MAUDSLEY DISCUSSION PAPER NO. 10

Mental Health Law: Discrimination or Protection?

Dr George Szmukler, Joint Medical Director, South London and Maudsley NHS Trust.
Dr Frank Holloway, Clinical Director, Croydon Borough Directorate, South London and Maudsley NHS Trust.

INTRODUCTION

Most societies have provisions governing the involuntary treatment of people with a mental illness. Two broad approaches to mental health legislation have been identified (Peele and Chodoff, 1999). Both require the presence of a mental illness. In one there must be an additional need for treatment, which might be in the interests of the individual’s health or safety or the safety of others. In the other approach, generally seen as narrower in scope, there must be evidence of risk or dangerousness in addition to the mental illness. In this paper we argue that neither formulation is satisfactory and that, in common with all other branches of health care, lack of capacity (or ‘competence’) to make treatment decisions should become the basis for compulsory treatment.

The need for a principled approach to compulsory psychiatric treatment is given added impetus by social fears exaggerating the link between mental illness and dangerous behaviour and the tendency to simplistically identify professionals to blame when adverse events occur (Szmukler, 2000). There is a major concern that the boundaries of compulsory psychiatric care will expand to include any individual with some evidence of mental disorder who represents a potential risk to others. We suggest that if our society is intent on protecting itself from dangerous persons through legislation, additional provisions are required for situations where people with capacity are deemed to represent a risk to others. Such generic ‘dangerousness legislation’, not dependent on the presence of mental illness or mental disorder, would need the highest degree of judicial oversight to ensure that abuses did not occur.

Our arguments are an extension of those presented elsewhere by Campbell and Heginbotham (1991), Campbell (1994), Rosenman (1994) and Szmukler and Holloway (1998) showing that mental health legislation as presently conceived discriminates against persons with mental disorder.
Evolving Mental Health Law

Jones (1991) has summarised 150 years of mental health legislation in England and Wales from the Lunatics Act of 1845 onwards. She contrasts the legal mode of thought, preoccupied with the liberty of the individual and the precise description of the circumstances within which individuals could be deprived of their liberty, with a medical approach that seeks to ensure that those in need of treatment and care receive it with the minimum of legal impediment. There has been an ebb and flow between these paradigms, with legalism triumphing in the Lunacy Act 1890, retreating through the Mental Treatment Act 1930 to apparent defeat with the medically-centred Mental Health Act 1959. The 1983 Mental Health Act represented a partial return to legalism, with provisions designed to ensure that medical powers, for example over forced treatment, would not be abused.

Jones argues that the normative, non-prescriptive approach to mental health law exemplified by the 1959 Act, which attempted to ‘medicalise’ the compulsory treatment of the mentally ill, is less stigmatising than its prescriptive predecessors and immediate, avowedly libertarian, successor. The pendulum seems to be swinging further back towards legalism. The Mental Health (Patients in the Community) Act, 1995, which introduced a power of ‘supervised discharge’, is a prime example of what Jones describes as ‘close-textured’ legislation. It spells out in detail the procedures to be adopted by professionals in order to achieve limited therapeutic aims (Holloway, 1996a). The ‘close-textured’, prescriptive approach reflects public and policy-makers’ concerns about the work of mental health professionals. These concerns were prominent in the late 19th Century, in part driven by popular literature about the treatment of the mentally ill, and have returned during the latter part of the 20th Century, now driven by the media and general societal distrust of professionals (Rose, 1998).

The Policy Background

Mental health policy

Mental Health Act reform is a key element in current UK government plans for ‘Modernising Mental Health Services’ (Department of Health, 1998). Current mental health policy is based on the assumption that ‘community care has failed’ since ‘it left far too many walking the streets, often at risk to themselves and a nuisance to others. A small but significant minority has been a
threat to others or themselves’. This requires the law to be changed ‘to ensure that patients who might otherwise be a danger to themselves and others are no longer allowed to refuse to comply with the treatment they need’ (Modernising Mental Health Services: Safe, Sound and Supportive: Department of Health, 1998, pg. 6). In addition a linked policy stream proposes what is in effect the preventative detention of ‘dangerous people with severe personality disorders’ (Home Office and Department of Health, 1999).

The policy emphasis on risk avoidance and coercion dates back to the early 1990s. It reflects a ‘moral panic’ about the dangers presented to the public by people with a severe mental illness in the era of deinstitutionalisation (Holloway, 1996b). This is despite good evidence from data on homicides in England and Wales that the risks to the public from the mentally ill have been, in relative terms, decreasing (Taylor and Gunn, 1999; Szmukler et al, 1999).

Implications of the Human Rights Act 1998

A further driver to reform of mental health legislation is the incorporation into UK law (under the Human Rights Act 1998) of the European Convention on Human Rights. Article 5.1 (e) of the ECHR allows for the ‘lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants’ in accordance with the procedural and substantive provisions of domestic law (currently the 1983 Mental Health Act). Article 5.4 states that ‘everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful’. The decision to detain a person under the 1983 Mental Health Act, although essentially a medical one, has always been subject to legal challenge through judicial review or application for habeas corpus, to a Mental Health Review Tribunal or to the European Court of Human Rights (Department of Health, 1993).

The functioning of the 1983 Mental Health Act

In preparation for reform, the Government commissioned a systematic review of the operation of the Mental Health Act (Wall et al, 1999). Its major finding was a 63% increase in the number of compulsory admissions in England between 1984 and 1996 (Hotopf et al, 2000), with a marked acceleration in the rate of use of compulsory powers in the period 1992-1996 (at the height of the
‘moral panic’). A consistent finding has been that black people are more likely to be admitted compulsorily. The majority of people with a psychotic illness from all ethnic backgrounds, at least in urban areas, experience compulsory admission at some time in the course of their illness. One study found that 20% of people with a psychotic illness were compulsorily admitted within a 3-year period (Johnson et al, 1998). Less clear is the impact of compulsory admission on the patient, although Wall et al (1999) quote unpublished data that compulsion is experienced as coercive. A report on the implementation of ‘supervised discharge’, which documents its sparse, uneven and grudging application (Pinfold et al, 1999), appeared too late to be included in the review.

Proposals for reform

An Expert Committee, under the chairmanship of Professor Genevra Richardson, was commissioned to put forward, within a tight time-scale, proposals for a revised Mental Health Act (Expert Committee, 1999). Their report was followed by a Green Paper setting out Government proposals for reform (Department of Health, 1999a). The Expert Committee, supporting the principles of autonomy and non-discrimination for patients with mental illness, argued for mental health legislation that was based on lack of capacity to make treatment decisions as a key test in determining the justification of compulsory treatment for mental illness (risk to others being an alternative test). The government in its Green Paper rejected the idea of placing capacity at the heart of mental health legislation, whilst endorsing the proposal to place all decisions about extended compulsory treatment in the hands of a legal body (the new Tribunal). A close reading of the Green Paper reveals the government’s preoccupation with risk reduction and eliminating ‘unacceptable’ variations in clinical practice. The move towards increasing coercion was underlined by the then Minister in a speech inaugurating the work of the Expert Committee: ‘non-compliance can no longer be an option’ (Boateng, 1998).

The ‘Bournewood gap’

The Bournewood case pointed to an apparent conundrum in the relationship between mental health law and the common law. The case concerned the legality of the informal hospital admission of a distressed person with a severe learning disability who lacked capacity but who did not object. Admission was against the wishes of his carers. Appeal reached the House of Lords which ruled in 1998 that this practice was lawful under Section 131 of the Mental Health
Act, which was interpreted as allowing for non-compulsory treatment of non-objecting patients with mental incapacity (R v Bournewood Community and Mental Health National Health Service Trust ex parte L (1998) All ER 319). However, there was judicial unease that the treatment of the non-objecting yet mentally incapacitated individual carried out under common law lacks the safeguards provided by the Mental Health Act for detained patients - Lord Steyn stated: “The general effect...is to leave compliant incapacitated patients without the safeguards enshrined in the Act of 1983. This is an unfortunate result”. The European Convention on Human Rights requires ‘detention’ of persons of ‘unsound mind’ to be only in accordance with a procedure prescribed by law, which is not obviously the case for the non-objecting incapacitated individual who could be seen as experiencing ‘de facto’ detention.

Thus there are major pressures for mental health law to be changed, but there is also a lack of coherence in the underlying principles that should guide such change. We argue, in common with Campbell and Heginbotham (1991) and the Expert Committee, that coherence can be achieved by starting from two basic principles – autonomy and non-discrimination.

The case for capacity-based mental health law

Non-consensual medical treatment

A patient with a ‘physical disorder’ such as cancer may refuse treatment even if the disease is life threatening. UK courts, and other common-law jurisdictions such as the United States, set a very high value on the autonomy of the individual. The ‘courts have ruled that a mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where the decision may lead to his or her own death’ (NHS Executive, 1999, para 1.2). Because we respect personal autonomy we accept the individual’s decision unless there is reason to believe that the patient’s decision-making capacity is impaired (Beauchamp, 1999). In the U.K., paternalistic interventions in medicine (with the notable exception of psychiatry) that over-ride the individual’s autonomy are only allowed when (1) a patient lacks the mental capacity to make treatment decisions for himself or herself, and (2) treatment is in the patient’s best interests

There is no current statutory definition of capacity, and the common law is at present widely regarded as unsatisfactory. However, following a report on mental incapacity by the Law
Commission (1995) and a period of consultation (Lord Chancellor 1997), the Government has proposed legislation which will clarify the meaning of *capacity* and *best interests* and define the powers of others to act on behalf of incapacitated patients (‘Making Decisions’ - Lord Chancellor, 1999). Proposed definitions are shown in Table 1. *Capacity* involves the patient’s ability to understand and retain information about the nature of the treatment and the consequences of accepting it or not, and to reason with that information. ‘*Best interests*’ attempts to determine what the patient might have chosen in this situation if he or she had capacity, based on past statements (as in an ‘advance statement’ or ‘directive’) or according to those who know the patient well. When a future period of incapacity is predictable, a patient may also appoint a person to take healthcare decisions on his or her behalf according to stated preferences or principles. The patient’s values are thus given weight, important in a multicultural society. However, the proposed legislation regarding decision-making for those with mental incapacity will not cover those with ‘mental disorder’. Evidently there is something different between mental capacity in ‘physical’ and ‘mental’ disorders, but there is no attempt to define what this might be.

*The anomalous position of mental illness*

In contrast to impairment in decision-making by patients with ‘physical disorder’, under the Mental Health Act 1983 and mental health legislation in most countries, detention and involuntary treatment of those with ‘mental disorder’ is governed by an entirely different set of tests. In England and Wales capacity plays no role in decisions to initiate psychiatric treatment against a patient’s wishes. The Mental Health Act 1983 allows involuntary treatment if the person is ‘suffering from a mental disorder (mental illness, mental impairment, severe mental impairment or psychopathic disorder); the disorder is of ‘a nature or degree which makes it appropriate…to receive medical treatment’; and, treatment is ‘necessary in the interests of the health or safety of the patient or for the protection of other persons’. (Capacity only appears when making judgements about whether there is a need for a second opinion in relation to drug treatment for a detained patient after 3 months, or for the dissenting patient for whom ECT is being proposed).

Let us stay only with the health or safety of the patient for the moment. Compared with the tests for those with ‘physical disorders’, those for ‘mental disorders’ fail to respect the autonomy of the patient. The patient’s reasons for rejecting the treatment are not explored (as they must be in
determining capacity), nor is the question of whether treatment is in the best interests of the patient. The sole considerations are the presence of a mental illness or disorder and the patient’s ‘health or safety’, presumably from the perspective of the clinician or treatment team (or other representatives of society). But we accept that patients with physical disorders, provided they have capacity, can make decisions that may be seriously detrimental to their health or safety. For them, ‘health or safety’ are not the ultimate values. For persons with capacity, their personal values are given dominion – this is what ‘autonomy’ means. Those with mental disorder are not given this respect; they may be treated against their will irrespective of their capacity to make treatment decisions for themselves.

Mental health legislation is discriminatory

There seems to be an underlying assumption that ‘mental disorder’ necessarily entails mental incapacity, so the question does not need to be asked. And also, that the values espoused by a person with a disordered mind are not to be taken seriously in determining where their best interests lie. By failing to respect the mentally disordered patient’s autonomy; by not presuming capacity unless there is reason for doubt; by assuming that mental disorder entails incapacity; and by enshrining these prejudices in legislation which applies uniquely to those with ‘mental disorder’ (which remains undefined), current mental health legislation discriminates against those with mental disorders and serves also to stigmatise them. The discrepancy in the degree of respect for the autonomy of patients is painfully obvious in two Government documents recently out for consultation – Making Decisions (Lord Chancellor, 1999), mentioned above, and the ‘Green Paper’ Reform of the Mental Health Act (Department of Health, 1999a). The former, which covers mental incapacity due to physical disorders, is founded on a respect for patient autonomy; the latter, which covers treatment for psychiatric disorders, explicitly elevates risk reduction above autonomy. No justification is offered for the latter.

We conclude that a form of ‘incapacity legislation’, such as the government is proposing for those with physical disorders, but which covers non-consensual treatment for all patients with mental incapacity, from whatever cause (head injury, post-ictal confusion, learning disabilities, schizophrenia, Alzheimer’s disease, psychotic depression, febrile toxic states) is the only fair legislation. Only then may an important source of discrimination against a stigmatised subset of incapacitated patients cease. The ‘Bournewood gap’ would also be eliminated; the same protections would be established for all persons lacking capacity who do not object to treatment.
The regime of the European Convention on Human Rights is held up as a sound protector of human rights and specifically endorses the compulsory confinement of those of ‘unsound mind’ provided it is has certain legal protections. If capacity-based legislation is thus ruled out, we should conclude that the relevant provisions of Article 5.1 are also discriminatory, and that the 50-year-old convention is in need of revision.

*The practical determination of capacity*

An objection to capacity-based legislation is that capacity is difficult to assess. It certainly will not be simple. However, it is the right problem to tackle and the one consonant with the rest of medicine. Doctors have rarely been trained to examine capacity and most of us have little experience in its assessment. However, research shows that with training and experience it can be reliably measured (Grisso and Appelbaum 1995a; Grisso et al, 1997; Grisso and Appelbaum, 1998). Key abilities required for the individual to have capacity can be tested - communicating a choice, understanding relevant information, appreciating the current situation and its consequences, and manipulating information rationally. Using structured research assessments of these abilities, Grisso and Appelbaum (1995a) found 52% of a cohort of hospitalised inpatients with schizophrenia lacked capacity (compared with 24% of inpatients with depression). Importantly, hospitalised patients with schizophrenia showed improvement in decision-making abilities over a two week treatment period (Grisso and Appelbaum, 1995b). A practical instrument to measure these competencies in routine clinical practice (the MacArthur Competence Assessment Tool – Treatment) has been developed (Grisso et al, 1997). It is unlikely that achieving precision in the assessment of capacity is harder than say, defining ‘mental disorder’ or specifying what constitutes sufficient danger to the health or safety of others to warrant involuntary treatment.

*Treatment for the protection of others*

Equally, if not more discriminatory than aspects of mental health legislation referring to the safety of the patient are those referring to the ‘protection of other persons’. People with mental disorders are virtually unique in being liable to detention (in hospital) because they are assessed as presenting a risk of harm to others, but before they have actually committed an offence. This
constitutes a form of preventive detention to which our society, in other contexts, has had an aversion on civil liberty grounds. Such provisions are available both under civil and forensic provisions of the Mental Health Act. As policy trends increasingly press psychiatrists to admit compulsorily people who exhibit anti-social behaviour or express thoughts of harming others (often in the absence of any clear association between such behaviours and the presence of a mental illness) the scope for expansion is immense.

**Violence and mental disorder**

Although some groups of people with mental illness are modestly more likely to be violent than the normal population, especially in association with substance misuse (Steadman et al, 1998), people with severe mental disorder perpetrate only a small fraction of serious violence in our society (Swanson et al, 1990). There is no evidence that violence is more predictable in those with mental disorder compared to the rest of the population. Indeed, the most predictably dangerous persons are those with a track record of dangerous behaviour, most of whom are not mentally ill – habitual spouse abusers, dangerous drivers (especially in association with alcohol), regular substance misusers, and those with a short temper who regularly place themselves in situations where they are likely to be provoked. Even if violence by the mentally ill were more predictable, this would still not justify a lower threshold for detention for those with mental disorder compared to the rest of us; nor does ‘treatability’. Groups of non-mentally disordered dangerous persons might respond just as well, if not better, to psychosocial ‘treatment’ programmes (eg meeting victims, counselling, penalties) aimed at reducing dangerous driving or domestic violence. The fact that treatment-resistant mentally ill patients who are deemed dangerous are detained the longest shows also that ‘treatability’ is a lame justification.

**The confusion of paternalism with the protection of others**

Mental health legislation confuses paternalism and the protection of others. These serve quite separate ends. The former is concerned with the health interests of the patient and empowers others to act when the patient lacks the capacity to act in his or her best interests. The protection of others turns on the risk of harm. This risk may not have much to do with illness or with a patient’s capacity to make treatment decisions. If a patient lacks capacity and treatment is in his or her ‘best interests’, involuntary treatment is justified. Whether there is a danger to others or not may not be especially relevant, although it would of course be taken into account in weighing
up whether treatment is in the patient’s ‘best interests’ and might prompt particularly urgent action to ensure the safety of patient and others.

Let us assume for the moment that dangerousness can be reliably linked to an individual’s mental disorder and further that some form of ‘treatment’ will reduce the risk. If the patient has capacity and rejects treatment, can we say that danger to others provides an ethically acceptable reason for involuntary treatment which should be given even if the (autonomous) patient regards it as not in his or her ‘best interests’? The Expert Committee (1999) offered a tentative ‘yes’ while recognising therein an inconsistency with the fundamental principle of respect for autonomy – which would demand that only those lacking capacity should enter the frame for involuntary treatment. We argue for a more principled position: if involuntary ‘treatment’ is imposed under these circumstances, then no health interest for the patient is being served. Protection of the public is the sole interest. It might be tempting to offer some kind of ‘best interests’ argument that if people with a mental disorder (with capacity) commit a serious offence they will after all probably be worse off. However, on this account anyone, ill or not, who is at risk of committing a violent act is not acting in his or her own ‘best interests’ and should thus be liable to preventive detention. Few would regard this as acceptable. ‘Best interests’ here are clearly not health-related ‘best interests’.

Table 2 may help to clarify the possible relationships between mental disorder, capacity and dangerousness, and ethically appropriate actions to protect others.

There is still a further consideration. Presumably if the patient has capacity, he or she understands the consequences of refusing treatment and must thus be considered as assuming responsibility for the outcome, in the same way as a person assumes responsibility for the consequences of heavy drinking while knowing that he or she will soon drive. Why should the fact of mental illness be of any relevance? Many potentially dangerous non-mentally disordered persons know that they are vulnerable to factors such as alcohol or certain provocative, but avoidable, social situations that increase their risk of becoming violent. We consider them to be responsible for any unacceptable later actions. Why not those with mental disorders (who have capacity)?
One must conclude that if preventive detention is to be allowed for the mentally disordered solely on account of their danger to others, so should it be for all of us. Otherwise it amounts to discrimination against those with mental disorder. For all persons - those with mental disorders who retain capacity as well as everyone else in the population - the liability to preventive detention should be equal. There are two questions to ask about a potentially dangerous person, and their ordering is crucial. *First* - what is the risk? Risk should be ascertained according to established risk factors, whether the person suffers from a mental disorder or not, and in an appropriate judicial setting. If the risk is deemed unacceptable, a *second* question arises - what can be done, if anything, to reduce it. At this point treatment might be offered to the dangerous mentally disordered person if this carries a likelihood of reduction of risk. If no ‘treatment’ or similar intervention exists, or if it is rejected, then a custodial disposal will be necessary. This of course amounts to a *generic dangerousness* or *preventive detention* provision against which many will recoil. If the principle of non-discrimination means anything then either we have generic legislation applicable to all of us or we have no preventive detention for anyone, including those with mental disorder. The present situation is clearly discriminatory against those with mental disorder – at an equal level of risk, the mentally disordered person is much more likely to be detained. That is, we ask the two questions in the *wrong* order: we first ask `is the person mentally disordered?; if so, we ask secondly: `is he or she dangerous?*

Why has this prejudicial situation arisen and why is it so rarely challenged? It presumably reflects deeply ingrained fears of the mentally ill and stereotypes of dangerousness which are so inherent in ‘folk’ notions of mental illness that their uncoupling is not even thought about. By failing to note the distinction between health interests and the protection of others, and by getting the order of the two key questions wrong, we allow the continuing possibility of abuses of civil liberties. The potential for abuse is clearly demonstrated in current proposals under which the application of a state-defined ‘diagnosis’ (‘dangerous severe personality disorder’) and an ascription of dangerousness will be enough to detain someone indeterminately even in the absence of a previous violent offence or the possibility of effective treatment (Home Office & Department of Health, 1999). Persons with mental disorder do not receive the protections from preventive detention that the rest of us do. Mental health legislation supports this, thus reinforcing an underlying stereotype that the mentally ill are inherently dangerous and is thus stigmatising.
A practical difficulty in risk prevention that has significant ethical implications should also be noted. This is the inherently poor predictability of rare events, such as incidents of serious violence, especially in non-forensic settings. Even with very good predictive tools, the rarer the event to be predicted (e.g. the more serious the violence), the poorer the ability to pick who will be violent and who will not. The inevitability of a large number of false positives would lead to the imposition of involuntary treatment or restrictions on many subjects who would not have been violent (Munro and Rumgay, 2000). This applies to all risk assessment, whether the subjects are mentally ill or not.

Compulsory treatment in the community

As the locus of psychiatric treatment has shifted from hospital to community and concerns about non-adherence to treatment have grown, many jurisdictions have introduced involuntary outpatient commitment orders. It is beyond the scope of this paper to discuss in detail the available evidence for the efficacy of compulsory community treatment, but it can be summarised in brief as follows: A series of outpatient commitment studies, uncontrolled and using before versus after comparisons, have found that following outpatient commitment, patients are admitted less often and experience fewer days as inpatients (reviewed by Swartz et al, 1995; Hiday, 1996). However, the concomitant introduction of outpatient commitment and significant service changes, including a greater emphasis on community treatment and reduction in bed use, may make it difficult to identify the actual cause of the changes observed. Perhaps these service changes on their own were responsible for the positive outcomes attributed to outpatient commitment (Swartz et al, 1995; Swanson et al, 1997). Two recent randomised controlled trials comparing outpatient commitment with the same range of services offered without compulsion found no differences in rates of rehospitalisation or violence (New York - Policy Research Associates, 1998; North Carolina - Swartz et al, 1999; Swanson et al, 2000). The North Carolina study found, in ‘post-hoc’ analyses, significantly reduced rates of rehospitalization and violence for the group receiving outpatient commitment as long as commitment was sustained beyond 6 months and service intensity was high. However these results are biased and unacceptable (Szmukler and Hotopf, 2000).
Nor do we have the space to review the potential risks of introducing compulsory community treatment in England and Wales, particularly the potential for deterring patients from seeking care (see Turner (1994) for an account of a UK debate on the issues). Here we focus on ethical issues.

*Types of community treatment order*

Three major types of outpatient commitment can be discerned (Power, 1998; Szmukler and Appelbaum, 2001):

1. **As a substitute for hospital admission**: the outpatient commitment order is considered a *less restrictive alternative* to compulsory inpatient admission, when alternatives to compulsory treatment have been exhausted.

2. **To facilitate earlier discharge from hospital (a form of conditional discharge)**: although the patient may not be well enough for full discharge and requires continued treatment under compulsion, this can be obtained in the community as an alternative to the hospital.

3. **To prevent relapse**: this type of order is applied where there is a proven history of relapse secondary to discontinuation of treatment, usually medication, and relapse is believed to be associated with significant risk to the patient or others.

*Capacity and involuntary treatment in the community*

If a patient lacks capacity and treatment is in his or her best interests, our analysis suggests no ethical objection to the treatment being given in the community rather than in a hospital. If treatment can be given safely and effectively in a community setting, and this is in the patient’s best health interests, there should be no bar. But there is an essential proviso - involuntary treatment should end when the patient stably recovers capacity.

We note here the evidence that community treatment orders under the ‘less restrictive alternative’ concept may continue long after the patient would have been discharged from hospital (McDonnell and Bartholomew, 1997). If outpatient commitment is used as an alternative to admission to hospital or is used to facilitate earlier discharge, criteria for terminating the order are essential. In our framework, the criteria for termination of the order would be based on
recovery of capacity to make treatment decisions or, if incapacity continues, the compulsory treatment no longer being in the best interests of the patient.

The use of outpatient commitment to prevent relapse in patients with a history of persistent non-compliance and an illness which puts them at risk is particularly difficult. Such orders are likely to be prolonged. Again, a justification in terms of continuing incapacity (or capacity which is ‘fragile’ – that is, only retained for brief periods) - is required. A further advantage of framing justifications in terms of capacity to make treatment decisions, is that other options for non-consensual treatment also present themselves. (e.g., advance directives, appointment of surrogate decision-makers and court appointed managers (see Law Commission, 1995; Halpern & Szmukler 1996; Srebnick & La Fond, 1999).

Involuntary treatment in the community for patients with capacity for the protection of others is unjustified on any health interest basis. This is crucially important given the increasing expectations from the public that they should be protected from disturbing persons who they see as threatening. Pressures on community mental health teams to act coercively steadily mount. Removal of the capacity criterion, whilst leaving a broad definition of mental disorder and the ability to ‘treat’ purely for the protection of others leaves enormous scope for abuse.

Conclusions

In this paper we have identified worrying trends in the treatment and care of people with a mental illness. These threaten to overwhelm positive policy trends, such as the statement of guiding values and principles set out in the recently published National Service Framework for Mental Health (Department of Health, 1999b, pg. 4). Driven by concerns about public safety and the control of violence, the UK is currently moving towards increasing coercion of the mentally ill. This is reflected in proposed new mental health legislation, which might be characterised as the iron hand of coercion fitted within the velvet glove of legalism and expressed in a rhetoric of care. Only by placing compulsory treatment on a firm ethical basis will professionals and their patients be protected from powerful societal forces that are threatening to distort the fabric of psychiatric practice. The current Green Paper on reform of the Mental Health Act 1983 represents a major lost opportunity to review the conceptual basis of compulsory care and to move towards a more consensual view of mental health services. Evidently our society has not
yet reached a point of moral sensitivity sufficient to be able to recognise how pervasively it discriminates against its most socially excluded group.
References


**Table 1** Proposed definitions in Law Commission Report on Mental Incapacity (1995) and ‘Making Decisions: The government’s proposals for making decisions on behalf of mentally incapacitated adults’ (1999)

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<tr>
<th>‘Incapacity’</th>
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<tr>
<td>A person is without capacity if, at the time a decision needs to be made, he or she is <strong>unable</strong> by reason of mental disability to make a decision on the matter in question, or unable to communicate a decision on that matter because he or she is unconscious or for any other reason.</td>
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<tr>
<th>‘Mental disability’</th>
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<tr>
<td>is any disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning.</td>
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The person is to be regarded as **unable to make a decision** by reason of mental disability if the disability is such that at the time when the decision needs to be made, the person is unable to understand or retain the information relevant to the decision, or unable to make a decision based on that information.

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<th>‘Best interests’</th>
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<td>Anything done for, and any decision made on behalf of, a person without capacity should be done or made in the best interests of that person. Guidance for deciding what is in the person’s ‘best interests’</td>
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<td>Regard should be given to the following factors:</td>
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<td>- the ascertainable past and present wishes and feelings of the person concerned, and the factors that person would consider if able to do so;</td>
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<td>- the need to permit and encourage the person to participate or improve his or her ability to participate as fully as possible in anything done for and any decision affecting him or her;</td>
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<td>- the views of other persons whom it is appropriate and practical to consult about the person’s wishes and feelings and what would be in his or her best interests; and</td>
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<td>- whether the purpose for which any action or decision is required can be as effectively achieved in a manner less restrictive of the person’s freedom of action.</td>
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<td>MENTAL DISORDER</td>
<td>+ NOT DANGEROUS</td>
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<tr>
<td>Lacks capacity</td>
<td>Treatment is not in patient’s ‘best interests’</td>
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<td></td>
<td>Involuntary treatment is not justified</td>
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<tr>
<td>Has capacity</td>
<td>The patient with capacity determines where his or her own best interests lie.</td>
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