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Reform of the Mental Health Act 1983: the Green Paper

The profession awaits the Government's White Paper on a new Mental Health Act (MHA) with trepidation. At the time of writing, the closing date for consultation on the Green Paper (Department of Health, 1999a) has passed. None the less, discussion and lobbying must continue.

It is important to recognise that the Green Paper was written with one principal purpose. The document *Modernising Mental Health Services* (Department of Health, 1998) makes it clear that the primary purpose of the mental health services is "to protect the public (safe, sound and supportive)". The then Secretary of State for Health in the foreword stated the intention to "bring the laws on mental health up-to-date. In particular, to ensure that patients who might otherwise be a danger to themselves and others are no longer allowed to refuse to comply with the treatment they need". While setting up a 'root and branch review' of the MHA 1983, there can be no doubt of the Government's purpose. The Parliamentary Under Secretary of State for Health in an address to the Expert Committee on the Review of the Mental Health Act 1983 (Richardson Committee) (Department of Health, 1999b) stated "non-compliance can no longer be an option". It has been suggested that this statement was meant to apply to the professionals involved in patients' care as much as to the patients (Peay, 2000).

One of the many recommendations of the report of the Richardson Committee (Department of Health, 1999b) was that assessment of capacity should be an integral part of the assessment, and grounds for detention, under the MHA. The Government's resolve stood firm despite the recommendations of its own Expert Committee, as demonstrated when the Green Paper states that 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". Given the very broad, inclusive definition of mental disorder, the proposals in the Green Paper would, if enacted (and resourced), meet the principle of public protection so clearly set out at the start.

The College responded to the consultation process both during the deliberations of Richardson and following publication of the Green Paper. The College supported the Richardson Committee in emphasising the importance of such principles as non-discrimination, patient autonomy and reciprocity in the framing of any legislation

that enables compulsory care or treatment. Concern was expressed about the broad definition of mental disorder. The College concurred with the necessity of removing the "stigma of imposing longer term assessment and treatment orders from psychiatrists' shoulders" and expressed reservations about many aspects of the tribunal's role. The importance of in-patient services and overall resources are not forgotten. The response is detailed, answering each consultation point. If there are members of the College who have not read the College's response to the Green Paper then I would urge them to do so. Is there more to be said?

One of the main principles of Richardson seems to have been forgotten: "The principles governing mental health care should be the same as those which govern physical health." This principle, if followed, makes the others redundant. Having stated the principle, it was watered down by Richardson and ignored entirely by the Government.

It is worth reviewing the principles governing medical care of the physically ill. Nearly 30 years ago Lord Reid gave judgement as follows: "There is no doubt that a person of full age and capacity cannot be ordered to undergo a blood test against his will . . . the only 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'état*, but also by gradual erosion; and often it is the first step that counts. So it would be unwise to make even minor concessions." (Lord Reid in *S. v. S.*, W.V., 1972.) Lord Donaldson M. R. more recently, was clear when he said "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." (Lord Donaldson, M. R. in *Re T*, 1992.) Judge L. Jay repeated this judgement and added: "The importance of this salutary warning remains undiminished." (Judge L. Jay in *St George's Health Care NHS Trust v. S*, 1998.) They are wrong. People with mental illness may retain capacity and yet not be permitted to refuse treatment under the current MHA. They are presumably lesser citizens.

People with physical illness who lack capacity can be treated without their consent only if it is either an emergency, and the treatment cannot wait until they are



capable, or the treatment is in the patient's best interest (the operation or other treatment will be in the best interest of the patient if, but only if, it is carried out in order to save his or her life or ensure improvement or prevent deterioration in physical or mental health) (*F. v. West Berkshire Health Authority and another*, 1989).

The Green Paper makes no acknowledgement of fairness or equality under the law for those with mental illness. Those suffering from mental disorder (mental disorder continues to be undefined) are to be detained "in line with our proposed principle that issues relating to the safety of the individual patient and of the public are of key importance in determining the question of whether compulsory powers should be imposed". There is no mention of treatability, the need for the patient to benefit or even for the intervention to be in the patient's best interest.

Given the introduction of the new tribunal, does it matter if psychiatrists are placed in the invidious position of having to recommend detention of patients in circumstances that may be ethically corrupt? Detention will be the responsibility of the tribunal, not the psychiatrist. There are two points of importance here. First, if the criteria for detention are met (as described by the psychiatrist) the tribunal must issue a compulsory order. It will not have the discretion currently given to an approved social worker. Second, if psychiatrists retain the authority to discharge a patient at any time then it is the psychiatrist who is responsible for the continued detention. Put bluntly, we continue to be gaolers not doctors!

Much of the discussion relating to the review of the MHA has centred on the grounds for detention, the role of the tribunal and the introduction of compulsory treatment in the community. Little attention has been paid to the role of the psychiatrist. The Green Paper states that the patient must be medically examined to support an application for detention. This is in accord with the European Convention (European Convention for the Protection of Human Rights and Fundamental Freedoms, 1950), which was incorporated in English law as the Human Rights Act 1998 on 2 October, which states that a person cannot be detained as being of unsound mind "unless he or she is reliably shown to be so as demonstrated by objective medical expertise and the nature of his or her mental disorder is such as to justify the deprivation of liberty". In addition, the psychiatrist will have a role in drawing up a care plan. (The Green Paper also states: "A clinician who is a member of the team that will be responsible for carrying out the formal assessment under compulsory powers should always take part in the initial application process." This gives some idea of the ignorance of the authors of the Green Paper about the nature of the service in which we work.)

Consideration should be given to a different model. Given that the Green Paper, if enacted, would, in effect, be a Public Protection Order (this is the Government's specified aim), the role of the psychiatrist could mirror that of other doctors who have responsibilities for patients who may present a risk to the public. The proposal below is suggested only for capacitous patients. All patients who lack decision-making capacity, with

regard to medical care, both mental and physical, should be treated in line with the Lord Chancellor's proposals *Making Decisions* (Lord High Chancellor, 1999).

It is proposed here that psychiatrists should no longer be responsible for recommending detention of patients. The Government should draw up a list of 'Grounds for Notification'. This could mirror the arrangements for infectious diseases or for when patients present a risk to the public by continuing to drive when they suffer from medical conditions that preclude driving. The doctor has a duty to notify the relevant authority not to take legal action to restrict the patient. The grounds would need to be clear and specific. It is, quite proper in a democracy, for parliament (rather than psychiatrists) to determine the grounds including whether or not 'risk to self' is a matter for detention. When a psychiatrist sees a patient whose condition includes those factors identified by the Government, then the law would require the doctor to notify whatever body, perhaps a tribunal or the magistrate's court, the Government sees fit to organise for this purpose. The notification might include a statement on whether or not the notifying psychiatrist believes a hospital is the proper place for detention; if it is determined that detention is appropriate. This would presumably depend on whether or not the person consented to medical intervention and would benefit from it. The Government may set out clear steps to be taken in response to such notification, including, perhaps, an approved social worker having to present the case to the tribunal (or court) for a decision to be made as to whether or not the patient should be incarcerated away from the rest of society. Alternatively, the tribunal may need to examine the patient to establish if the notification warrants the patient's detention (perhaps via its legal member) and if that detention should be in hospital (perhaps via its medical member). Although psychiatrists would have a duty under law to notify the appropriate body, they would not be involved with recommending detention of such patients. Treatment would, of course, only be with the patients' consent (they retain capacity). If the patient appealed to a higher court it would be for the tribunal to justify its decision.

Is this pedantic nonsense? An article in the *Journal of Mental Science* (Anonymous, 1898), entitled 'Lunatics at large and the public press', argued that the 1890 Lunacy Act was, because it required periodic re-certification, highly restrictive to compulsory detention 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'". A hundred years ago psychiatrists wanted detention for the mentally ill while government and lawyers were concerned about individual liberty.

Times have changed. Psychiatrists surely believe discrimination against those with mental illness should be viewed in the same way as discrimination against any



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other group of people. The existence of a MHA is discriminating. The Green Paper proposals, with its all inclusive criteria for detention and indefinite compulsory treatment in the community (the grounds for release from the order are hard to understand) will turn the clock back to the 19th Century (Zigmond & Holland, 2000). This is not just a matter of ethics. One precursor to reducing the morbidity and mortality resulting from mental disorder is to persuade people to use the services, to seek help when it is needed. This could be achieved by making the services more acceptable to patients. An increasing threat of detention is likely to do the reverse. Again, there are similarities between the needs of those with mental illness and those with physically illness – especially when public health is an issue. A recent leading article in the *British Medical Journal* relating to the care of those with tuberculosis is eloquent:

“If public anxiety rises, and this is allied to physicians’ and public health officials’ frustration over failure 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 coercion.” (Coker, 1999)

The profession expressed impotence prior to the introduction of discharge under supervision, Mental Health (Patients in the Community) Act 1995. During the consultation process, following publication of the Green Paper, it was said many times that the task was to respond to the listed consultation points as the Government would not ‘listen’ to anything else. In the

BBC television programme, Dr Who rejected the ‘Resistance is Futile’ statement from the Daleks. We would do well to follow Dr Who’s example.

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