

# Unethical Mental Health Law; History Repeats Itself

Zigmond, A.\* and Holland, A.J. \*\*

## Introduction

The powers enshrined in mental health legislation go directly to fundamental principles central to any caring and democratic society. The tension and dilemma that exists is, on the one hand, the importance of respect for an individual's right to make decisions affecting his/her own life to, on the other, the recognition that there are people with mental disabilities that may be vulnerable to abuse and/or neglect and who throughout their lives or at particular times need care and/or treatment, which they may not seek or be able to consent to themselves. In any society it is through case law and statute that an attempt is made to resolve this tension and to ensure that individual rights are not infringed and that those who need care and treatment receive what is in their best interest. Thus a change in such legislation requires the most rigorous of examination and must be judged on the grounds that it a) does not infringe accepted principles such as those of the United Nations Declaration of Human Rights and the European Convention, b) is based on sound ethical principles and does not conflict with the established law of the country, and c) it is practicable and achieves the right balance with respect to the potential tension described above. As practising clinicians (one working in an acute psychiatric service the other in a district learning disability service) we are not in a position expertly to judge the first of these but we believe we can contribute to the second and the third. In this paper we consider specifically the reasons for, and the consequences that follow, the failure on the Government's part to accept the central importance of decision-making capacity assessment in any new mental health legislation.

The Green Paper proposals for a new Mental Health Act for England and Wales have now been published<sup>1</sup>. A broad definition of 'mental disorder' has been retained, a new system of tribunals is to be established and compulsory treatment in the community would become lawful. However, it rejects the recommendation of the expert committee chaired by Professor Richardson<sup>2</sup> that the assessment of

3 Lord Donaldson, M.R. in *Re T. (Adult: Refusal of medical treatment)* [1992] 4 All ER 649.

4 *Lord Reed in S.v.S., W. v. Official Solicitor* [1972]

5 *Judge L Jay in St George's Health Care NHS Trust v S.* [1998] 3 All ER 673.

6 *County Asylums Act 1808*

7 *Journal of Mental Science* 110 (1898) taken from *The British Journal of Psychiatry*, vol. 174, April 1999.

8 Terman, L. (1916) *The measurement of intelligence*, Houghton, Boston

9 Goddard, H. 1913 *The Kallikak Family*, Macmillan, New York.

an individual's decision-making capacity should be a determining factor in the use of compulsory detention. Given this, it does not address the relationship between this legislation and the proposed Mental Incapacity Act. The failure to recognise the central place of decision-making capacity in a modern Mental Health Act is, we believe, a serious omission as it is a reflection of a failure to acknowledge that the basic principle of autonomy is central to such legislation.

## **Background**

“Prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death”<sup>3</sup>. The principle underlying this proposition may be taken from Lord Reed<sup>4</sup> “There is no doubt that a person of full age and capacity cannot be ordered to undergo a blood test against his will..... The real reason is that English law goes to great lengths to protect a person of full age and capacity from interference with his personal liberty. We have too often seen freedom disappear in other countries not only by coup d’etat but by gradual erosion; and often it is the first step that counts. So it would be unwise to make even minor concessions”. Indeed in 1998<sup>5</sup>, Judge L Jay said, “The importance of this salutary warning remains undiminished”.

So what is it that makes it proper for the Government in the Green Paper to go against the recommendation of its expert committee and suggest that the notion of capacity “may not be relevant to the final decision on whether a patient should be made subject to a compulsory order. It is the degree of risk that patients with mental disorder pose, to themselves or others, that is crucial to this decision”? Why is it that the mentally disordered may be considered to be lesser citizens to such a degree that interference with their personal liberty, *despite* the fact that they may have the capacity to make that decision for themselves, is considered perfectly proper? History may be instructive.

People were detained in asylums in ever increasing numbers from 1808 onwards<sup>6</sup> leading, in 1845, to the formation of the “Alleged Lunatic’s Friend Society” by James Luke Hansard, “for the protection of the British subject from unjust confinement on the grounds of mental derangement” which, in turn, led to the Lunacy Act of 1890.

An article in the Journal of Mental Science<sup>7</sup> entitled “Lunatics at Large and the Public Press” argued that the 1890 Act was highly restrictive to compulsory detention “as it required periodic re-certification” and that it had led to an increase in assault, homicide and suicide. The authors blamed the popular cry of “the liberty of the subject” as being responsible for this “foolhardy” legislation. The article ended “the public should be clearly instructed that the annually recurring and possibly increasing horrors from the crimes of “Lunatics at Large” are the price it pays, under the existing lunacy law, for protection from an illusory danger to the “liberty of the subject”

Similarly, the ‘science’ of eugenics was used to justify the compulsory detention in ‘colonies’ (later hospitals) of the ‘feeble-minded’ and of ‘idiots’ and ‘imbeciles’. At that time it was considered that there was a direct link between ‘feeble-mindedness’ and ‘criminality’ - “the fearful role played by mental deficiency in the production of vice, crime and delinquency...not all criminals are feeble minded but all feeble-minded are potentially criminals<sup>8</sup>”. Goddard<sup>9</sup> in a study of two families of common descent stated that “....the best material out of which to make criminals, and perhaps the material from which

<sup>10</sup> Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-57, Chairman - Lord Percy, cmnd 169.

<sup>11</sup> *F v West Berkshire Health Authority and another (Mental Health Act Commission intervening)* [1989] 2 All ER 545.

they are most frequently made, is feeble-mindedness”.

Whilst in the late 19th and early 20th centuries the medical profession and eminent scientists of the day may have been arguing for greater restrictions it was subsequent legislative change that fundamentally led, very appropriately, to more enlightened practice and modern service developments. The irony is that this position would now appear to have been reversed.

Following the Royal Commission of the Law Relating to Mental Illness and Mental Deficiency<sup>10</sup> the Mental Health Act 1959 made many radical changes including the recognition that informal admission to hospital for treatment of a mental disorder was preferable to compulsory detention. Lord Russell likened the care of the mentally ill to that of the physically ill; “A doctor is not that sinister figure which in former times he was represented to be, anxious simply to confine a man in a dungeon for life... he is treating mental disorder in exactly the same way as he treats any other disease, with a sole view to its cure. When we use such phrases as ‘the liberty of the subject’ - and no-one attaches more importance to real liberty than I do - let us reflect on what the circumstances are. If your daughter has a fever, is she not restrained to bed instead of being allowed to run out into the cold air to die of double pneumonia? You do not invite the justices to do that - you do it as a matter of course... when the patient has recovered the patient is grateful for it”.

Although the new Act was framed in a more positive manner and reflected the role of treatment and rights to appeal it still rendered possible the detention in hospital of people with different types of mental disorders including mental illness, psychopathic disorder and what was then referred to as ‘mental subnormality’. The 1983 MHA made some further relatively small changes including changing terminology from ‘mental subnormality’ to ‘mental impairment’ and restricting the definition further, this being a compromise between those who wished for this category of mental disorder to be removed completely and those who wished for no change.

However, more recently it has been recognised that the law, as it stands, is unsatisfactory. The two main concerns expressed come from different perspectives but it is important to consider them both as, together with the historical background, they set the scene for the present day context of the Green Paper. They are as follows:

First, as described above, development of case law established the central importance of autonomy and with this the common law framework<sup>11</sup> that sets out the principles of ‘necessity’ and ‘best interest’ for substitute decision-making for those lacking decision-making capacity. However, this highlighted the lack of statute to provide a legal framework for substitute decision-making on behalf of adults who lacked the capacity to make decisions for themselves and with this the fact that there was no easy means for lawful intervention if a vulnerable and incapacitated person is at risk of abuse, or needs health treatment. In addition, the present lack of statute means that there is no method of appeal, other than seeking judicial review, if there is a disagreement as to what is in that particular person’s ‘best interests’. This came to a head with the case of *Bournemouth and Mr L*.

Secondly, there remains a continuing Government perspective carried over from previous Conservative administrations, that the ‘mentally disordered’ may be dangerous. For this reason, it is said, mental health legislation must be framed in a manner that separates it from the principles that guide the treatment of physical illness. A series of tragic incidents and subsequent enquiries led not only to the

care programme approach and the establishment of the supervision register but to a belief that mental health legislation is not effective because it is neither applicable to all 'mentally ill' patients in all settings nor does it have the 'correct focus'. 'Protection of the public' is seen as central and any consideration as to whether increasing restrictions and greater legal powers are really the most effective method of care and risk reduction would appear to have been lost.

The contrast between these two perspectives is most striking when comparing the report of the review of the Mental Health Act chaired by Professor Richardson and the Government's Green Paper. The former explicitly recognises the place and limitations of mental health legislation and lays out, for example, the key principles of non-discrimination, respect for autonomy (consensual care), and reciprocity. Whilst some, including the authors of this article, would argue it does not go far enough, it recognises the central ethical and legal importance of decision-making capacity. In the Green Paper it is accepted that for 'most people' these principles hold true nonetheless they should not be guiding principles in legislation that will be primarily concerned with the provisions covering compulsory care and treatment for mental disorders. This is remarkable, as such legislation should be precisely the legislation that should be based on sound ethical principles!

Imagine two people, one with depression and one with cancer. In both cases it is clear that they *are* able to make rational judgements about their treatment. They both recognise that they are ill and that their illnesses can be treated and that there are consequences to not receiving treatment. In the case of the former the fact he/she has capacity has no relevance and even if fully capable his/her unwillingness to consent can be over-ridden. In the case of the latter it is central and for treatment to proceed without the consent of this person with capacity, would be an assault. Is this right? The position becomes absurd when it is realised that the depressed patient may be entitled to refuse treatment for an accompanying cancer - just not for his/her depression.

### **Present proposals**

There are many patients who may require care and protection within a legal framework, on the grounds that they may not be able to make decisions for themselves, for example, unconscious patients, young children, those with acute confusional states, people with dementia and those with severe learning disabilities. The events relating to paediatric cardiac surgery at Bristol would support the view that many such patients may require greater protection than is currently available. Two current proposed statutes are relevant, the proposed Mental Incapacity Act<sup>12</sup> and the proposed new Mental Health Act. We consider the issues relevant to both.

The need for a statutory framework for substitute decision-making for those people with a mental disability resulting in incapacity has been recognised in the government's proposals for making decisions on behalf of mentally incapacitated adults. The question, therefore, is whether additional legislation and protections for those with a mental disorder should be greater than, or different from, that proposed for other potentially mentally incapacitated adults. There are a number of reasons for believing that separate legislation is damaging to the care of people with a mental disorder.

---

13 Coker, R *Public health, civil liberties and tuberculosis. British Medical Journal*, 7196, 29th May (1999).

14 *Department of Health. Statistical Bulletin. The Stationary Office* (1999).

First, the two statutes at present refer essentially to the same populations although the proposed mental health legislation could include a wider group as it does not depend on the presence or not of incapacity. The consequence that follows from having two statutes is the need to determine which applies when and if both apply, which takes precedent and how to deal with the problem of double jeopardy that will potentially face some people. For example, in future what about Mr L (*Bournewood*) if he really did need admission. Because of his severe learning disability he is very likely to remain incapable of making treatment decisions for himself. Should he therefore be admitted without consent (because he is unable to consent) using the Mental Incapacity Act or a new Mental Health Act? Similarly, if a person with a learning disability is considered to have the capacity to accept or reject particular advice and therefore the Mental Incapacity Act cannot apply, can and should his expressed wishes be overridden using the new Mental Health Act? Presumably any treatment for a physical disorder would be through the use of the Mental Incapacity Act and any treatment relating directly to his mental disability, through the use of the Mental Health Act!

Secondly, such an approach is undoubtedly stigmatising. Patients believe so; that is one of the reasons why they may reluctantly agree to informal admission in order to avoid detention. Families know this, in that it is not unusual for relatives to want the patient kept in hospital for treatment, but are reluctant to agree to formal detention. Indeed the Expert Committee reviewing the Mental Health Act recognise this and give it as one of their reasons for believing that the learning disabled should not be included (on the basis solely of learning disability) within the framework of a Mental Health Act. Clearly a law which covered all incapacitated patients, whatever the cause, would be less stigmatising than one which refers specifically to mental health and the treatment of mental disorder.

Thirdly, a Mental Health Act, which enables the compulsory care and treatment of patients, reduces the need to make provision that is acceptable to patients. Comments in a recent editorial in the *British Medical Journal*, although it was referring to tuberculosis, is just as true for the mentally ill: "If public anxiety rises, and this is allied to physicians' and public health officials' frustration over failures to ensure and monitor compliance, calls for detention of non-compliant individuals will be heard loudly. These calls for coercive measures, where individuals fail to recognise their social obligations, need to be tempered with a co-ordinated approach, which supports individuals with tuberculosis. Both civil rights and public health can be protected, but the emphasis should be on resource and organisational requirements, rather than on coercion."<sup>13</sup>

A counter argument might be that the Mental Health Act saves lives. Even if this were true there would still be grounds for concern as it is recognised that those with physical illnesses should be autonomous and there is no reason to believe that patients with mental disorder who have the capacity to make health-care decisions should be treated differently. However, there is no reason to believe that such legislation does reduce mortality. In the 10 years 1987/88 to 1997/98 the number of detentions under the Mental Health Act increased by 63%, indeed the rate of detention of informal patients in hospital using Section 5(2) increased by over 80%<sup>14</sup>. There has been no commensurate fall in the suicide or homicide rate during this time.

15 Taylor, P.J. and Gunn, J. *Homicides by people with mental illness: myth and reality*. *British Journal of Psychiatry*, 174, 1999.

16 *Managing Dangerous People with Severe Personality Disorder, Proposals for Policy Development*, Home Office, 1999.

17 Power, S. *A patient's choice*. *British Medical Journal*, 7206, 7th August (1999).

18 Grisso, T. and Applebaum, P.S. *Comparison of standards for assessing patients' capacities to make treatment decisions*. *American Journal of Psychiatry* 152, 1033-1036, (1995).

Fourthly, perhaps the real concern of legislators is not for those people who may harm themselves, but for those who may harm others. Surely, it is argued, the public has a right to be protected from such patients. This needs to be explored further. A Medical Incapacity Act could authorise the detention of patients who lacked capacity when appropriate and in the person's best interest. The courts could deal with patients with capacity charged or convicted of offences. The core concern appears to be those patients who suffer from mental disorder, retain capacity and might, just might, be a danger to others. This issue of the dangerousness of the mentally ill has been comprehensively examined and in the context of society generally shown to be a serious misconception<sup>15</sup>. There is also a further problem with respect to 'dangerousness' and 'public protection' that particularly applies to an additional piece of proposed legislation<sup>16</sup>. There are a number of ways of assessing the effectiveness of a particular treatment or medical intervention; this is the notion of "number needed to treat". That is how many patients would need to receive a drug or other intervention in order for one patient to benefit. This concept could be applied to the idea of detention (under a Mental Health Act) to prevent homicide. How many patients would need to be detained (unnecessarily) to prevent each homicide? Is it ten, a hundred, a thousand? The reality is that the ability to predict an act of violence to be committed by a particular individual at a particular time is extremely poor. For those people who are not mentally disordered the courts, when assessing guilt, use the "beyond unreasonable doubt" test on the grounds that it is better to let ten guilty men go free than imprison one innocent man. One must question why people with mental disorder are to be treated so differently.

There is recognition within society, including the medical profession, that there are a very small number of patients with medical conditions who present a clear serious risk to the public and yet who refuse medical intervention. Such patients can currently be detained under the Public Health (Control of Diseases) Act 1984. This legislation, with amendment, would enable the courts to detain those very few patients about whom there is no doubt of the risk they present.

Finally, it may be worth returning to another item from the British Medical Journal, a Personal View entitled "A patient's choice". "For my uncle life without drink was no life at all. He drank heavily from the age of sixteen until two weeks before his sixtieth birthday, the day he died. It runs against much of what I feel as a doctor but I admire him for his refusal to listen. Informed he made his choice and a patient's choice - no matter how damaging it seems to those who only see the small picture - should always be respected"<sup>17</sup>. People who are mentally ill and able to make treatment decisions for themselves fit the same category.

## **The Future**

There is a danger that just like molecular genetics or brain scanning becoming the 'holy grail' for neuroscientists, 'capacity' becomes the same for 'enlightened' professionals and campaigning organisations. Whilst much research has been undertaken, particularly in the USA, on mental illness and capacity<sup>18</sup>, there remain many uncertainties, most importantly how it might be assessed and then applied within the context of English and Welsh and Scottish Legislation. However, the concept of decision-making capacity is being clarified with a clear move to the concept that decision-making

19 *Assessment of Mental Capacity, Guidance for Doctors and Lawyers, British Medical Association and The Law Society, British Medical Association, (1995).*

20 Wong, J.G., Clare, I.C.H., Gunn, M.J. and Holland, A.J. *Capacity to make health care decisions: Its importance in clinical practice. Psychological Medicine, 29 (2): 437-446, (1999).*

21 Wong, J.G., Clare, I.C.H., Holland, A.J., Watson, P.C. and Gunn, M.J. *The capacity of people with a 'mental disability' to make a particular health care decision. Psychological Medicine (in press)*

capacity is determined functionally not by diagnosis and that it is decision specific. For example, the following would be considered to be critical; the ability to understand and retain information, to appreciate its significance and to be able to communicate one's choice<sup>19</sup>. A person with a learning disability or with dementia may be capable of some but not all decisions. Someone with a relapsing and remitting mental illness may be perfectly capable of making decisions when mentally well but not when mentally ill (see Wong, et al, 1999, for review)<sup>20</sup>. Capacity maybe enhanced through the way information is given with the identification of what it is that should be expected of a person<sup>21</sup>.

There are undoubtedly people with a mental disorder who require treatment for their illness and their health or safety or the safety of others may be at risk because of their behaviour. Treatments, particularly for people with mental illness, are of potential benefit and people with progressive illnesses associated with increasing mental disability or with lifelong disabilities need care and support even if they cannot determine that for themselves. A means of lawful intervention in the absence of consent is necessary. We end this paper with a brief summary of options.

First, it should be accepted that adults who are *able* to make treatment decisions for themselves have the right to expect that their decision about whether to accept treatment would be respected. This applies to the treatment of both physical and mental disorders. For those that do not have the capacity to make that decision for themselves, due to the presence of a mental disability, treatment can take place under the direction of the proposed new Mental Incapacity Act. Under these circumstances treatment (and if necessary admission to hospital) can proceed if it is in the person's best interest and the least restrictive alternative. Additional safeguards in the case of specific interventions (ECT, medication etc) would need to be made. Where treatment takes place it will be influenced by the nature and degree of the person's mental or physical disorder and the risks to his/her health, his/her safety and the safety of others. Subject to further consideration about how capacity might be assessed this is, in our view, the favoured option. It meets the key ethical considerations laid out by Professor Richardson - it would be non-discriminatory (i.e., treats mental and physical disorders similarly) and respects the principle of autonomy for those with capacity and would resolve the issues raised by '*Bournewood*'.

A second option would be similar to that expressed above. However, acknowledging the possibly (albeit not in the view of the authors) insurmountable problems of assessing decision-making capacity, to opt for the Richardson Committee compromise of a differential threshold for detention as between those patients with and those who lack capacity.

Thirdly, if the above is not acceptable, any future mental health legislation should be much more focused and only concerned with the assessment and treatment of acute mental illness rather than providing a legal framework for people with life long or progressive disorders (e.g. dementia) that might affect a person's decision-making capacity. The definition of 'mental disorder' in any new legislation would be limited to mental illness. The focus of mental health legislation would be exclusively the assessment and treatment of acute and serious mental illness in the short term. The Mental Incapacity Act would provide the wider framework for substitute decision-making including the admission to hospital for treatment of physical or mental disorder (other than mental illness). From the Government's perspective the former would not include the concept of decision-making capacity but the latter would. This solution continues to discriminate against the mentally ill but does ensure, for example, that as far

as people that are presently detained under the category of 'mental impairment' are concerned, their autonomy is respected if they are capable of making such admission or treatment decisions for themselves (except if mentally ill and requiring treatment). It would also go some way in resolving the dilemma highlighted by *Bournewood*, in that as the patient lacked the capacity to make that decision for himself, the Mental Incapacity Act would have provided a legal framework for admission (and thereby a means of appeal), but he would not have been subject to detention under mental health legislation as he was not mentally ill.

Fourthly, that the new legislation remains essentially as proposed in the Green Paper. We believe that such an approach fails on many counts, most importantly it does not show the leadership that we might have expected from this Government in countering historical prejudices against those with mental disorders and ensuring a just and non-discriminatory legislation, nor will it address public safety fears. These are much better addressed through enhancing the respect for and quality of relevant health, housing and social care services. The combination of the broad definition of mental disorder and the removal of the need for a capacity assessment as a 'filter' in the process of compulsory detention opens the door to the potential detention of many people. For people with learning disability it turns the clock back to the 1959 MHA and possibly even further, to the 1913 Mental Deficiency Act. The lack of any requirement to consider the 'treatability' of the person's mental disorder carries the risk of making this closer to a Public Order, rather than a Mental Health Act.

\* Dr Martin S Humphreys, BDS, MB, BS, MRCPsych  
Senior Lecturer and Honorary Consultant Forensic  
Psychiatrist, Reaside Clinic, Birmingham B45 9BE

\*\* Dr Helen M Smith, MPhil (Cantab), MBChB,  
MRCPsych Clinical Lecturer and Specialist Registrar in  
Forensic Psychiatry, Reaside Clinic, Birmingham B45 9BE

1 Review of the Mental Health Act 1983. Report of the  
Expert Committee. Department of Health.

2 Reform of the Mental Health Act 1983. Proposals for  
Consultation. Department of Health.

3 Wall, S., Churchill, R., Hotopf, M., Buchanan, A.,  
Wessely, S. Systematic review of research relating to the  
Mental Health Act 1983. Department of Health.