Case Commentary

Brian was given a diagnosis of borderline intelligence and sexual deviation with some paedophiliac tendencies. He had a history of being involved sexually with children. The involvement was such that he would touch them and they would touch him so that sometimes he was led to the point of climax. Brian reported hearing voices, at times calling his name, and having self destructive thoughts of killing himself by drinking shampoo or hanging. An overdose of tablets were taken with the intention of dying. He found that he still had impulses to have young boys undress, fondle and touch him, that were hard to control. Treatment with antiandrogen preparations did not seem to help and caused the complication of lactation. The concern of the staff caring for the patient was that he continued to be aroused by young boys and it was considered that he would pose a risk to their safety if he was living outside of a supervised setting.

The view of the staff was that the interests of the community would be best served by a Compulsory Treatment Order being made so that Brian was required to reside in a hospital or a suitable community facility. The difficulty was in deciding if the patient fulfilled the definition of mental disorder under the Mental Health (Compulsory Assessment and Treatment) Act 1992. This act defines mental disorder as:

> an abnormal state of mind (whether of a continuous or an intermittent nature) characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it:
>
> a) poses a serious danger to the health or safety of that person or of others; or
>
> b) seriously diminishes the capacity of that person to take care of himself or herself.

It was considered debatable whether his mental abnormalities were of such a degree as to fit this definition. The feeling of the staff was that the changes in cognition, perception and mood were relatively minor and he was not considered to be at serious risk of self harm on a day to day basis. The staff were clearly concerned that he would pose a danger to others in the community.
The case for the presence of a mental abnormality was thus presented as strongly as possible, with the decision being left to the Judge as to whether it met the appropriate criteria.

COMMENTARY 1

John Dawson
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I see no compelling ethical objection to the course of action proposed. The staff seem to have no effective treatment for Brian but there is no requirement of 'treatability' within our current committal criteria. If the clinicians believe in good faith, on the basis of an adequate professional assessment, that Brian *may be* "mentally disordered", they are entitled to put the acid on the Judge to make the legal decision. The responsible clinician is the applicant for the Order and bears the main burden of bringing forward evidence to justify compulsion. As long as they do not fabricate or distort evidence, or deliberately pass over material which points the other way, clinicians are entitled to put the strongest case. They might also arrange legal representation for Brian, through an approach to the District Inspector.

Whether this evidence would justify civil committal is a difficult point. Few Judges would have difficulty finding that a threat of this kind is sufficient evidence of "serious danger ... to others". It is the evidence of "abnormal state of mind" that is less convincing. Section 4 of the 1992 Act states that no person shall be subject to civil committal "by reason *only* of ... (b) That person's sexual preferences; or (c) That person's criminal or delinquent behaviour; or ... (e) Intellectual handicap". This undercuts much of the evidence likely to be advanced, but not all of it. Regardless of section 4, a person may be subject to compulsory treatment who plainly meets the definition of "mental disorder", and the disorder need only be "intermittent". The hearing of voices could be considered a disorder of perception; self-destructive thoughts may be symptomatic of mood disorder; inability to control self-destructive and antisocial impulses may be considered a disorder of volition (of will, choice or control).

Taken *together, along with* the evidence of "borderline intelligence" (which need not be wholly discounted), these features might well convince a Judge. Patients with diagnoses of "borderline personality" and "psychopathic and/or narcissistic personality" have been found to meet the definition of "mental disorder" by the Southern Review Tribunal.

The only major distinction between the 1969 and 1992 Mental Health Acts which might affect the outcome is the exclusion from the recent Act of "intellectual handicap" as a sole ground for committal. Contrary to the impression conveyed by recent journalism, there was no criteria under the 1969 Act covering paedophilia per se, nor should there be.

Beyond the ethics and legalities of the individual case, a more difficult question is whether the stance adopted by the staff is politically wise or in the long term interests of psychiatric services, mental health professionals or the majority of their patients. Why did the staff believe it is in the best interests of the community to preventively detain this man within a psychiatric service when there is said to be no treatment available and therefore no prospect of discharge: simply because the patient poses a threat to children? Would they preventively detain in this way all people they consider a threat to

children? If not, why Brian in particular: because his responsibility is diminished due to his "borderline intelligence"? Would they support the removal from prison to hospital of all convicted offenders of borderline intelligence? Or is the distinguishing feature the apparently *driven* nature of his propensities? Could not this be said of all repetitive offenders?

While the short-term consequences of effectively imprisoning one individual in a psychiatric hospital may appear beneficial, the long-term consequences of adopting this approach as a general policy may hopelessly blur the functions of the mental health and penal systems, undermine the principles of the criminal law and silt up forensic facilities with untreatable patients - to the detriment, especially, of other consumers of psychiatric services. We already have a *sentence* of preventive detention which covers predatory sex offenders and permits their indefinite imprisonment. Unless a person is frankly mentally disordered or suffers from a more than mild intellectual disability, in my view, their control should remain under the provisions of the criminal law.

COMMENTARY 2

Carmel Rogers
Mental Health Lawyer

The lawyer's duty to act in accordance with the proposed patient's instructions

As his lawyer, Brian has instructed me to oppose this application and that is precisely what I must do - I cannot act other than in full accord with *his* instructions as to how to act. I cannot act in his "best interests" as those interests might be defined by defensive psychiatry, or defensive (or offensive) psychiatrists. Given Brian's opposition to this application, I must convey that strength. For Brian, compulsory detention in a hospital has the same meaning as jail for another of my clients, Mr Dol Lar who stands accused of corporate fraud, and it is my duty to defend both of them from outcomes that neither desire. In that hearing room I will be the only voice that Brian has, *for Brian* and *he* is why I am there. It may be uncomfortable to hear it but there is a striking dissonance distinguishing what Brian says are his own best interests and what the applicant clinician protests his "best interests" are.

It is with considerable alarm that I note the clinical staff involved in the decision to apply for a Compulsory Treatment Order purport to know not only Brian's best interests but *the interests of the community* (which purportedly would be best served by Brian copping a Compulsory Treatment Order). I will remind the Judge, respectfully of course, that the 1992 Mental Health Act incorporated a presumption that the mentally disordered should, if at all possible, be treated in the community. This presumption is underwritten by the belief that all of us have a place in our community and like it or loathe it, Brian is not an exception.

Elastic diagnostic criteria

It is fair to say that the notoriety of psychiatry's elastic diagnostic criteria is deserved. With each revision of the DSM, new diagnostic criteria arrive upon the heels of a forever unfolding script of social fads - post-traumatic stress disorder and premenstrual dysphoric syndrome spring to mind. Nowhere is this elasticity more evident than in the borderline states and in the burgeoning province of personality disorder. A crucial ethical question that arises is - should diagnostic criteria of amoebic-like elasticity be used for the purpose of justifying compulsory detention and treatment under the title of "mental disorder"?

What the reader might consider is "personality disorder" might very well be different from what I consider it to be. Homosexuality would have been a good example. What may have been considered to be a disorder twenty years ago has clearly changed and therein lies the problem - "personality disorder" is surely just the arsenal of dominant social categories of the acceptable and the unacceptable and not a valid category of mental disorder.

Our 1992 Mental Health Act, unlike the UK model, does not include personality disorder or psychopathy in the pivotal section 2 definition of "mental disorder". Section 27(2) provides that no Compulsory Treatment Order can be made other than when the patient is mentally disordered. Not even the applicant clinician in this case will attempt to argue that alleged sexual deviance is a major psychosis such as schizophrenia or bipolar affective disorder. The best this clinician can hope to argue is that Brian has a behavioural or social rather a mental disorder. Section 4 is stark - criminal or delinquent behaviour does not suffice to sustain a Compulsory Treatment Order.

The danger of dangerousness

It has been stated that psychiatry's capacity to predict future dangerousness is inferior to our ability to predict the weather. Is it morally justified to detain a person indefinitely in the event that they *may* sexually offend again in the future because they have done so in the past? Why is it not okay to lock up a rapist forever because he *may* reoffend but it is okay to detain the paedophile in the mental health system? The answer to that is to me chrystal clear - it is not okay.

To me as a lawyer, the only legitimising rationale for compulsory detention is treatability in circumstances when the proposed patient or patient is unable to make the decision as to the necessity for treatment himself. If, as seems to be the constant refrain of the literature on personality disorder and borderline states, treatment has little or no efficacy, then just what is the moral basis of compulsory detention in these circumstances?

As the Mason report and much of the case law has emphasised, there is no justification for compulsory detention other than where the condition of the proposed patient can be treated.

Epilogue

For a change, the Judge is convinced by my submissions on behalf of Brian and considers that my cross-examination of Brian's Responsible Clinician has disclosed a damning array of inconsistencies between this application for a Compulsory Treatment Order and the provisions of the Mental Health Act 1992. Brian walks free.

A few weeks after the Compulsory Treatment Order hearing I notice that a new tenant is moving in next door to where I live with my two sons aged 7 and 10. My peeking out the window at the flat next door confirms the worst - oh no! It's Brian. Did I really do the right thing in appearing for him to defeat the Compulsory Treatment Order application? Could Byron have been correct afterall -

> A legal broom's a moral chimney-sweeper,
> And that's the reason he himself's so dirty.
>
> (Don Juan)

I don't feel so eloquent now, in fact, I feel distinctly dirty. In doing the "right" thing for Brian did I do the wrong thing for my sons? What do you think?

COMMENTARY 3

Grant Gillett
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Bioethics Research Centre

This case raises for me three interesting analytic issues:

a) In what ways can a community protect itself against behaviour that is unacceptable and yet respect freedom of individual members?

b) What is meant by mental disorder?

c) How should we interpret the Mental Health Act to ensure maximal respect for individuals with behavioural problems?

a) Any community defines norms of behaviour for itself. (In some cases, eg where slavery is practised, these norms are unjust and need to be reformed.) In general the community has certain remedies when norms are violated. For instance, if one person injures another then there is a legal process whereby the victim is compensated and the perpetrator punished. The punishment usually includes both a disincentive to future unacceptable behaviour, and the need for the community to be protected from that individual. This process assumes that each member of a community is responsible for his/her own actions. When the threat to the community is due to some dysfunction in an individual then most caring communities undertake a responsibility for treatment in addition to custody. Compulsory treatment is a mechanism by which a given community can take steps to make sure that a person suffering a disorder which makes him or her dangerous to self or others, can both be taken into custody and receive treatment (which they may not see the need for). Thus those involved with any person who is acting in ways which are considered harmful to others have to make a basic decision about whether that person is responsible for those acts and should be treated as such or whether the acts result from a dysfunction requiring treatment.

b) This brings us to the problem of mental disorder. The paradigm cases of such disorder are clearly disturbed in their thinking to the point where they are not responsible for what they are doing. The ability to plan and take reasoned account of one's own actions is something we take for granted but is not present in a severely disturbed psychiatric patient whose mind is crowded by confusing and often frightening thoughts and images. This patient is not in that category. He has impulses which we regard as unacceptable and finds that in actual life he cannot control them. Therefore if he is to qualify in the terms of the Act he must be regarded as having a disorder of volition or will. We are all familiar with these to some extent in that many of us act in ways we regard as ill-advised. Many of us suffer from spending an extra hour in front of television or in bed when other things clamour for our attention. Some people spend money which should be saved for other purposes. Some of us take too much drink on occasions when recognise the need for moderation. How bad do you have to be to be regarded as having a disorder of volition? For instance the kleptomaniac seems clearly disordered but beyond that all is grey. Pathological gamblers, binge drinkers, and anorexics all seem to be thinking clearly yet they do not seem to strike the right balances in their life projects. This patient is somewhere in this group. He has impulses, and cannot deal with them in a way that keeps him out of trouble. Is he a person who acts in ways that are unacceptable but is responsible for those actions or has he a disorder which mitigates his responsibility by interfering with his exercise of will? He clearly needs help of some kind and yet it may not be helpful to classify him as having a disorder which absolves him from moral responsibility for his acts.

A further consideration is the lack of effective treatment for Brian's problem. Treatments include such things as counselling and self-monitoring that are also used with normal individuals who have fallen foul of community norms in ways which are not due to a mental disorder. Here we should, perhaps, determine our response on the basis of the balance between what one philosopher has called our reactive and our objective attitudes (Strawson, 1974). We adopt reactive attitudes when we treat a person as responsible for what they do, so that his or her behaviour is a fit subject for praise and blame and other moral judgments. We take up the objective attitudes when we realise that the person concerned has to be treated as a dysfunctional system (by, for instance, using drugs to modify its responses). Most psychiatric care is a mixture of the two and treatment aims to move a person from the dysfunctional situation to being able to take his place among us as a person engaging in normal interactions and relationships. The patient is obviously somewhere between these two ends of the spectrum.

c) Should we interpret the Mental Health Act broadly to embrace individuals like this, or should we reserve it for those individuals who are clearly disordered? The problem is, to some extent generated by the need both to ensure that the patient gets help and to safeguard him from being a victim of circumstances he cannot change or control. (We would not, for instance, cast him in the victim role were he to be a multiple rapist where there is no question of psychiatric disorder.) His capacities as a thinking and acting person are generally intact (given that he has one area where his thoughts and actions are markedly different from those of most of us). He seems therefore to qualify as a needy person with problems in the control and direction of his life rather than as a victim of a disorder which has deprived him of his ability to make meaningful decisions in his own interests. On this basis it seems wrong to group him with those who genuinely suffer a mental disorder even though we might acknowledge that he has psychological or behavioural problems which require special attention and intervention by skilled professions.

This implies that the community retains its normal power to protect itself from unacceptable or criminal behaviour, in this case acknowledging that he needs some kind of rehabilitatory care.

Reference

Strawson, P.F. 1974 *Freedom and resentment and other essays* Methuen: London