

postnote

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REFORM OF MENTAL HEALTH LEGISLATION

In 2002, the government published a draft Bill setting out proposed changes to the current Mental Health Act (MHA) 1983. While the need to reform current legislation is widely accepted, the proposed changes have been criticised by health professionals, service providers, users and carers alike. The government is currently consulting about the changes. This briefing analyses issues concerning overlap with other legislation and examines alternative ways forward for mental health policy and the provision of services.

Understanding mental health

Mental health is one of the government's clinical priorities. Mental health problems affect one in four people in their life-times and can lead to high levels of stigma and social exclusion. It is estimated that mental health problems cost the NHS, social services, local authorities, employers and the criminal justice system a total of around £38.5 billion in England in 2000/01.¹ Surveys reveal a widespread public perception that people with mental health problems are violent and pose a threat to society.² However, this is not generally the case; as discussed later the vast majority of people with mental health problems pose no danger to society at all.

The UK has traditionally adopted a medical view of 'mental illness', based on diagnostic categories such as 'schizophrenia', 'manic depression' and 'personality disorder'. However, there is a growing impetus in the UK away from this 'diagnose and treat' view towards a more holistic approach. This new approach views mental health problems as lying on a continuum with normal experiences, and places more emphasis on assessing each individual patient's needs.

The proposed changes

Background

This approach is evident in recent changes in UK mental health policy. The mental health care system has been

Box 1 The MHA 1983

The current legislation focuses almost entirely on the position of patients in hospital. The MHA 1983 sets out the measures for the compulsory admission of patients to hospital and defines procedures for their continued detention or discharge. It provides the legal authority to assess and treat people with a mental disorder in hospital without their consent where this is necessary for their own health or safety or for the protection of others. Under the Act, any compulsory treatment received by patients with a 'psychopathic disorder or mental impairment' must be 'likely to alleviate or prevent a deterioration' of their condition. This may exclude a small number of potentially dangerous individuals with severe personality disorder whose condition is not considered 'treatable'. In general, the Act is not concerned with the provision or adequacy of services to patients, although it does place a duty on health authorities and social services to provide after-care services to those who have been released from detention under the Act.

reorganised following the introduction of community care policy via the NHS and Community Care Act 1990. Reform of the MHA 1983 (see box 1 for an outline of the current Act) was announced in a 1998 policy paper which promised a new legal framework to replace the MHA 1983.³ It also promised a National Service Framework for Mental Health, setting out service models and national standards for the NHS, published in 1999.⁴

It was widely agreed that the 1983 Act needed amending to take account of: advances in our thinking about mental health; developments in mental health care policy and therapeutic practice; changes in the structure of the NHS; and changes in the role of mental health professionals. The government had also expressed its wish to see the new legislation break the link between compulsory treatment and detention in hospital: the 1983 Act allows compulsory treatment primarily for those detained in hospital and this may exclude certain categories of patient (see box 1).⁵

The Department of Health (DoH) appointed an Expert Committee (the Richardson Committee), to start the review in 1998. Its remit was to consider what changes in legislation were needed, how new legislation might be extended beyond hospitals into community settings and how to provide care while balancing the rights of individual patients with the need to ensure public safety. It reported in 1999, outlining the general principles which should underpin the new MHA (see box 2).⁶

The draft Mental Health Bill 2002

Following the Richardson Committee's report, DoH published a White Paper⁷ in 2000. This formed the basis of a draft Bill in June 2002 which proposed:

- A single broad definition of 'mental disorder';
- A Mental Health Tribunal with powers to make orders for assessment and/or treatment under compulsion.
- Care-plans - all patients undergoing compulsory treatment will have a care plan without which they cannot be treated on a compulsory basis.
- New safeguards – scrutiny of compulsory treatment beyond 28 days by an independent Tribunal which will be given independent expert reports.
- Advocacy services - new specialist independent mental health advocacy services will be available to everyone being treated under the Act with the aim of empowering people with mental health problems and involving them in the development of services.
- Nominated persons – new proposals to allow patients a say in choosing a person to speak for them.
- Community treatment - the Bill provides for orders that can allow treatment under compulsion in the community, as well as in a hospital.
- Human rights – the Bill is intended to align the new MHA more closely with modern human rights law.

As discussed later, while some of the proposed changes have been welcomed, the proposal to allow treatment under compulsion in the community has proved particularly controversial. The proposed changes to the MHA have to be viewed in the context of reform of other legislation, summarised in the table on page 3. Two policy areas of particular relevance to the MHA are discussed in more detail below.

People with Severe Personality Disorder

In parallel with the consultation on reform of the MHA 1983, the Home Office (HO) conducted a consultation on '*Managing Dangerous People with Severe Personality Disorder*' in July 1999. DoH and HO are developing facilities for treating the very small number of people who are dangerous by virtue of suffering from severe personality disorder (box 3). The Dangerous with Severe Personality Disorder (DSPD) Programme has been established and is proceeding under existing Mental Health and Criminal Justice legislation. Aspects of the Programme would be supported by changes proposed in the Bill but the Programme does not depend on it.

The draft Mental Incapacity Bill 2003

Another key aspect of a new MHA will be the provisions it makes for some people who lack the capacity to make decisions on their own behalf such as adult patients who

Box 2 Richardson principles

The Committee recommended the inclusion within new legislation of statements of principle to set the tone and guide its interpretation. Key principles identified include:

- Informal care, patient involvement, equality, respect for diversity, and recognition of the role of carers;
- Patient autonomy - the provision of care on a consensual basis wherever possible with full (informed) patient involvement in decision making;
- The provision of the least restrictive alternative compatible with the delivery of safe and effective care;
- Reciprocity - restriction or removal of civil liberties for the purpose of care must be matched by adequate quality of services.

The Committee also concluded that the Bill should be based on a broad definition of mental disorder, but with strict criteria for imposition of powers under the new Act.

Box 3 The DSPD programme

DSPD is a joint initiative between the **Department of Health, Home Office and Prison Service**. The aim of the programme is to develop, pilot and evaluate new mental health services for the very small number of people who are dangerous as a result of a severe personality disorder.

Cross cultural comparisons – several countries in continental Europe do not put the supervision of those with antisocial personality disorder into the mental health system. In Switzerland and Germany, for instance, people who have committed certain offences are followed up under security measures for an indeterminate period, with or without a preceding prison sentence. During this time they take part in a social therapy programme. The Netherlands has a range of security measures under which people can be detained indefinitely; at one end of this range are high security units.

have a long-term incapacity to consent and who are in a hospital or nursing home receiving treatment for a serious mental disorder. A more general draft Mental Incapacity Bill, introducing new mechanisms to allow welfare, healthcare and financial decisions to be taken on behalf of all persons lacking capacity, is being considered by a joint committee of both Houses. It sets out key principles (box 4) and ways in which decisions can be lawfully taken on behalf of adults who are unable to make decision for themselves. The Incapacity Bill aims:

- to empower adults who may lack capacity, enabling them to maximise their autonomy;
- to protect adults who lack capacity and those who care for them;
- to allow people to choose those they trust to take decisions for them if they should lose capacity.

ISSUES

Response to the Draft Mental Health Bill

Some aspects of the draft Bill – including the new emphasis on advocacy and the new safeguards - have been welcomed by the stakeholder community. But there has also been considerable opposition to the proposals from the Royal College of Psychiatrists and from professional health and legal groups and service users united as the Mental Health Alliance.⁸ There is concern that the Bill:

Summary of relevant legislation

| Legislation | Brief Description |
|--|--|
| Draft Mental Incapacity Bill 2003 | Makes provision for decision making on behalf of adults lacking legal capacity |
| Draft Mental Health Bill 2002 | Proposes, among other things, a new legal framework for the compulsory treatment of people with mental disorder |
| Human Rights Act 1998 | Provides for UK courts to review all UK legislation from the perspective of compatibility with the European Convention on Human Rights |
| Disability Discrimination Act 1995 | Deals with discrimination in the provision of goods, facilities and services |
| Mental Health (Patients in the Community) Act 1995 | Provides for supervised discharge orders for certain patients discharged from hospital following detention for treatment |
| NHS and Community Care Act 1990 | Establishes the legislative framework for the restructuring of both the NHS and community care system |
| Mental Health Act 1983 | Basic legal framework for the compulsory treatment of people with a mental disorder |

Box 4 Draft Mental Incapacity Bill – key principles

Determining capacity – sets out to explain what is meant by capacity concentrating on whether someone is capable of making a particular decision at the time when that decision needs to be made.

Best interests – sets out criteria for assessing what is in the best interests of someone who lacks capacity (e.g. by considering what he/she has said in the past and consulting those close to them).

General authority to act reasonably – introduces the concept of a general authority to act that clarifies the circumstances in which decisions can be taken on behalf of others without the need for any formal authority.

- may not incorporate all the principles expressed by the Richardson Committee (see box 1);
- may broaden the criteria for compulsion, which could lead to excessive and/or variable rates of compulsion, particularly in the community;
- is founded on a different legal approach from the Mental Health (Care and Treatment) (Scotland) Act 2003 (it is likely that some patients will be subject to compulsion in one jurisdiction but not in the other);
- might potentially contravene the European Convention on Human Rights, if it set a lower threshold for compulsory hospital admission than is currently found in sections 2 and 3 of the MHA 1983.

A detailed analysis of each of these potential concerns is beyond the scope of this POSTnote, which will focus on issues involving compulsion in the community, the DSPD programme and mental incapacity.

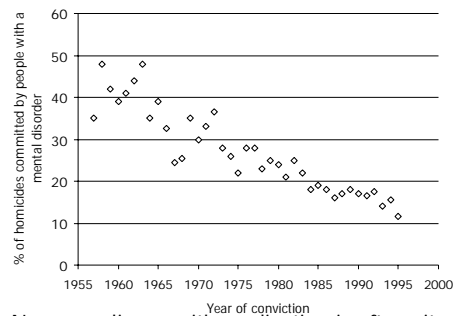
Compulsion in the community

The issue of compulsory treatment in the community has been the subject of longstanding professional debate and the introduction of such powers remains contentious.

The proposed powers will break the automatic link between treatment under compulsion and detention and may include requirements for people to reside in a specified place, attend specified places for medical treatment, occupation, education or training or to allow access to the care team. The government sees the

Box 5 Treatment under compulsion

Dangerousness – it is perceived that one of the reasons for introducing new powers is violence by people with mental disorder. However, psychiatric patients are generally not a significant danger to the public. For instance, as the figure below illustrates, while there was a fivefold increase in homicide in the UK from 1957 to 1995, the proportion of these committed by people with mental health problems has fallen by 3% a year.⁹



Non-compliance with medication is often cited as another circumstance where compulsion could be used to prevent an individual posing a threat to society. However, poor risk management, past offences, inadequate care planning, communication problems and lack of inter-agency working are also important contributory factors.

Cross cultural comparisons - powers to enforce medication in the community do exist in a number of other countries. Two studies in the USA evaluating compulsory treatment in the community provide mixed evidence for the effectiveness of this measure. However both agree that the level of resourcing for services in the community is a crucial component of a successful outcome.

Local variation in compulsory admissions - there is evidence of considerable local variation in compulsory admissions made under the MHA 1983, both in requests to social services departments for section assessments and rates of detention. This is partly explained by socio-economic deprivation and supply side factors such as availability of community resources and approved social workers.

introduction of such orders as a means of providing care in the least restrictive way to those people with mental health problems who may represent a risk to themselves but pose no risk to society. However, some groups have expressed concerns that there is mixed evidence that compulsory treatment in the community has proved effective (box 5). They are also worried that the proposals may lead to the inappropriate use of compulsory orders. A key issue here will be how effective new safeguards such as the Mental Health Tribunal prove to be in scrutinising/authorising compulsory treatment in the community.

Compulsion and severe personality disorder

The draft Mental Health Bill proposes that people with a mental disorder may be liable to compulsion for as long as their disorder is sufficiently serious, if it is necessary for their protection or that of others and if there is treatment available which is appropriate to their condition. The government sees this as closing a perceived 'loophole' in the 1983 Act under which people judged as a potential risk to society but whose condition is not considered 'treatable' cannot be detained and thus

cannot receive compulsory treatment. Some groups are concerned that the new proposals may reinforce public perceptions of the risk posed by people with mental health problems (see box 5) and result in greater use of compulsory powers. Again, a key issue will be the role of the Mental Health Tribunal, which has to authorise all compulsion beyond 28 days, and monitor a patient's condition to determine whether compulsion is still merited.

Mental Incapacity

As noted previously, Parliament is currently considering a draft Mental Incapacity Bill. The proposed reforms to the MHA provide some safeguards for persons with long term incapacity. It is widely agreed that it is important that the new mental health and incapacity legislation are consistent with each other.

Other ways forward

Since the draft Bill was published in 2002, patient and professional groups have sought changes. Some of the most widely supported proposals are discussed below.

Impaired decision making - Many groups agree that an assessment of capacity should be an integral part of the compulsion process. They advocate a clause stipulating that the mental disorder is of a nature or severity so as to impair the individual's judgement to the extent that the individual is incapable of making valid decisions about health care. This would also be in line with the core criteria for compulsion in the Mental Health (Care and Treatment) Scotland Act 2003.

Advanced directives - These have the aim of specifying a person's wishes when they are 'well' (capable) for what they want to happen when they are 'ill' (incapable) and unable to make decisions. Many groups would like to see more use made of advance directives, as these can promote individual autonomy and empowerment, enhance communication between patients and those involved in their care, as well as protecting individuals from receiving unwanted treatment.

Human rights - The Mental Health Bill has been drafted to comply with the European Convention on Human Rights (ECHR). The Human Rights Act (HRA) requires that English and Welsh courts must try to read legislation compatibly with the ECHR. Since this dates back to 1950 it, and subsequent court judgements, may be out of line with modern thinking on mental health. For instance it refers to 'persons of unsound mind', 'vagrants' and 'drug addicts' and exempts these groups from the protection afforded to others (governments are permitted to restrict the liberty of these groups in certain circumstances). Many groups argue that it is only by assessing a person's ability to make valid consensual judgements about their mental health care that a judgement can be made as to whether the individual is of 'unsound mind'. They thus argue that such a criterion should be an integral part of the new MHA in order for it to be compatible with the HRA.

The wider context

In addition to the specific proposals outlined above, mental health services user groups have also called for wider government measures to address mental health problems. For instance, some wish to see greater government action to address the problem of discrimination against people with mental health problems. The Independent Living Movement wishes to see people with mental health problems being given the personal assistance, support and conditions to live as independently as those without such problems. It has pointed out the importance of ensuring that the new MHA is compatible with the Disability Discrimination Act 1995, which safeguards the disability benefits entitlement of people with mental health problems.

Many groups argue that there is little evidence to demonstrate that compulsion is better at ensuring adherence to community treatment and reducing hospital usage than a fully functioning and well resourced community service. They suggest that improving community and inpatient services as well as providing appropriate education and support for mental health service providers/users is central to reform. One way of achieving this may be to foster collaboration between a wide range of service providers (e.g. social, health, employment, education and voluntary services), service users, their families/carers and communities.

Overview

Patient and professional groups have suggested a number of changes to the Bill, which they feel would strengthen the proposed changes and ensure they remain compatible with human rights. These include applying compulsion on the basis of patients' capacity to make decisions for themselves and to those convicted of violent crimes. The future success of a new MHA will depend on sufficient resources being available to implement it.

Endnotes

- 1 www.mind.org.uk/Information/Factsheets/Statistics/Statistics+5.htm
- 2 www.mind.org.uk/Information/Factsheets/Public+attitudes/
- 3 *Modernising mental health service - safe, sound and supportive*, DoH 1998.
- 4 *A National Service Framework for Mental Health*, DoH, 1999.
- 5 House of Commons Library Research Paper 02/80, Dec 2002.
- 6 Department of Health (1999) *Report of the Expert Committee : Review of the Mental Health Act 1983*. Stationery Office.
- 7 Department of Health (1999) *Reforming the Mental Health Act. 1983. Proposals for Consultation* (Cm 4480): Stationery Office.
- 8 The Mental Health Alliance consists of over 60 organisations from the mental health field. It was established in 2000, following widespread concern about the Government proposals for new mental health legislation.
- 9 Source: Taylor et al, *British Journal of Psychiatry*, 174, 9-14, 1999

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