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Submission to Independent Review of the Mental Health Act

Reform of the Mental Health Act and human rights: an analysis

Since human rights are central to the justifications for treatment of persons against their will, I present an argument on the direction that reform should take. We have an opportunity now to refashion our mental health law so as to make it consistent with fundamental human rights principles. The present law clearly fails in this regard.

The call for submissions places an emphasis on empirical evidence. If, as I claim, the Mental Health Act (MHA) discriminates against people with a diagnosis of a mental disorder by failing to respect their human rights on an equal basis with all other people, then the case for remediation is urgent, regardless of any empirical data concerning the MHA. However, I do provide research evidence where it is relevant to human rights interests.[1]

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[1] At the outset, troubling from an ethical point of view is the huge variation in involuntary hospitalization rates from country to country, and even within countries. In Europe in 1998-2000 the rates ranged from 6 per 100,000 in Portugal to 218 per 100,000 in Finland [***Salize HJ, Dressing H (2004) Epidemiology of involuntary placement of mentally ill people across the European Union. Br J Psychiatry 84:163-168***], while a later study of six European countries found rates ranging from 32.1 per 100,000 in Sweden to 190.5 in Germany [***Priebe S, et al (2005) Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries. BMJ 330:123-126***]. Variation within a country is demonstrated, for example, by Norway, where involuntary admission rates have varied fivefold [***Hoyer G (2008) Involuntary hospitalization in contemporary mental health care. Some (still) unanswered questions. J Mental Health 17:281-292***] or Sweden [***Kjellin L, Ostman O, Ostman M (2008) Compulsory psychiatric care in Sweden: development 1979-2002 and area variation. Int J Law and Psychiatry 31:51-59***].

Equally significant are changes in rates of involuntary hospitalisation over time. In England, compulsory admissions to hospital increased by 63% between 1984 and 1996 [***Hotopf M, et al (2000) Changing patterns in the use of the Mental Health Act 1983 in England, 1984-1996. Br J Psychiatry 176:479-484***], and by another 29% between 1996 and 2006 [***Keown et al. (2008) Retrospective analysis of hospital episode statistics, involuntary admissions under the Mental Health Act 1983, and number of psychiatric beds in England 1996-2006. BMJ 337:a1837***]. The rate has then increased by 46% in the last decade. In contrast to England, however, the compulsory admission rate in Sweden declined steeply between 1979 and 2002 [***Kjellin ibid.***].

While differences in service provision may contribute significantly, there is clearly a large scope for arbitrariness in the use of compulsory powers despite their similar governing criteria across European states. From an ethical perspective, such arbitrariness is unacceptable.

A detailed account of both the argument concerning discrimination in conventional mental health law, as well as the relevant research evidence is available in: ***Szmukler G. (2017) 'Men in White Coats': Treatment under Coercion. Oxford, Oxford University Press***

A further introductory remark is appropriate. Discussions about reform of the MHA sometimes derail into discussions about resources. Priority, some say, should be given to improving under-resourced services ahead of any reform of mental health legislation. Resources are obviously extremely important in the current unhappy state of mental health services. However, if a sector of our society is not accorded human rights on an equal basis with others, then urgent measures to rectify the discrimination must be taken. Such an inequality cannot be tolerated in a fair, democratic society. While discrimination and resources are separate issues, it may indeed turn out that by reducing the discrimination and social marginalisation of people with a mental illness, thus improving their standing in society, they and their supporters will seek help earlier, with less need for involuntary hospitalisation and coercive measures.[2]

How mental health law discriminates

The principles governing detention and involuntary treatment in mental health law have remained fundamentally unchanged for around two centuries. They reflect damaging stereotypes of people with mental illness that undermine their human and civil rights.

The common, deeply entrenched criteria for compulsion are two: first, the presence of a 'mental disorder', and second, a risk of harm to the person with the disorder, or to others. Such 'disorder + risk' civil commitment legislation now needs replacement. The reason for this is a decisive one – it discriminates against people with mental illness by depriving them of rights enjoyed by others.

The discrimination is clear when we compare this 'disorder + risk' schema with involuntary treatment in the rest of medicine. In contrast to the

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[2] Consideration might also be given to a reduction in the cumbersome machinery involved in the regulation of deprivation of liberty and involuntary treatment. The schema in the MHA dates from the 1959 Act. The practice of psychiatry has changed enormously since then. The processes of mental healthcare is much more visible to the community. Less burdensome, more responsive, and arguably more effective schemas are possible. Examples include the Northern Ireland Mental Capacity Act 2017 and the provisions in the New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992. For a summary see ***Lynch G, Taggart C, Campbell P. Mental Capacity Act (Northern Ireland 2016. BJPsych Bulletin, 2017; DOI:*** *10.1192/pb.bp.117.056945;*
For New Zealand see ***Community Law Manual Online*** *http://communitylaw.org.nz/community-law-manual/chapter-20-mental-health/what-this-chapter-covers-chapter-20/*

stasis in civil commitment law, general medicine in the past 40 years or so has seen a revolution in the respect accorded to patient self-determination (or 'autonomy'), and a parallel decline in 'paternalism'. This has been through the development of the doctrine of 'informed consent'. It is only when a person lacks the capacity to give such consent, that the possibility of non-consensual or involuntary treatment enters the frame. (Non-coercion and adequate disclosure of relevant information are also necessary). With a lack of capacity, there is a further requirement – treatment must be in the person's 'best interests'. We then accept that patients with 'physical' disorders, provided they have decision-making capacity, can make decisions that may be seriously detrimental to their health, even if life-threatening.

In contrast, under conventional mental health legislation, decision-making capacity (DMC) plays little or no role in the initiation of detention or involuntary psychiatric treatment. (In some jurisdictions, for example, Germany and states in the USA, while detention is based on 'disorder + risk', involuntary treatment requires some form of capacity evaluation. How valid a consent can be under the threat of detention is an important question here). In the majority of jurisdictions 'disorder+ risk' is essentially the formula for both detention and involuntary treatment.

There is thus a failure to accord *equal respect* for autonomy or self-determination to all categories of patient. For a person with a diagnosis of a mental disorder who rejects treatment, key abilities underlying decision-making do not demand special attention as they do for general patients – for example, the ability to understand important information about the illness and treatment, to appreciate the relevance of that information to the person's predicament, and to reason with that information in the light of the values and life goals that are important to the person. Nor does the question arise of whether the proposed treatment is in the best interests of the person – crucially, this is necessarily from the perspective of the person; for example, what would the person have chosen in the current circumstances if they had retained capacity (clearest in the case where there is a valid advance directive). Is their current decision concerning treatment consistent (or coherent) with their deep beliefs, values, commitments and personal life goals?

There is an underlying assumption evident in mental health legislation that a mental disorder *necessarily* entails mental incapacity and that the beliefs, values and preferences of a person with a 'disordered mind' are not a valid guide to where their best interests lie. However, research has shown that even among the very ill, those admitted to acute psychiatric wards, around 50% retain DMC.[3] The *stereotype* of a person with mental disorder as incompetent to decide is embodied in legislation that applies uniquely to those with such a disorder. It thus discriminates unfairly against those persons.

Many people, including clinicians, endorse involuntary treatment for people with a mental disorder even when they retain DMC where there is a risk of serious harm. The implications of this position are serious and difficult to accept. Despite being motivated by beneficent motives, supporters of this position are in essence endorsing the stigmatising stereotype of the person with a mental disorder as being necessarily incompetent and incapable of sound judgment. Even if the test for DMC is clearly passed, it is proposed that such people - as opposed to everyone else - are still somehow not truly competent to make decisions about their well-being – they are not entitled to being treated as agents, full 'persons', or full 'rights-holders'; there is always a doubt about the validity of their choices and actions. The putative impairment is unable to be articulated by the proponents of this view; it is apparently ineffable - there is no test that is proposed that persons with a mental disorder can pass that would affirm their status as full agents. Is this what the proponents of this view intend to endorse? If so, this represents a strongly negative and discriminatory view of people with a mental illness – indeed, it reflects the stereotype mentioned above. Beneficence here, in effect, becomes maleficence.

Treatment for the protection of others

There is a second form of discrimination. People with mental disorders are uniquely liable to detention (usually, or eventually in hospital) because they are assessed as presenting a *risk* of harm to others, without having

[3] ***Okai et al. Mental capacity in psychiatric patients: Systematic review. Br J Psychiatry 2007;191:291-297; Owen et al. Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study. BMJ 2008;337:a448***

actually committed an offence (or being strongly suspected of having committed one) like the rest of us. This constitutes a form of *preventive detention*.

Now, at any one time in the population there is a group of people who could be considered as representing a significant risk to others. Some people with a mental disorder, a small proportion only, will fall into this group. They will represent only a tiny percentage of the total of risky people in the population, the vast majority of whom will not have a mental disorder.[4] Nevertheless, civil commitment law permits the detention on the basis of risk alone, only of those with mental disorder - not the much larger body of the risky group without.

How can this be justified? Equals are being treated unequally. There is no evidence that risk is easier to assess in those with mental disorder, nor that violence is more predictable in this group. Could 'treatability' be a justification? Extremely lengthy hospitalisations in secure hospitals suggest this is not so. And it is possible, indeed highly probable, that psychosocial interventions such as controlled drinking or anger management programmes for non-mentally disordered risky persons would have a greater impact on violence in our community. After all, those with a mental illness account for only a few percent of serious violence in our society.[5]

One must conclude that the 'protection of others' criterion is discriminatory. If preventive detention is to be allowed for those with a mental disorder solely on account of the risk posed to others, to avoid

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[4] The risk of violence for those with a mental illness, in the absence of drug or alcohol misuse or antisocial personality, is only modestly, if at all higher than for the rest of the population. [***Coid J, et al. Violence and psychiatric morbidity in a national household population--a report from the British Household Survey. Am J Epidemiol. 2006;164:1199-1208; Elbogen EB, Johnson SC. The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psychiatry. 2009;66:152-161; Fazel S, et al. Schizophrenia and violence: systematic review and meta-analysis. PLoS Med. 2009;6:e1000120***.

[5]Only a few percent of serious violent crimes are committed by people with a mental illness – around 1.6% by people with a psychosis or affective disorder, and then in 80% of cases complicated by alcohol or drugs. [***Flynn S, Rodway C, Appleby L, Shaw J. Serious violence by people with mental illness: national clinical survey. J Interpersonal Violence 2014;29:1438-1458***].
A rarely mentioned finding concerns the frequency of violent attacks committed by perpetrators perceived by the victim as having been mentally ill. The British Crime Survey reported that for each year between 2002/3 and 2004/5 perpetrators were perceived by their victims as mentally ill in 1% of violent attacks [***Home Office Statistical Bulletin. Violent Crime Overview, Homicide and Gun Crime 2004/2005. Coleman K, Hird C, Povey D; 2006.]***

discrimination, so should it be for all of us. This would amount to a generic dangerousness provision that many find unacceptable (and unlikely to be possible under the European Convention on Human Rights). But the principle of non-discrimination requires that either we have laws applicable to all of us; or to none of us, including those with mental disorder.

Thus those with mental disorder are denied the protections from preventive detention enjoyed by the rest of us. Such a provision reinforces the second damaging *stereotype* - that those with a mental illness are *intrinsically dangerous*. Furthermore, the uncertain boundary around the notion of 'mental disorder' and our poor ability to accurately assess 'risk' offer a less legally demanding back-door to the detention of people considered to pose a threat to the social order. The Soviet Union in the 1960s-70s was a stark example, but nearer to home, the Dangerous Severe Personality Disorder programme was arguably another.[6]

Eliminating the discrimination in the law

To eliminate the discrimination entirely there are two clear possibilities. First, we could adopt mental health type law for all medical conditions, or second, we could adopt a capacity-best interests schema for mental disorders.

I doubt that many of us would opt for the 'doctor knows best', patient disempowerment entailed in the first option. The second option is thus preferable. (Given the fundamental values in our society, it is also hard to come up with a credible alternative to a schema that supports choice and self-determination).

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[6] There is further discrimination in relation to forensic treatment disposals under the MHA, particularly in relation to s37/41. Such orders are indeterminate (but reviewable) and often result in a deprivation of liberty of the mentally disordered offender which far outlasts the normal term of a prison sentence for the same offence. This could be remedied by such treatment orders having a maximum duration commensurate with the seriousness of the offence. If the person were to still meet the criteria for involuntary treatment at the conclusion of the court order, a civil order could be imposed. If the ill person were assessed by the court at sentencing to be an ongoing risk beyond the normal period commensurate with the seriousness of the offence, then a non-discriminatory method of prolonging the deprivation of liberty would be through an 'extended sentence' (5 years, 8 years or for life, depending on the current offence and offending history). Extended sentences are available for convicted persons, whether mentally disordered or not. For a detailed discussion see ***Szmukler G. Men in White Coats: Treatment under Coercion. 2017; pp192-207. Oxford, Oxford University Press***

Opting for a capacity-best interests framework in mental health care leads to a further step in the argument. If the framework is to be the same as for non-psychiatric disorders, separate mental health law becomes redundant. Hence the proposal for a 'Fusion Law' - a generic law applicable across all medical specialities (as well as social care), in all settings, where a person has a difficulty in making a serious treatment decision. Involuntary treatment would only be permitted, first, when the objecting person has an impairment of decision-making capacity - from any cause - and, second, if treatment were in the person's best interests. The 'fusion' approach builds on the strengths of the two existing legal regimes. Capacity-based legislation's strength, giving weight to autonomy is counterbalanced by a number of weaknesses - a lack of sufficient attention to detention and the use of force. But these are the areas in which civil commitment schemes are strong: these measures are clearly authorised and regulated. Indeed, the lack of clarity in these areas in capacity-based legislation may engender problems concerning patients with 'physical disorders' who object to treatment. Clinicians may be reluctant to use force unless they can rely on clear statutory authority.

A problem with separate mental health and capacity regimes is the lack of clarity about which should apply when patients meet the criteria of both; or when both may be required for the same person because they object to treatment of a mental disorder and an unrelated physical disorder at the same time.

While a fusion-type proposal is the clearest solution to the current human rights problems with existing mental health law, many will say that this might be a step too far at this stage. Nevertheless, I would strongly urge the Committee to support a position that would bring the Mental Health Act into closer alignment with the principles of the Mental Capacity Act 2005. At a minimum this should include an impaired decision-making capacity criterion, as well as a 'best interests' criterion.

The Law Commission's recent recommendations concerning Liberty Protection Safeguards may offer useful pointers to guiding principles for the detention of patients in hospital within such a context.[7]

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[7] Law Commission 2017 ***Mental Capacity and Deprivation of Liberty***. Law Com No 372 *https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/*

Capacity-based law

The Mental Capacity Act 2005 in England has taught us much about capacity-based law. While, as is to be expected with new law, there have been some problems with implementation, the Act is generally held in high regard.[8] I know of no calls for it to be repealed.

Capacity can be as reliably assessed in psychiatry as in general medicine.[9] There is no reason to believe that principles along the lines of the Mental Capacity Act cannot be applied in mental health care. Such legislation has been drafted and enacted.[10] Measures - for example, the important involvement of those who know the person well, independent advocacy, second opinions, appeals to a tribunal where there is disagreement - can be devised to ensure that patients are not regarded as lacking capacity simply because they disagree with their doctors.

The concepts of 'capacity' and 'best interests' have advanced over the years, particularly in relation to the assessment of the 'use' and 'weigh' (or 'appreciation' and 'reasoning') elements of the former, and the special regard to be given to the person's wishes, beliefs and values in the assessment of the latter.[11] The Law Commission in the report, cited above,[7] has

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[8] House of Lords. ***Mental Capacity Act 2005: post-legislative scrutiny. Report of Select Committee.*** London: The Stationery Office; 2014.

[9] The inter-rater reliability using a structured interview is extremely high. In at least four studies of psychiatric patients Kappa values with the well established McCATT have been greater than 0.8. [***Okai et al. Mental capacity in psychiatric patients: Systematic review. Br J Psychiatry 2007;191:291-297; Cairns et al. Reliability of mental capacity assessments in psychiatric in-patients. Br J Psychiatry 2005;187:372-378***.]

[10] Northern Ireland Assembly. ***Mental Capacity Bill. 2016*** *http://www.niassembly.gov.uk/globalassets/documents/legislation/bills/executive-bills/session-2014-2015/mental-capacity/mental-capacity-bill--as-amended-at-cs.pdf*

[11] Special regard to the person's beliefs and values are especially important in relation to evidence concerning patients' experiences of involuntary admission and treatment. A key research finding on patients' attitudes to involuntary treatment is the correlation between 'not having a voice' or 'not being listened to' and feeling 'coerced'. For example, the large MacArthur project on Mental Health and the Law found that lower levels of coercion were associated with 'beliefs that others acted out of genuine concern, treated the patient respectfully and in good faith, and afforded the patient a chance to tell his or her side of the story' [***MacArthur coercion study. (2004)*** *http://macarthur.virginia.edu/coercion]*.

Regard for the person's beliefs and values is also important in a pluralistic society such as ours, and may help to counter the over-representation of ethnic minority groups among those involuntarily admitted. If the person's voice is heard, as it must be in a capacity-based framework, an involuntary admission is less likely to occur.

While many patients report health benefits, generally fewer than 50% of patients later regard their detention as justified. For example, in a Swedish study, only 32% of involuntary patients interviewed at discharge stated that they would want to have the same treatment in the future [***Kjellin L, et al (2004) Coercion in psychiatric care - patients' and relatives' experiences from four Swedish psychiatric services. Nordic J Psychiatry 58:153-159***]. Similarly, a recent large English study found that only 40% of involuntary patients regarded this measure as justified when interviewed

recommended an amendment to the Mental Capacity Act to give particular weight to the person's wishes and feelings, and that the stronger and clearer these are, the greater the weight that should be given to them. (Chapter 14)

There is also here an approach to engagement with the important UN Convention on the Rights of Persons with Disabilities 2006 (CRPD). The Convention now ratified by 164 countries (including the UK) aims, as does the generic fusion proposal, at eliminating discrimination towards persons with disabilities (including mental health disabilities). The key concepts of 'will and preferences' in the CRPD, it can be argued, are reconcilable with capacity-based law, but certainly not with conventional mental health law.[12] The fusion law offers the most credible instantiation of those principles in practice. Support for decision-making is a crucial component. Advance directives may assume an important role in the expression of a patients' will and preferences when ill. These fit easily within a capacity-based framework.

'Positive' rights

The current Mental Health Act includes little reference to so-called 'positive' rights (economic, social and cultural rights) for persons with a mental disorder. These are well articulated in the UN Convention on the Rights of Persons with Disabilities, with a special focus on eliminating discrimination. Consideration might be given to the inclusion of all or some of these in a reformed Mental Health Act, or a reference to the Convention.

In *summary*, the human rights case for significant reform of the Mental Health Act is decisive. The discrimination such law entails cannot be supported. The right to liberty must mean the same for everyone regardless of their physical or mental impairments. The solution for eliminating that

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one year later [***Priebe et al. (2009) Patients' views and readmissions 1 year after involuntary hospitalisation. Br J Psychiatry 194:49-54***]. An important finding was that those patients who were least satisfied with their treatment experience in the first week of admission were more likely to be readmitted on a compulsory order within the 12 months of follow-up.

[12] ***Szmukler G, Bach M. Mental health disabilities and human rights protections. Global Mental Health 2015;****https://doi.10.1017/gmh.2015.18;*
Szmukler G. The Convention on the Rights of Persons with Disabilities: 'Rights, will and preferences' in relation to mental health disabilities. Int J of Law and Psychiatry 2017: *https://doi.org/10.1016/j.ijlp.2017.06.003.*
Szmukler G. Men in White Coats: Treatment under Coercion. 2017; Ch 7,8. Oxford, Oxford University Press

discrimination is a decision-making capability mental health law – better still, a decision-making capability generic law. A number of jurisdictions, recognising the human rights failures in conventional mental health law, have recently enacted the former (Tasmania, Western Australia, Queensland in Australia[13]; India[14]; Norway). Northern Ireland has taken the ground-breaking step of enacting a generic fusion-type law.

A law that applies equally to everyone promises to enhance the social standing of people with a mental illness, to reduce stigma and the 'coercive shadow' of psychiatry, and to encourage people (including those with different cultural values) to seek help earlier with less need subsequently for involuntary interventions.

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[13] ***Callaghan S, Ryan CJ. An evolving revolution: Evaluating Australia's compliance with the Convention on the Rights of Persons with Disabilities in mental health law. 2016; UNSW Law Journal 39:596-624.***

[14] Mental Healthcare Act 2017. ***Ministry of Law and Justice, The Gazette of India, April 7,2017/Chaitra 17, 1939 (SAKA)***