

## The independent review of mental health legislation: a real opportunity for change?

There have been many critics of the discriminatory nature of the 1983 Mental Health Act, most notably people diagnosed with mental health challenges themselves (see, e.g. Chamberlin, 1977 and O'Hagan, 2014) and Professor George Szmukler and his colleagues (Dawson and Szmukler, 2006; Szmukler and Holloway, 1998, 2000; Szmukler, 2010, 2017). Based on the work of such people, we have written about the intrinsically discriminatory nature of mental health legislation in the pages of *Mental Health and Social Inclusion* (Perkins and Repper, 2014).

In particular, current mental health legislation in England and Wales denies those diagnosed with a mental disorder the rights accorded other citizens in two primary ways.

First, unlike any other citizen who may be a danger to themselves or others, it allows people diagnosed with a “mental disorder” to be detained because they might commit an offence. On civil rights grounds, UK law does not permit this sort of preventative detention for anyone else who are at risk of causing harm to others, like, habitual spouse abusers or those who are drunk and may drive dangerously. Again, those deemed to have “mental disorders” are denied the rights accorded to other citizens:

Justice requires that all people posing equal risk should be equally liable to preventive detention (Szmukler in Szmukler and Weich, 2017, p. 1).

Second, as Szmukler (in Szmukler and Weich, 2017) describes, two sets of rules exist for involuntary treatment – one for psychiatry and one for the rest of medicine:

[...] having one law for decisions about physical illness and another for mental illness is anomalous, confusing and unjust (Bamford Review of Mental Health and Learning Disability, 2007, p. 36).

If you have a physical illness, then you have the right to refuse treatment, even if that treatment may save your life. The only exception to this is, under the terms of the 2005 Mental Capacity Act, if your ability to make decisions is impaired: you are unable to understand what you are told about your condition and treatment and the consequences of accepting or refusing it. If you have been diagnosed with a “mental disorder”, under the terms of the 1983 Mental Health Act, your ability to make decisions can be ignored. You may be fully able to make decisions, but you can still be forcibly detained and treated if professionals think that the nature and degree of this disorder make detention and treatment necessary for your own health and safety or for the protection of others. This is discriminatory because one law applies to those diagnosed with mental health challenges – one based on a “disorder, diagnosis and risk model” – while another law applies to the rest of the population – one based on a “capacity and best interests model” (Szmukler, 2017). This is in direct contravention of Article 14 of the United Nations Convention on the Rights of Persons with Disabilities (UNCPRD) because it permits compulsory detention and treatment on grounds that include disability (which includes “mental disorder”).

If we are to create a non-discriminatory legal framework:

A key point is that **the law must be generic**: namely that it applies to everyone who has a problem with decision making, whether the diagnosis is physical or psychiatric, and in any setting – medical, surgical, psychiatric or in the community. A specific ‘mental health’ law is not necessary: the law should be formulated so as to apply throughout medical specialties, from psychiatry to orthopaedic (Szmukler in Szmukler and Weich, 2017, pp. 1-2) (added emphases).

Northern Ireland have taken the ground-breaking step to do just that. Their journey is described by Harper *et al.* (2016).

It started with the Bamford Review of Mental Health and Learning Disability which was established in 2002 and completed its work in 2007 with the publication of a report on legislative reform (Bamford Review of Mental Health and Learning Disability, 2007). This review endeavoured to be inclusive and ensure that the voices of people who use services and their carers were given priority and it focussed on human rights and equalities concerns:

A rights-based approach is proposed as the guiding principle for reform of legislation which should respect the decisions of all who are assumed to have capacity to make their own decisions. Grounds for interfering with a person's autonomy should be based primarily on impaired decision-making capacity. New legislative solutions are, therefore, required for issues posed by the effects of disorder of the brain or mind on an individual's decision-making capacity and which affects his/her own personal health, the need for care and treatment, safety and the welfare or the safety of others (Bamford Review of Mental Health and Learning Disability, 2007, p. 26).

Unlike the rest of the UK, the report did not recommend separate mental health and mental health capacity legislation but instead sought to bring these together in the form of a generic "fusion law" covering both mental health and mental capacity and applicable across all medical specialties and social care. While this type of "fusion law" has been discussed previously (see, e.g. Dawson and Szmukler, 2006), the Mental Capacity Act (Northern Ireland) 2016 represents a major step forward in enacting such a law. A radical departure from a "disorder, diagnosis and risk" model, it puts impaired decision-making capacity at the heart of all compulsory treatment and intervention. Compulsory detention and/or treatment is only permitted when a person:

- a) has impairment of decision-making capacity; and
- b) the intervention proposed is in the person's best interests (Lynch *et al.*, 2017, p. 4).

To be sure, the Act is not without its critics. There are those who have questioned the concept of "best interests" as determined by someone else – arguing that it is only the person's own wishes that should prevail – and there are some who would argue that substitute decision making is never permissible and contravenes the UNCRPD. However, the UNCRPD does acknowledge that there may be times when it is not possible to determine a person's preferences, but, in such circumstances, it is the "best judgement of a person's will and preferences" rather than their "best interests" that should be the yardstick:

Where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the "best interpretation of will and preferences" must replace the "best interests" determinations. This respects the rights, will and preferences of the individual, in accordance with article 12, paragraph 4. The "best interests" principle is not a safeguard which complies with article 12 in relation to adults. The "will and preferences" paradigm must replace the "best interests" paradigm to ensure that persons with disabilities enjoy the right to legal capacity on an equal basis with others (Committee on the Rights of Person's with Disabilities, 2014, p. 5).

Szmukler (2017) argues that the concept of "best interests" has evolved over the years and now requires attention to be paid to the person's deeply held beliefs, values commitments and personally important life goals – moving in the direction of the "will and preferences" of which the UNCRPD speaks.

Despite such criticisms, the Mental Capacity Act (Northern Ireland) 2016 is a major step forward from intrinsically discriminatory mental health legislation to a generic legal framework that applies to all citizens. But will such an approach extend beyond Northern Ireland?

In 2017, the United Nations Committee on the Rights of Persons with Disabilities examined the UK Government's progress in fulfilling its commitments to the UNCRPD, to which the UK has been a signatory since 2007. As part of this inspection, as well as the Government being required to submit a report, disabled people's organisations are invited to submit their own assessment (Disability Rights UK and Disability Wales, 2017). For the first time this included reference to the 1983 Mental Health Act not being compliant with the UNCRPD:

The Mental Health Act 1983 is non-compliant, principally because it permits compulsory detention and compulsory treatment on grounds that include disability ("mental disorder"). People with "mental disorders" are exceptional amongst citizens in that they can be compulsorily detained on the basis of a perception that they may be a risk to themselves or others in the future; and in that they can be compulsorily treated even when they are entirely capable of taking decisions themselves. There is no

actuarial basis for decisions on risk of future harm and no option to challenge in legally the way risk is applied to the individual. Legislation permitting compulsory treatment became more draconian with the passage in 2008 of a law introducing Supervised Community Treatment Orders (CTOs) (Disability Rights UK and Disability Wales, 2017, p. 22).

This report recommended that the UN Committee call on the UK Government to:

1. Carry out an urgent review of Community Treatment Orders in the light of randomised controlled trials demonstrating that, despite substantial curtailment of individual freedoms, they confer no benefits to those detained (Burns *et al.*, 2013) and, even at long term (four year) follow-up, fail to improve social outcomes (Vergunst *et al.*, 2017).
2. Develop options to replace both the 1983 Mental Health Act and the 2005 Mental Capacity Act to ensure new legislation that complies with the UNCRPD. Such new legislation should:
  - break the link between the permission of compulsory detention and diagnosis;
  - ensure that safeguards prioritise respect for the will and preferences of the person; and
  - continue to invest in the development of community-based alternatives to support people with mental health challenges, learning disabilities, autism and dementia (all of whom are subject to detention under the Mental Health Act).

In its concluding observations to the UK following the examination, the UN Committee on the Rights of Persons with Disabilities recommended that the Government:

Repeal legislation and practices that authorise non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairment (UN Committee on the Rights of Persons with Disabilities, 2017, p. 8).

Abolish all forms of substituted decision-making concerning all spheres and areas of life by reviewing and adopting new legislation in line with the Convention to initiate new policies in both mental capacity and mental health laws (UN Committee on the Rights of Persons with Disabilities, 2017, pp. 6-7).

Whether as a consequence of this (or more general concern about the ever-increasing rate of compulsory detention under the Mental Health Act – 2015/2016 saw a further 9 per cent increase in the number of detentions to 63,622 from 58,399 in 2014/2015 and 43,361 in 2005/2006[1] – and gross over-representation of people of black/black British ethnicity among those detained under the Act[2]), on 4th October 2017, Prime Minister Theresa May, announced an Independent Review of mental health legislation and practice[3]. This review is designed to examine:

- Why rates of detention are rising – what can be done to reduce inappropriate detention and improve how agencies respond to people in crisis?
- Reasons for the disproportionate number of black people being detained under the Act and what should be done about it.

This review offers a real opportunity to move beyond discriminatory mental health legislation and create new generic “fusion” legislation that replaces both the 1983 Mental Health Act and the 2005 Mental Capacity Act. Legislation that moves from a “diagnosis, disorder and risk” paradigm to one that puts impaired decision-making capacity and the person’s will and preferences at the heart of all compulsory treatment and intervention. A law that applies to everyone who has a problem with decision making, whether the diagnosis is physical or psychiatric, and in any setting.

There will be those who argue that, the act ensures that people who need help get it. That without a dedicated Mental Health Act “[...] lives would be lost, and more people in distress would go without help” (Weich, 2017, in Szmukler and Weich, 2017). That the real challenge is to resource services properly. But people are dying in detention now, and there is little or no evidence that compulsory detention and/or treatment improves people’s lives. As Warner, 2009 demonstrates:

A growing body of research supports the concept that empowerment is an important component of the recovery process (Warner, 2009, p. 1).

The choice is not between resources and rights – we need both.

Will the opportunity for real change offered by the current of mental health legislation in England and Wales be taken?:

The moral case for reforming mental health law is decisive. The discrimination such law entails can no longer be supported. The solution for eliminating this discrimination is a generic law (Szmukler in Szmukler and Weich, 2017, p. 2).

Will we develop and extend the ground-breaking steps taken in Northern Ireland (and ensure compliance with the UNCRPD)? Or will we continue to tinker around the edges of intrinsically discriminatory mental health legislation?

## Notes

1. <http://digital.nhs.uk/catalogue/PUB22571> (accessed 5 December 2017).
2. [www.cqc.org.uk/sites/default/files/20161122\\_mhareport1516\\_web.pdf](http://www.cqc.org.uk/sites/default/files/20161122_mhareport1516_web.pdf) (accessed 5 December 2017).
3. [www.gov.uk/government/news/prime-minister-announces-review-to-tackle-detention-of-those-with-mental-ill-health](http://www.gov.uk/government/news/prime-minister-announces-review-to-tackle-detention-of-those-with-mental-ill-health) (accessed 5 December 2017).

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