

### Transcending mental health law

We live in an era in which debates on the need for mental health reform are over-focused on single issues (like how to 'get people who live in the community to keep taking their medication') or, even worse, single cases (how to prevent another tragedy like the killing by Jason Mitchell). This prevents rational policy-making. Unusual cases make bad law. Narrow proposals for risk reduction ignore many of the most pertinent risks: that service users will be victims of attack, but have no access to justice because they are not seen as 'credible witnesses'; or that they will be detained for fear of violence when in fact they would not have been violent (Sayce, 1995). The recent statement on prime time British TV by Dr Deahl that he would rather detain nine people unnecessarily than discharge one who went on to harm a member of the public, shows how 'single issue' risk analysis can lead straight to breaches of natural justice ('Panorama', 13 October 1997, British Broadcasting Corporation).

In this context a paper that returns to first principles and asks why we need mental health law at all, is both welcome and refreshing. Szmukler & Holloway (1998) pose the question of whether special laws for mentally disordered people are discriminatory *per se*; and rightly conclude that they are. Why, for instance, should someone with mental health problems be detained for a crime they have not yet committed when someone who regularly drinks to excess and beats up his wife cannot be? On what precise basis is the service user to prove her/himself innocent of a crime not yet committed? And why can people diagnosed mentally ill be treated without consent even when they are capable of deciding – when other people with capacity are allowed to make decisions that may (to others' minds) be wrong-headed? As the American consumer movement leader Judi Chamberlin puts it, consumers (users in UK terms) want the 'right to be wrong' (Chamberlin, 1994).

Szmukler & Holloway helpfully distinguish between two entirely different laws that are potentially needed, each with a completely different purpose: one to permit, with safeguards, treatment without consent when someone is incapacitated (a paternalistic law); the other to take preventive action if someone is likely to commit crime (a social control measure). The first would apply to anyone incapacitated, whether by unconsciousness, dementia or any other cause; the second to anyone posing high risk of committing dangerous crime, whether mentally disordered or not. This separation could help reduce discrimination against those who currently have a record of being 'sectioned', which conjures up images of dangerous disturbance which are often entirely misplaced. The proposed

separation is also firmly based in principles of non-discrimination.

Discussions in the British Government's Disability Rights Task Force (a Ministerial group established in 1997 to make recommendations for a Disability Rights Commission, and comprehensive, enforceable civil rights for disabled people) have highlighted the need to audit existing laws, and new proposals, to ensure they are free of discrimination on grounds of disability. Mental health law should be a prime candidate for such attention.

But if the authors' arguments are based on sound principle, they raise formidable difficulties of interpretation and implementation: the devil is in the detail. Three issues stand out.

First, who decides whether someone is incapacitated? This is no objective judgement, but relies on whether (in the view of whoever assesses it) a person understands information and can make a choice about it. So, where does that leave the person who is diagnosed with schizophrenia, disagrees, and believes they are rather in communication with God? If they can understand entirely what a neuroleptic drug is and refuse it, are they capable or incapable of making that decision? In whose frame of reference does the information have to be 'understood'? As Chamberlin argues, incapacity could be reduced in meaning to 'disagreeing with your psychiatrist'. This may suggest the need for a legal test, drawing on professional advice, rather than clinical decision-making alone.

Second, the need for safeguards for people deemed incapable is paramount. Research from the MacArthur study (1998) suggests incapacity is often short-lived, sometimes limited to hours or days. This may indicate a need to overturn the notion of lengthy treatment sections, replacing them with the principle that no one should be treated without consent once capacity is regained.

Third, the proposal to introduce non-discriminatory provisions for prevention of violent crime is ethically deeply problematic, as the authors recognise: would we simply bring non-mentally ill people's rights to the same abysmal level as is currently experienced by those diagnosed mentally ill?

This paper is an extremely timely contribution to a debate that needs, next, to go deep into both principle and the detail of practice. The debate could usefully be widened to include other (and equally distinct) legislative measures prioritised by service users: notably stronger anti-discrimination law than the flawed Disability Discrimination Act 1995; and entitlement to services, building on the model of the Community Care (Rights to Services) Bill presented to Parliament by Tessa Jowell, but not passed, in 1995. As society began to fulfil its

responsibilities towards service users, we should also debate afresh the responsibilities to be expected of users, for instance in relation to criminal law. If our debates are sufficiently far-reaching, The forthcoming review of the Mental Health Act 1983 could mark the beginning of a radical shift towards non-discriminatory policy and practice.

MACARTHUR RESEARCH NETWORK (1998) *The MacArthur Treatment Competence Study. Executive Summary*. Charlottesville, VA: Virginia.

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