Reform of the Mental Health Act: its direction and impact

The legal framework which determines what doctors can do to their patients, under what circumstances and with what limitations is determined by Parliament (statute law), the courts (common law) and the General Medical Council (as arbiter of medical ethics). In a nutshell we must put the needs of our patients first, we must have the consent of those patients who are able to decide for themselves, we must act in the best interests of the patient if they lack capacity, we must not ignore advance refusals and we must not partake in euthanasia. Emergencies may preclude a full assessment of these issues. It is generally agreed that relying on common law does not give a satisfactory framework for the care and treatment of those who lack medical decision-making capacity. Scotland now has an Incapacity Act 2002 and the government has agreed to introduce a bill for England and Wales.

Why then do we need something different for the mentally ill? Why do we have a Mental Health Act? There is no equivalent for the physically ill. Legislation for the mentally ill has a long history (at least since the 14th century), and the past 250 years have seen some 35 Acts of Parliament determining how society and doctors are to treat this group of people.

The principle that the mentally ill are not entitled to the same human rights as the physically ill is, unfortunately, enshrined in the Human Rights Act 1998. This incorporated the European Convention on Human Rights and Fundamental Freedoms into British law. Article 5 details the grounds upon which citizens may be arrested. It states ‘Everyone has the right to liberty of person. No one shall be deprived of their liberty save in the following cases ….’ ‘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.’ This means that those of ‘unsound mind’ along with ‘vagrants, alcoholics, and drug addicts’ may be locked up without conviction of a crime, without a trial and without even a suggestion they are a threat to anyone. The term unsound mind includes people who suffer from a learning disability, mental illness or personality disorder.

THE PRESENT POSITION

The current Mental Health Act 1983 authorizes (but does not require: doctors may use their judgment) the detention in hospital, for assessment or treatment, of patients with a mental disorder in the interests of their health or safety or for the protection of others if they are ill enough to need to be in hospital. It requires that there is no alternative to admission to hospital. For those being detained as suffering from a personality disorder it is required that the treatment will alleviate or prevent a deterioration in the patient’s condition. It does not permit detention of those who are ‘suffering’ solely from promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.

Patients, their carers, most professional groups and the government thought the legislation needed reform. The government established an Expert Committee to undertake a ‘root and branch review’ of the Mental Health Act (Report of the Expert Committee, 1999). This was followed by a green paper, white paper and draft mental health bill. The direction of the reform has placed the government at odds with its own expert committee, the Royal College of Psychiatrists, the British Medical Association and 55 other organizations (representing service users, carers, nurses, psychologists, social workers, lawyers, health service managers and many others) which have joined the Mental Health Alliance.

THE DRAFT MENTAL HEALTH BILL

Under the draft Mental Health Bill (for England and Wales) 2002 (Department of Health, 2002) the grounds for making a patient subject to compulsion (no longer can one use the word ‘detention’ as the forced treatment may take place in the community), and the processes that follow on from this are very different from the current Act. The main differences are as follows:

Proposals that are generally opposed

1. Anyone can require a trust to order that anyone else is examined by a psychiatrist
2. The criteria for making an order are that the mentally disordered patient ‘warrants medical treatment’ (note not even specialist treatment) in the interest of their health or safety or for the protection of others, the treatment is available and s/he refuses it
3. The definition of medical treatment is very broad including ‘care’ and ‘education’
4. There is no requirement for the ‘treatment’ to benefit the patient
5. Doctors have no discretion as to whether or not to make someone subject to compulsion if the criteria are met
6. There are no exclusion criteria
7. The number of routes for discharge from an order have been reduced from four (currently) to two in some circumstances and one in others. The consultant in charge of the patient’s care loses the absolute right to discharge the patient even if the patient is detained only because the consultant recommended it in the first place.

Proposals that are generally approved

1. All patients will have a right to advocacy
2. After the initial assessment all compulsion will be authorized by a tribunal.

Proposals that have mixed reviews

1. There is a very wide definition of mental disorder (‘any disorder or

disability of mind or brain which results in an impairment or disturbance of mental functioning')
2. The compulsion to accept treatment need not be in hospital (thereby removing the need for the patient to be ill enough to require admission)
3. Some patients subject to compulsion will be under the care of a psychologist rather than a psychiatrist
4. Most tribunals will not have a medical member
5. There will be compulsion in prison.

This list is far from exhaustive.

There are also some notable omissions. There are issues which are not in the draft bill (or current act) but which were recommended by the expert committee and would be widely welcomed. Examples include compulsion being permitted only when the patient has impaired judgment, that there must be 'positive clinical measures which are likely to prevent deterioration or secure an improvement in the patient's mental condition' and the treatment is in the patient's 'best interest'.

LIKELY EFFECT IF THE DRAFT BILL BECOME LAW

Psychiatric patients are markedly stigmatized making some people reluctant to seek help. These proposals would make this worse. First there is the implied, and largely wrong, association between psychiatric illness and violence. To give some kind of perspective to this each year 40 people are killed by the mentally disordered (of whom 20 are known to the services), 400 are killed by corporate manslaughter, 3000 by drivers and 5000 by hospital-acquired infection. This is not to suggest that every death is not a tragedy.

Second patients will know that psychiatrists will be required to enforce treatment on them, not only in hospital but also in the community and not only when they are poorly but also when they are well (to prevent relapse) even though they are capable of making their own decisions, the treatment is not necessarily in their best interest and they are not necessarily a danger to anyone.

We have seen the impact on patients' behaviour when they believe that doctors are acting neither with their consent nor in their best interest, in relation to the body parts scandal at Alder Hay and other hospitals. Consent rates for post-mortems and organ donation plummeted. Patient avoidance will certainly limit effective intervention, resulting in increased risks for patients and the rest of the community.

The number of patients subject to mental health legislation is likely to increase. All those currently detained will have to be made subject to compulsion, as will those who currently meet the criteria but are not detained because the doctors or social worker (who is part of the process) think it would not be helpful (because this discretion is lost). In addition there will be a new group of patients made subject to an order who do not meet the current criteria but will meet the new, much wider criteria (including the absence of the need to find a hospital bed).

The increased number of orders will occur alongside a likely reduction in the number of staff. Over 95% of psychiatrists who have contacted the Royal College of Psychiatrists about the draft bill have expressed views ranging from concern to horror. Many younger colleagues wrote about the draft bill affecting their career choice, in that they would move away from general adult psychiatry. Older colleagues wrote about retiring at the first opportunity. It should be noted that 15% of consultant posts in psychiatry are currently vacant. These factors are likely to cause serious resource difficulties for the further development of important innovations in psychiatric practice.

WHAT SHOULD A MENTAL HEALTH ACT LOOK LIKE?

First a Mental Health Act must be preceded by, or passed alongside, an Incapacity Act. The content of the former can only be determined against the provisions of generic incapacity legislation. Second the basic principles of non-discrimination, patient autonomy, informal care where possible and reciprocity must be incorporated. Third patients should not be forced to accept treatment unless, as a minimum, they suffer from a mental disorder which impairs their judgment in relation to treatment decisions and the treatment is in their best interest (or, if the compulsion is because s/he represents a serious risk to others, there are positive clinical measures which are likely to prevent deterioration or secure an improvement in the patient's mental condition) and there is no reasonable alternative to giving the treatment under compulsion. Fourth compulsion in the community should only be permitted if the patient has previously been detained in hospital and has relapsed as a result of non-compliance in the community. Fifth there must be the continuation of the current exclusion criteria to reduce the risk of compulsion for 'social control'.

The equivalent bill in Scotland (awaiting Royal Assent) has adopted these principles and is broadly welcomed. It is worth noting that if the two bills become law there will be a group of patients who will meet the criteria for being made subject to an order in England but not Scotland. HM

KEY POINTS

- There is a long history of discriminatory legislation against the mentally ill.
- The principle of treatment without consent only when a person lacks capacity should apply to the mentally ill as it does to the physically ill.
- Increasing stigma will not reduce risk.
- The mentally ill are not significantly more dangerous than others.
- Compulsion should always benefit the individual patient.

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