors in the last ten years, Appelbaum included, is remarkably low. The APA would require that the patient understand that he or she is being admitted to a psychiatric hospital or ward for treatment, and that release from the hospital may not be automatic, and he or she can get help from the staff to initiate procedures for release.[40]

The American literature is of limited assistance as it is intended to co-exist with a separate standard of involuntary admission such as a dangerousness standard. In the 1979 Appelbaum and Bateman paper, the concern was that even informal psychiatric admissions had consequences, and that acceptance of those consequences required a level of capacity. These concerns may also have been implicit in the *Zinermon* case in 1990. The more recent American literature can be seen as attempting to ensure in the light of this ruling that potential patients wishing admission, or at least not objecting thereto, should not be precluded by an overly onerous threshold.

If capacity is to serve as the sole threshold of compulsion, the dynamic will of course be very different. Persons found capable under the American system would still be compellable; this would not be the case if incapacity became the threshold of compulsion in England. The co-existence of a separate compulsion threshold makes a number of the criteria in the American test nonsensical. Thus the American literature argues for the necessity of understanding rights to release, to be competent to decide admission. Such a result would be paradoxical if incapacity is to be the threshold of

confinement, since the failure to understand the rights to release would result in a finding of incapacity and potentially confinement, in turn resulting in the loss of those same rights to release. Similarly, some American formulations require the patient to understand that the voluntary admission could become involuntary, if an attempt was made to leave. That would not be the case if incapacity were the threshold of compulsion.

Some of Appelbaum and Bateman's 1979 criteria are helpful. What is proposed is an admission to a psychiatric facility, for example, so competent individuals would clearly need to be capable of understanding that. It seems reasonable that they would need to understand that admission was proposed because of mental illness. They would thus presumably need to understand that they would be living in the facility, at least until such time as they changed their mind and decided to leave, and that might well entail an understanding of the inpatient setting, as Appelbaum and Bateman suggest. It seems reasonable also to expect some understanding of the roles of doctors and nurses in the facility, and some understanding of the reasons admission is proposed. As Appelbaum and Bateman note at various points in their paper, comprehension cannot necessarily mean complete agreement with medical staff; but their list may provide at least a helpful starting point in understanding the range of issues relevant to capacity.

The list conceals a variety of complexities, however. In the usual case, it will be expected that the individual would receive treatment in the facility, and Appelbaum and Bateman go so far as to include an understanding of the right to refuse treatment in their criteria (6b, above). This is too simplistic, since some

patients will capacity to consent to treatment, and these patients will not have a right to refuse treatment. Is it necessary that the individual be competent to consent to treatment, in order to consent to the admission? Presumably not, since the functional approach to capacity and the argument for capacity as the determinant of treatment rights implicitly separate treatment decisions from admission decisions. Removing treatment from the equation for most patients would however mean that their capacity to decide their own admission would not necessarily imply an understanding of the prime purpose for their admission.

Ought the requirement be restricted to an understanding that treatment will be available if they wish it? If so, how do we understand admission capacity for those without treatment capacity? Would they need to understand that they would be treated without their consent following admission, in order to have capacity to decide the admission? Neither result here seems desirable. If such understanding were not required for admission capacity, an otherwise competent individual could refuse admission, perhaps to avoid the treatment to which ex hypothesi they are unable to consent. If the treatment could only be offered in the facility, that would effectively allow them to make the treatment decision through the back door. If instead the patient were found to lack capacity to consent to the admission, then other real objections to admission could be overridden and the patient admitted, even if, for example, the treatment could also be given (albeit less conveniently) outside the facility.

In their seventh question, Appelbaum and Bateman acknowledge that informal psychiatric admission carries with it consequences. The range of these is more

substantial than they identify, however. It is not merely the risk of a transfer to involuntary status that is relevant, but also social risks, including discrimination, stigma, potential child custody issues and potential loss of employment or housing.[41] To what degree does the patient have to understand those social results in order to be competent to be admitted voluntarily?

This all applies when the question of admission capacity is limited to an understanding of what is entailed by psychiatric admission. To be realistic, however, a refusal to enter a psychiatric facility implies another choice of care and accommodation. This may be the continuation of the status quo, but if a family or group home is refusing to allow the individual to remain without a period in psychiatric care, refusal of psychiatric admission may instead involve the need to negotiate some new and other form of care arrangement. It is at least arguable that when refusal of psychiatric admission will result in such negotiations, the determination of capacity to decide on psychiatric admission may require consideration of ability to pursue those negotiations. In that event, consideration of capacity to remain in the community may include issues of capacity to seek out and enter care relationships such as with meal providers and home help, and capacity to manage ones accommodation. Is it further relevant whether the relevant social service agencies are agreeable to providing services under the circumstances, rendering the person of marginal capacity a compliant user, or whether the social services agency is refusing to provide the services, in which case active negotiation by the individual may be required? Capacity is a difficult measure to use in such circumstances, since it is intended to assess an individual's abilities, in English law the abilities to understand, retain and appreciate the importance of relevant information, to use it to

reach a decision, and to communicate the decision. It feels wrong to have the determination of an individual's capacity at least partly contingent for example on whether the services of the social service agency are offered willingly or only after negotiation. This may nonetheless be unavoidable here, as the functional test of capacity relates to the decisions actually to be made by the individual.

Does the determination of capacity to decide psychiatric admission also include the capacity to understand the risks of social interactions in the community that may flow from ones disorder? To put it another way, does it include a requirement that the individual understand his or her level of dangerousness? Presumably it must. Otherwise, people with psychiatric disabilities who were thought to be dangerous as a result of a psychiatric disorder, even if the predictive value of that was fairly good, could remain uncontrolled without understanding the dangerousness of their situation. It is difficult to see a judge reaching such a result.

This result poses considerable difficulties for those who advocate a capacity test in preference to a dangerousness test, since it would seem that a dangerousness test enters implicitly. Unlike a well-drafted statutory dangerousness test, however, there is little to define this back-door dangerousness test. It is likely to be impressionistic by the psychiatrist, and difficult to challenge. In practice, the concern of users regarding capacity tests is that people are found capable if and only if they agree with the views of their physician. If patient lawyers are to find themselves arguing about dangerousness in any event, it is to the advantage of their clients that it is done according to a clear statutory structure.

At least in theory, if a capacity test were adopted, a person who acknowledges their dangerousness might be able nonetheless to decline psychiatric admission. They might say that they acknowledged their dangerousness, but preferred to run the risk of harming themselves or others in the community rather than consenting to psychiatric admission. This possibility would undoubtedly make the current government hesitant about allowing such a test to be used. An actual case would also place considerable pressure on a court to bend the rules to deny capacity. This raises the other difficulty of capacity: it is an extremely slippery concept, and courts have in the past been willing to tailor the concept to their desired result. Obvious recent cases of this in a treatment context involve pregnant women, religious objections to blood transfusions, and force-feeding of individuals.[42] For a meaningful standard of admission to be obtained, a clearer standard needs to be legislated than seems likely with capacity.

If a capacity standard were used, there would therefore be considerable pressure to make it a very high capacity standard. At this point, the analogous concerns to those expressed about capacity and treatment by Hale L.J. become relevant. Under the current system, with its separate standard for compulsion, there is no corresponding pressure towards a high standard of admission capacity. I am aware of no empirical study as to the standard actually used currently by clinicians. Assuming (as seems likely) that it is below that which would apply if capacity were the standard for compulsion, there is now a class of people whose refusals to enter hospital are being honoured, who would lose that right in a system based solely on capacity. For advocates of patient autonomy, this is an undesirable result.

The use of capacity as a threshold for involuntary admission appears extremely attractive on the surface. It does reflect what is used for somatic treatments, and as such makes problems of discrimination disappear. This approach would however require that all aspects of the capacity test be satisfied: incapacity on any one relevant factor (eg, self-appraisal of dangerousness) would result in a finding of incapacity. It risks becoming a hard test to pass, and an easy one to fail. This is particularly true in English law, which sets the thresholds of capacity relatively high, requiring understanding, retention and appreciation of knowledge, ability to use it in reaching a decision, and the ability to communicate the decision. The courts in England have a tradition of deference to medical professionals, particularly in psychiatric situations, and a desire to behave paternalistically to psychiatric patients. It is likely therefore that most of the ambiguous issues above would be incorporated into a test of capacity, raising the threshold for the patient. Capacity might well be a hard test for a potential patient to satisfy.[43]

The introduction of a capacity threshold of course begs the question as to how decisions would be made for those lacking capacity, a question that arises both for treatment decisions and admission decisions. The Richardson Committee proposed a variety of criteria. The requirements that a serious mental disorder be present, the principle of least restrictive alternative, and a best interests test would apply to all potential patients under compulsion, but additional criteria would be specific to whether or not the individual had capacity. Those lacking capacity would be subject to the following additional criteria:

> That, in the case of a patient who lacks capacity to consent to care and treatment for mental disorder, it is necessary for the health or safety of the patient or for the protection of others from serious harm or for the protection of the patient from serious exploitation that s/he be subject to such care and treatment, and that such care and treatment cannot be implemented unless s/he is compelled under this section.[44]

Reflecting the additional autonomy interest accorded to the reasoning subject in liberal theory, persons with capacity would be subject to more stringent standards of confinement. Richardson proposed that they would be compellable if there were a substantial risk of serious harm to the safety of others (or *perhaps* to the patient)[45] if he or she remained untreated, and there were positive clinical measures to be provided which would prevent deterioration or secure improvement of the patient's condition.[46]

The temptation in drafting additional compulsion criteria for persons lacking capacity is to set the standards relatively low, to ensure that people who are helpless and vulnerable may be protected. If, however, the threshold of capacity is high, as suggested above, the ranks of those lacking capacity will include many who do not match the stereotype of the helpless and vulnerable. For this group, these additional criteria will be of considerable importance to ensure a meaningful standard of confinement. The needs of the 'incapable' group may thus vary considerably between individuals, and it is not obvious how a set of criteria would be phrased to meet all needs.

It is not obvious that the standards of broader law relating to incapacity may be introduced unaltered into these areas. The recent bill on incapacity law published by the Department of Constitutional Affairs would allow people in anticipation of incapacity to make prospective refusals of medical treatment, and to appoint substitute decision-makers. In the absence of such mechanisms, it stops short of a pure substituted judgment test such as applies in some other jurisdictions. It does require that regard be had to what the wishes of individuals would have been had they had capacity, and among other things also requires consideration of their current, albeit incompetent wishes.[47] Ontario legislation has adopted similar requirements into its structures for treatment, with previously expressed wishes regarding treatment being binding and a right to appoint alternative decision-makers who are required to decide according to a substituted judgment test.[48] Here again, the same rules apply in Ontario to psychiatric as to somatic treatment, apparently with reasonable success.

Admission decisions are a different matter, however. For example, whatever one may think of a dangerousness standard of compulsion, it does seem socially and politically unacceptable that an individual lacking capacity who is manifestly dangerous to others should be left at large, because they had expressed a firm desire in the past not to be admitted to a psychiatric facility. That would however be the effect of applying an approach that allows enforceability of prior wishes or substitute judgment to compulsory admissions. The mental incapacity bill would avoid largely this difficulty by having a non-exhaustive list of factors to be considered in making decisions for persons lacking capacity.[49] Outside treatment decisions, where prior wishes are binding, the criteria it lists must be considered, but do not determine decisions. The difficulty with this in an admissions context is that a non-exhaustive

list means there is no enforceable standard: there is unfettered discretion as to what else may be considered. For psychiatric confinement, it is difficult to see that this could meet the standard of clarity required by the ECHR. Perhaps for these reasons, neither the draft bill nor the Ontario legislation uses a general capacity standard for compulsory admission. Ontario uses dangerousness, and the draft bill specifically rules psychiatric compulsion out of its jurisdiction. At the same time, adopting different standards for making decisions in a psychiatric context begins to undercut the non-discriminatory nature of the capacity approach, and hence its attraction. It further begs the question of what the other criteria for compulsory admission would look like.

VI. THE STONE SYSTEM

If the problems of the status quo and capacity are both admitted, how are decisions regarding compulsory admission to be made? One possibility is treatability, an option popular with psychiatrists and other physicians since it justifies compulsion by reference to the services offered by those professionals. Here again, however, some formula is necessary to take into account the intrusiveness of the intervention, that nature of potentially adverse effects and the right of patients to autonomy in the absence of reason to the contrary.

The system developed by American psychiatrist Alan Stone in the mid-1970s warrants consideration, as it is an attempt to integrate therapeutics with an awareness of patient rights.[50] In Stone's system, confinement would be available only if the following criteria were met:

A reliable diagnosis of severe mental disorder had been made

The immediate prognosis was one of major distress

An effective treatment existed

The patient must offer incompetent refusal of treatment

The proposed treatment must be such that the reasonable patient would consent.

Stone's system has much to recommend it. It focuses on the needs of and medical possibilities for the specific patient. It acknowledges the right of a competent patient to refuse treatment, but does not use capacity to consent to psychiatric admission as the controller of such admission. Instead he offers a selection of criteria related to the severity of the disorder and the availability and reasonableness of treatment to determine whether the admission takes place. The requirements relating to reliability of diagnosis and efficacy of proposed treatment require reasonable medical standards. The requirements of severe mental disorder and prognosis of major distress include a threshold of weight and urgency to the patient's condition, implicitly acknowledging that intervention has its costs and must only be undertaken in situations of some necessity. The requirement that the reasonable patient would consent allows consideration of a variety of factors, including those such as adverse effects that would disincline a patient to consent to the treatment.

The wording seems clear enough to provide an applicable standard as to who may be compelled. As with any statutory framework, the language of these criteria is 'open-textured', that is, subject to interpretation around the edges. How severe is 'severe', how major is 'major', and how effective is 'effective', for example? While it might be appropriate to consider whether marginal re-phrasing can limit these ambiguities, no phrasing will eliminate them entirely. The phrasing above does have the advantage that it would be broadly understandable to the professionals who would be primarily in charge of its application. The final criterion however re-enforces the need for some form of consideration removed from the medical officer responsible for the individual's treatment. The risk is this criterion otherwise becomes self-fulfilling, as it is difficult to imagine doctors prescribing treatment to which in their view a reasonable patient would object. This was in fact the result in Hoge's 1989 study of the criteria, where for a total of 483 patients, not a single doctor considered that the reasonable patient would refuse the treatment the doctor proposed.[51] This criterion is however of particular significance, as it is here that potential problems of the proposed treatment such as adverse effects enter the equation. It is therefore not necessarily obvious that the 'reasonable patient' would have shared the doctor's self-assessment as to the desirability of consent.

The obvious solution to these problems is an initial routine consideration of cases by an independent arbiter. This would allow a second opinion on the applicability of the open-textured language, and a view independent of the treating physician as to the approach of a reasonable patient. The routine nature of the review is particularly important in this case, since the fact that ex hypothesi the individual is

thought by the admitting physician to lack treatment capacity increases the likelihood that they will also be unable to ensure that the relevant standards are met. This in turn of course increases the financial costs of the system, although the degree of increase is a matter of speculation, since some form of review process would be necessary for any set of criteria.

Stone's criteria were not drafted with more recent concerns of advance treatment refusal or substituted judgment in mind, although there is no reason why they could not be factored into the system. This would presumably be with a gloss on the clause relating to incompetent treatment refusal.

The close association of the Stone criteria with treatability of the disorder is both its advantage and its problem. As with some of the capacity-related criteria discussed above, it would not necessarily allow intervention in the case of the manifestly dangerous person with a mental disorder. Persons who could not be treated to the standard noted, or who offered a competent refusal of the treatment, would remain at large. This is not necessarily an argument against Stone. Instead, it must be asked whether we should intervene in these circumstances.

VII. DANGEROUSNESS: A SECOND LOOK

In some cases at least, there is at least a coherent argument in that we should intervene in the case of the dangerous person with mental disorder. Dangerousness is not a stranger to the English legal psychiatric landscape. Precedent back to the sixteenth century allows confinement of 'lunatics' to restrain them from killing or

doing mischief such as setting fire to a house.[52] The standard continued through the nineteenth century, most famously re-stated by Chief Baron Sir Frederick Pollock in *Nottidge v. Ripley*.[53] The resonances of this continue to the present time. Thus the nearest relative's right to obtain the release of an individual is restricted when the patient is 'likely to act in a manner dangerous to other persons or to himself',[54] and references to safety of the public are contained in the existing admission criteria, as noted above.

The prime objection to the dangerousness standard appears to be that it is prospective. The critics of the government's draft mental health bill tend to assume that the actual commission of a criminal offence would justify confinement, but until the actual commission of the offence, the law should not intervene. Yet this must be a red herring, in the sense that it is not clear what criminality of an action adds to the action itself. Consider for example an individual yelling aggressively and brandishing a knife. To ensure an appropriate standard, we would presumably wish an appropriately serious crime to have been committed to justify confinement. No homicide or battery is committed unless the individual actually stabs someone. No assault is committed unless someone feels threatened, a factor which may be effected by apparently arbitrary factors such as how fast the brandisher can run relative to passers by, or whether a fence separates the brandisher from passers by. Unless we are to divorce the law of confinement from the condition of the potential patient entirely, it seems bizarre to decide confinement on such arbitrary bases. It makes more sense to consider the actions, rather than the legal question of criminality, and the likelihood that the action will occur.

The use of a dangerousness standard on its own does allow the possibility that some people will be admitted to psychiatric facilities for whom curative treatment may be unavailable. How far should that sway us from the standard? The reality is that if intervention is justified, the people must go somewhere. Prison is not an appropriate option, if the individual has committed no crime: our object for those with mental disabilities is surely not punishment. Persons with, for example, treatment-resistant mental illnesses may already be housed in psychiatric facilities, so it seems difficult to argue that the nature of the institution is of itself unsuited. Indeed, the more general notion of a hospital as only a place of cure is of itself problematic, as people with incurable physical disorders may remain in hospital if there is no other suitable place for them. This is obviously not an ideal solution for the individuals in question, but it would seem that it is not necessarily contrary to social policy.

This is not necessarily an argument for a dangerousness standard, for prediction is difficult. Decisions based on the impressions of psychiatric professionals are roundly criticised as inaccurate, sometimes little better than chance. More formalised systems are often based on criteria such as race, sex, age, or social class. These raise obvious human rights problems. How would we defend a system where the decision to confine was based, even if only in part, on the basis that an individual was black, male, young or poor?

Even with the best systems, predictions are only predictions. The most extensive trial has been recently completed in the United States, by the MacArthur project.[55] Their strongest statistics involved 939 people, at several sites. Of these 176

were in fact violent over the course of the study. Using a variety of criteria in combination, they were able to arrive at five risk bands, summarised below:

Table 1[56]

Risk Class	Number of Cases in Class	Percent of class violent	Number of people violent	Percentage of total violent people contained in this class	Number of people not violent in class
1	343	1.2	4	2	341
2	248	7.7	19	11	237
3	183	26.2	48	27	135
4	102	55.9	57	32	45
5	63	76.2	48	27	15

Even in the highest risk category, therefore, almost one in four of the sample was not violent in the following year. A compulsion standard based on membership in risk class 5 would still wrongly compel one person in four, a ration that must cause concern given the extremity of the legal powers provided to the psychiatric system. Even with such a high proportion of wrongful compulsions, only 27 per cent of persons who would be violent within a year would be caught. Increasing the proportion of violent people admitted of course also increases the proportion of people admitted who are not violent. To catch more than half of violent people, class 4 would have to be included. That would mean 60 people, or 36 per cent of the 165 people admitted, would not turn out to be violent, and so on up the chart.

It should be emphasised that the McArthur study is the best predictor available; adoption of other criteria will yield a statistically worse result. McArthur itself is, however, as yet too complex to be used in a clinical setting.

The standards of dangerousness contained in the draft mental health bill are exceptionally badly drafted. The relevant criteria are contained in clause 6(4) of the bill:

> 6(4) The third condition is –
>
> (a) in the case of patient who is at *substantial risk of causing serious harm to other persons*, that it is necessary for the protection of those persons that medical treatment be provided to him, and
>
> (b) in any other case, that –
>
> (i) it is necessary for the health or safety of the patient or *the protection of other persons* that medical treatment be provided to him, and
>
> (ii) that treatment cannot be provided to him unless he is subject to the provisions of this Act. [italics added]

Not merely is there no indication as to how dangerousness is to be ascertained, it is not even really clear what the clause means. A patient who is 'at substantial risk of causing harm to other persons' in sub-clause (a) is to be treated under compulsion even if the compulsion is not necessary. Quite why this unnecessary compulsion is justifiable is at best highly questionable, and if such rational argument fails to result in

the implosion of this clause, recourse may be had to law. The *Winterwerp* decision allows the detention of persons of unsound mind under Article V of the ECHR only if they suffer from a mental disorder of a kind or degree warranting compulsory confinement.[57] It is difficult to see that such a standard can be met in cases when detention is not 'necessary'. Such unnecessary confinement is further expressly disallowed by the decision in *Witold Litwa v. Poland*, where the ECtHR states:

> 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 that the person concerned be detained. That means that it does not suffice that the deprivation of liberty is executed in conformity with national law but it must also be necessary in the circumstances.[58]

Also problematic is how this clause (a) group compares to those who are compelled under clause (b) 'for the protection of other persons'. Protected from what, if not 'substantial risk of serious harm', yet as they are in a separate sub-clauses, with sub-clause (b) having the additional requirement in (ii), those identified in sub-clause (b) must be broader than sub-clause (a). Are we to understand that someone may fall under the (b) criteria even if the risk of harm were non-substantial or if the harm itself not serious? That is sufficiently absurd that it cannot be what the government intends, but it is the only consistent reading of the criteria. In the unlikely event that it is what the government intends, it raises the same ECHR points as those under clause (a), above.

All that said, as noted previously, it does seem an unnerving result that we would be able to leave manifestly dangerous people with mental disorders at large, even if for example they were unaware of their own dangerousness. If it were agreed, as argued above, that one need not wait for an actual criminal injury prior to intervention, is it possible to draft a statute which meets that standard? Ontario's statute seems a serious attempt:

15(1) Where a physician examines a person and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
(c) has shown or is showing a lack of competence to care for himself or herself

and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;
(e) serious bodily harm to another person; or

(f) serious physical impairment of the person

the physician may make application in the prescribed form for a psychiatric assessment of the person.[59]

This section specifies danger in terms of the nature and degree of the potential injury, but also requires precipitating events in order to justify intervention. On its face, it would seem to require cogent and immediate reasons based in the actual behaviour of the potential patient to authorise intervention. If the decision is that a dangerousness standard is the appropriate way forward, it is this sort of specificity that should be required.

VIII. CONCLUSION

The government has done itself no favours in the consultation process surrounding mental health reform. It appointed an expert committee whose report it largely ignored. Instead, it set forth its proposals in fashions apparently designed by spin doctors to placate a perceived moral panic rather than making an intellectually coherent case for its views. While content to ride the wave of concern over risks of allegedly dangerous patients, it consistently failed to acknowledge the fact that rates of homicide related to mental disorder have been falling for many years.[60] It therefore completely ignored the efforts of those in the system who achieved that result. Statements such as 'Care and treatment should involve the least degree of compulsion that is consistent with ensuring that the objectives of the [treatment] plan are met'[61] would inevitably be read as 'compulsion will be no more than necessary, to ensure

that the patients do what they are told' – an approach hardly likely to endear it to those believing in patient rights. If the government had set out to alienate, it is difficult to see that it could have done a better job.

If the furore is in retrospect tiresomely predictable, it does not make the problem go away. We need a new Mental Health Act, and our choice is between a variety of standards and approaches, all of which have their problems. It is time for the government to have the debate about real options, and for people in the mental health policy community to engage with those real options.

My own view, subject to the arguments that may arise in those debates, is that we should ensure that incapacity is the criterion for compulsory treatment. We should further maintain the existing rule that those lacking capacity to make admission decisions based on a low threshold of capacity should be admitted on some form of best interests test. As we have seen, decisions regarding capacity for psychiatric admission do not divide neatly from broader questions of capacity, so this standard belongs in the new Incapacity Act, not in specialised mental health legislation. To meet ECHR requirements of clarity, that threshold may require more express articulation than is currently the case.[62] Such clarification is desirable in any event, to ensure that the threshold remains low.

Capacity cannot, however, provide the sole legal framework for psychiatric detention, and the other criteria we adopt will prove problematic. They will be specific to people with mental disabilities and will therefore, in a sense, be inherently discriminatory against that group of people. That is distasteful, but as we have seen,

adoption of a capacity test simpliciter will result in an irresistible pressure to raise the threshold of capacity, removing rights from the very people our anti-discriminatory policy aims to empower.

What should the additional criteria look like? Here, the ineptitude of the government in managing the reform process should not blind us to the merits of its approach. The question is when social control is justified in a psychiatric crisis. Dangerousness provides a standard where the public interest in intervention is clear, and a properly drafted dangerousness standard may provide the best way forward. The government's approach may therefore be the right one; but a shame about the drafting. If that is the case, the way forward is to engage in a serious debate as to what a proper dangerousness standard should look like. The Ontario legislation provides a good starting point for discussion.

[1] Earlier versions of this paper were read to the Society of Legal Scholars annual conference (Leicester de Montfort University, 2002), to the Socio-Legal Studies Association annual conference (Nottingham Trent University, 2003), and to the International Academy of Law and Mental Health (Sydney, 2003). I thank the participants in those meetings for their comments.

[2] Department of Health, *Draft Mental Health Bill*. (Cmnd 5538 2002).

[3] Department of Health, *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital* (the 'Fallon Report') (Cmnd 4194 1999).

[4] Home Office and Department of Health, *Managing Dangerous People with Severe Personality Disorder: Proposals for Policy Development*. (Stationery Office, 1999).

[5] Department of Health, *Review of the Mental Health Act 1983: Report of the Expert Committee* (the 'Richardson Report'). (Department of Health, 1999).

[6] Department of Health, *Reform of the Mental Health Act 1983: Proposals for Consultation*. (Cmnd 4480 1999).

[7] Department of Health, *Reforming the Mental Health Act*. (Cmnd 5016 2000).

[8] For commentaries regarding the reform process, see P. Bartlett, 'English Mental Health Reform: Lessons from Ontario?' (2001) 5 *Journal of Mental Health Law* 27; P. Bowen, 'Reform of the Mental Health Act 1983: Convention implications of the Green Paper' (2000) 4 *Journal of Mental Health Law* 99; R. Brown, 'Response to the Draft Mental Health Bill' rpt (2002) 8 *Journal of Mental Health Law* 392; A. Buchanan, 'Psychiatric Detention and Treatment: A Suggested Criterion" (2002) 6 *Journal of Mental Health Law* 35-41; M. Clayton, 'A Successor Body to the Mental Health Act Commission' (2000) 4 *Journal of Mental Health Law* 157; M. Clayton, 'The Separation of the Mental Health Act Commission's Functions: Inspectors, Visitors and Advocacy', (2002) 7 *Journal of Mental Health Law* 97; L. Davidson, 'Human rights vs public protection: English mental health law in crisis' (2000) 25 *International Journal of Law and Psychiatry* 491; A. Eldergill, 'IS ANYONE SAFE? Civil Compulsion under the Draft Mental Health Bill' (2002) 8 *Journal of Mental Health Law* 331; P. Fennell, 'Reforming the Mental Health Act 1983: 'Joined Up Compulsion'' (2001) 5 *Journal of Mental Health Law* 5; M. Gunn, 'Reforms of the Mental Health Act 1983: The Relevance of Capacity to make Decisions' (2000) 3 *Journal of Mental Health Law* 39; M. Gunn and A. Holland, 'Some thought son the proposed Mental Health Act' (2002) 8 *Journal of Mental Health Law* 360; Law

Society, 'Response to the Draft Mental Health Bill' rpt (2002) 8 *Journal of Mental Health Law* 373; Liberty, 'Response to the Draft Mental Health Bill' rpt (2002) 8 *Journal of Mental Health Law* 380; M. Mullins, 'The new Mental Disorder Tribunal' (2000) 3 *Journal of Mental Health Law* 28; G. Otten, 'Response to the Draft Mental Health Bill' rpt (2002) 8 *Journal of Mental Health Law* 386; J. Peay, 'Reform of the Mental Health Act 1983: Squandering an Opportunity?' (2000) 3 *Journal of Mental Health Law* 5; M. Pedler, 'Mental Health and Compulsion' (2000) 3 *Journal of Mental Health Law* 16; H. Prins, 'Offenders, Deviants or Patients: Comments on Part Two of the White Paper' (2001) 5 *Journal of Mental Health Law* 21; Royal College of Psychiatrists, 'Response to the Draft Mental Health Bill' rpt (2002) 8 *Journal of Mental Health Law* 376; G. Szmukler and F. Holloway, 'Reform of the Mental Health Act: Health or safety?' (2000) 177 *British Journal of Psychiatry* 196; A. Zigmond and A. Holland, 'Unethical Mental Health Law: History Repeats Itself' (2000) 3 *Journal of Mental Health Law* 57.

[9] Cl. 6(4)(a).

[10] Mental Health Act 1983, s 2(2)(b); see also s 3(2)(c). The standard is also contained as clause 6(4)(b)(i) of the draft bill.

[11] S. 3(2)(b). The draft bill would instead require that 'appropriate' treatment be available for all cases of compulsion. This would appear to be a lower standard than that contained in s. 3(2)(b).

[12] See, eg., *Winterwerp v The Netherlands*, 2 E.H.R.R. 387, para. 45.

[13] By Mental Health (Patients in the Community) Act 1995.

[14] See s. 63.

[15] Charter of Fundamental Rights of the European Union (2000/C 363/01).

[16] European Convention. *Draft Treaty establishing a Constitution for Europe* (Conv 850/03). See particularly Part II, which comprises the Charter of Fundamental Rights of the Union and unlike the Nice Charter, would be of direct effect.

[17] P. Taylor and J. Gunn, 'Homicides by people with mental illness: myth and reality', (1999) 174 B*ritish Journal of Psychiatry* 9.

[18] See for example Glasgow Media Group, *Media and Mental Distress*, G. Philo (ed), (Longman 1996).

[19] See Jill Peay, *Decisions and Dilemmas: Working with Mental Health Law* (Hart 2003), esp at chapter 4.

[20] The standard was originally contained in Mental Health Act 1959, s. 25.

[21] See *Re F (Mental Patient: Sterilization)* [1990] 2 A.C. 1; [1989] 2 W.L.R. 1025.

[22] See, eg, A. Buchanan, 'Psychiatric Detention and Treatment: A Suggested Criterion' (2002) 6 *Journal of Mental Health Law* 35; M. Gunn, 'Reforms of the Mental Health Act 1983: The Relevance of Capacity to make Decisions' (2000) 3 *Journal of Mental Health Law* 39; M. Gunn and A. Holland, 'Some thought son the proposed Mental Health Act' (2002) 8 *Journal of Mental Health Law* 360; G. Szmukler and F. Holloway, 'Reform of the Mental Health Act: Health or safety?' (2000) 177 *British Journal of Psychiatry* 196.

[23] Richardson Committee Report, paragraph 5.18.

[24] Paras. 15.10-25.

[25] See s. 63, 58. Both of these sections are subject to section 57 of the Act, which prohibit specified treatments absent the competent consent of the patient. Currently, the treatments in question are psychosurgery and surgical implantation of hormones to reduce male sex drive. The structure of the Act makes these treatments unavailable to patients lacking capacity, be they informal or involuntary.

[26] The right of competent confined patients to consent to or refuse treatment was originally established in Equality Rights Statute Law Amendment Act, 1986, S.O. 1986, c. 64 and the Mental Health Amendment Act, 1987, S.O. 1987, c. 37, both amending the Mental Health Act, R.S.O. 1980, c. 262. They are now contained in the Health Care Consent Act 1996, S.O. 1996, c 2, sch A.

[27] On the therapeutic desirability of voluntary treatment, see further B. Winick, 'Competency to Consent to Treatment: The Distinction between Assent and Objection' (1991) 28 *Houston Law Review* 15; B. Winick, 'Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence Analysis of Zinermon v. Burch' (1991) 14 *International Journal of Law and Psychiatry* 169.

[28] *Report of the Committee for the Prevention of Torture* (Council of Europe 2000) para 41.

[29] [2001] E.W.C.A. Civ. 1545.

[30] *Wilkinson* at para 30.

[31] *Wilkinson* at para 80.

[32] *Re MB (Medical Treatment)* [1997] 2 F.L.R. 427 at 437.

[33] See, eg., *Re MB* (above), Re *T* [1992] 4 All E.R. 649, *Re L (Medical Treatment)* [1998] F.L.R. 810, *Tameside and Glossop Acute Services Trust v CH* [1996] 1 F.L.R. 762, *Norfolk and Norwich Healthcare (NHS) Trust v W* [1996] 2 F.L.R. 613, *A Metropolitan Borough Council v DB* [1997] 1 F.L.R. 767, *R v Collins and Ashworth Hospital Authority ex parte Brady* [2000] L.L.R.M. 355. Cases

where capacity is affirmed when the issue is disputed are rare: see, eg., *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All E.R. 819; *B v Croydon DHA* (1994) 22 B.M.L.R. 13 (where the affirmation of capacity by the trial judge was expressly doubted on appeal: [1995] 1 All E.R. 683).

[34] *Zinermon v Burch*, (1990) 494 U.S. 113, 110 S.Ct. 975, 108 L.Ed. 2d 100 (U.S.S.C.).

[35] *R v Bournewood Community and Mental Health NHS Trust, ex p L* [1998] 3 W.L.R. 107.

[36] See P. Bartlett, 'Capacity and Confinement: When is Detention Not Detention?', in K Diesfeld and I Freckelton (eds) *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment* (Aldershot: Dartmouth, 2003).

[37] 494 U.S. 133-4.

[38] There are no English sources that address this question. American sources include American Psychiatric Association, 'Consent to voluntary hospitalization', task force report 34 (APA, 1992); P. Appelbaum and A. Bateman, 'Competency to Consent to Voluntary Psychiatric Hospitalisation: A Theoretical Approach' (1979) 7 *Bulletin of the American Academy of Psychiatry and the Law* 390; S. Hoge, 'On Being "Too Crazy" to Sign into a Mental Hospital: The Issue of Consent to Psychiatric Hospitalization' (1994) 22 *Bulletin of the American Academy of Psychiatry and the Law* 431; and B. Winick, 'Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence Analysis of Zinermon v. Burch' (1991) 14 *International Journal of Law and Psychiatry* 169, esp at 182-91.

[39] Or, more properly, what ought one be incapable of knowing to lack such capacity, since English law carries a presumption of capacity. For ease of grammatic construction, the discussion will proceed on the basis of what must be known to have capacity, although it should be recognised that this is in a sense misleading.

[40]American Psychiatric Association, 'Consent to voluntary hospitalization', task force report 34 (APA, 1992). For authors in broad support, see eg B. Appelbaum, P. Appelbaum and T. Grisso, 'Competence to Consent to Voluntary Psychiatric Hospitalization: A Test of a Standard Proposed by the APA' (1998) 49 *Psychiatric Services* 1193; S. Hoge, (above) and B. Winick, (above).

[41] For a discussion of these subjects, see S. Hoge (above). Hoge, a psychiatrist, does not view these as medical questions, and therefore fiercely objects to psychiatrist involvement in their use as admission criteria.

[42] See above, footnote 33.

[43] Such a view is consistent with the existing empirical studies. With a relatively high capacity threshold such as is presented in the 1979 Appelbaum and Bateman paper, roughly two thirds of voluntary admissions appear to have sufficiently compromised ability to call their capacity into serious question: see Y. Melamed, R. Kimchi, D. Shnit, D. Moldavski and A. Elizur, 'Clinical Assessment of Competency to Consent to Psychiatric Hospitalization' (1999) 22 *International Journal of Law and Psychiatry* 55 at 57; P. Appelbaum, S. Mirkin, A. Bateman, 'Empirical Assessment of Competency to Consent to Psychiatric Hospitalization' (1981) 138 *American Journal of Psychiatry* 1170 at 1173. The use of the more minimalist APA standard leads inconsistent results. More than half of the patients in Poythress's study showed evidence of impairment on a standard similar to the APA criteria. Interestingly, currently involuntary patients in this study proved to be more competent by a statistically significant amount, 47 per cent lacking capacity compared to 63 per cent of voluntary patients: N. Poythress, M. Cascardi and L. Ritterband, 'Capacity to Consent to Voluntary Hospitalization: Searching for a Satisfactory *Zinermon* Screen' (1996) 24 *Bulletin of the American Academy of Psychiatry and the Law* 439. Appelbaum et al achieve a similar result on a similar test based on two questions requiring recall of information, but a markedly improved result when patients were instead given a true/false test of similar information: B. Appelbaum, P. Appelbaum and T. Grisso (above) at 1195. The impaired ability to recall is further consistent with the earlier Appelbaum study, which showed 62 per cent with impaired ability to recall information relevant to the 'minimal clinical criteria', very broadly similar to the APA standard: P. Appelbaum, S. Mirkin and A. Bateman at 1173. Some methodological reservations are appropriate for all these studies, and a simple mapping between numerical score and incapacity is bound to be problematic. Nonetheless, the studies are consistent with the view that an incapacity standard would sweep a considerably larger proportion of people under its aegis than are currently liable to be detained under the Mental Health Act.

[44] Richardson Committee, para 5.95.iv.

[45] The Richardson Committee declined to recommend whether the risk harm to the patient would be sufficient to warrant intervention: para 5.97. The government declined to consult on the point in its green paper.

[46] Richardson Committee, para 5.95.v.

[47] Department of Constitutional Affairs. *Draft Mental Incapacity Bill* (Cmnd 5859 2003).

[48] Health Care Consent Act, S.O. 1996, c 3, Sch. A.

[49] *Draft Mental Incapacity Bill*, cl 4(2).

[50] A. Stone, *Mental Health and Law: A System in Transition* (National Institute for Mental Health, 1975).

[51] S. Hoge, P. Applebaum, A. Greer, 'An Empirical Comparison of the Stone and Dangerousness Criteria for Civil Confinement' (1989) 146 *American Journal of Psychiatry* 170 at 172.

[52] M. Brook, 'Faux Imprisonment', *La Grande Abridgement*, (n.p.: 1573), vol. 1, at 330.

[53] *The Times*, 27 June 1849, p. 7.

[54] Mental Health Act 1983, s. 25.

[55] J. Monahan, H. Steadman, E. Silver, P. Appelbaum, P. Clark Robbins, E. Mulvey, L. Roth, T. Grisso, and S. Banks, *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence* (Oxford University Press 2001).

[56] Adapted from Monahan et al, table 6.7.

[57] *Winterwerp*, above, para 45.

[58] Witold Litwa v. Poland, (Application no. 26629/95) Decision dated 4 Apr 2000, para 78.

[59] RSO 1990, c M-7.

[60] Taylor, P. and Gunn J. 'Homicides by people with mental illness: myth and reality' (1999) 174 *British Journal of Psychiatry* 9.

[61] Department of Health White Paper (2000), para 2.11.

[62] This will depend in part upon the outcome of the litigation in *L v. Bournewood*, currently before the EctHR.