

Mental health law: civil liberties and the principle of reciprocity

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At a conference organised by the Law Society, Mental Health Act Commission, and Institute of Psychiatry possible reform of mental health legislation in England and Wales was discussed. It was concluded that radical legal reform was required, and that the law should be designed specifically for provision of care in both hospital and the community. Reform should be based on principle rather than pragmatism, particularly the principle of reciprocity—patients' civil liberties may not be removed for the purposes of treatment if resources for that treatment are inadequate. Protection of society from nuisance or even violence is insufficient reason for detention. Legal provision for compulsion of patients, whether in hospital or the community, must be matched by specific rights to treatment.

Mental health law removes from some psychiatric patients civil liberties otherwise inherent in our legal system. Through both statute and common law it balances a patient's right to autonomy with doctors' duty of care by reference to the health and safety of the patient. It also balances the civil rights of individual patients against the right of society to protection. Does current law correctly strike these various balances? The conference *The Mental Health Act 1983: Time for Change?* organised by the Law Society, Mental Health Act Commission, and Institute of Psychiatry (London, November 1993) offered a major review of aspects of mental health legislation in England and Wales on the tenth anniversary of the act. John Bowis, minister of state, Department of Health, opened the conference by asking whether changes in the organisation of mental health care have created the need for a radical review of the act or whether only fine tuning is necessary. I comment on some of the opinions voiced at the conference.

Lack of resources

Civil rights are granted by law but effected by resources. Hence the "principle of reciprocity" insists that restriction or removal of civil liberties for the purpose of care must be matched by adequate quality of services. This is pursued in some American states to the point where courts discharge otherwise detainable psychiatric patients because of lack of services. Even protection of the public cannot justify detention for treatment without adequate resources. Indeed, public protection is not achievable without adequate resources, as is perhaps shown by some of the recent cases of homicide in the community.¹ The Royal College of Psychiatrists' confidential enquiry into suicides and homicides suggests that these cases are not so infrequent as to amount to a minor "incidental" problem of current community care provision (personal communication).

Professor Murphy, for the Mental Health Act Commission, described a total of £3 billion (\$4.5 billion) spent towards mental health care as "ill-directed, uncoordinated, and inadequate." The reduction in the numbers of acute psychiatric beds has caused a doubling of costs per bed and a transfer of resources from long stay care. Necessary increased staffing of acute beds is reflected in the proportion of patients

who are "sectioned" having risen by 40% nationally (80-90% in some London districts). Hence, the process of transferring care to the community leaves a "residue" problem of acute care which limits the resources available for community care. As a result "resources are increasingly almost entirely reserved for those who do not want them."

Principle rather than pragmatism

The 1959 and 1983 Mental Health Acts arose from considered pragmatism, including the experience of dealing with dangerous patients,^{2,3} hospital inquiries,⁴ pressure from civil rights groups,⁵ and response to judgments of the European Court of Human Rights.⁶ Professor Brenda Hoggett, a law commissioner, argued for radical legal change that was based not on pragmatism but on principle. Aside from reciprocity, such principles would include promotion of self determination; services designed for the individual; least restriction; close proximity of services; protection from exploitation, neglect, and abuse; and patients taking all decisions of which they are capable.

Ian Bynoe, legal director of the mental health charity MIND, went further by calling for reform to make mental health law congruent with common law provisions, which base non-consensual medical treatment solely on incapacity to consent. Professor Hoggett advocated separation of legal rules between provision for "disabled" as opposed to "disordered" people and for "dangerous or dissenting" as opposed to "vulnerable" people.^{7,8} She also requested new legislation to fill the legal lacuna relating to treatment for physical disorders of people who were mentally incapacitated.⁹

Principles for new mental health act

- Promotion of self determination and personal responsibility; patients taking all decisions of which they are capable
- Protection from exploitation, neglect, and abuse
- Proper consideration of views of family and carers
- Services designed for individuals
- Preference for care in the community; hospital care based on closest proximity
- Procedural safeguards consistent with European Convention on Human Rights
- Principle of reciprocity: adequacy of service to match infringement of civil rights

The recent case of re C¹⁰ has established the principle of advance directives, although they could not be used to refuse future treatment for a mental disorder. The same case confirmed that even psychotic delusions that are specifically related to a patient's decision to accept or refuse medical treatment for a physical disorder need not necessarily remove the patient's capacity to accept or refuse such treatment. This emphasises that capacity is determined by reference to a legal test and is reliant on medicine only in an evidential way.

Compulsion in the community

Community care challenges current perceptions of mental health civil rights. The 1983 Mental Health Act

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Medical consent by mentally incompetent adult patients

- Competence is based on a legal test—the ability to understand in broad terms the nature and purpose of the treatment
- The Mental Health Act 1983 is solely for treatment of mental disorder; patients cannot be “sectioned” to facilitate treatment of a physical disorder
- No legal basis for proxy consent
- If a patient refusing treatment is incompetent the patient can be treated without consent if he or she would otherwise die or suffer grave harm
- For unconscious patients there is a presumption of implied consent
- Advance directives can be made but not to cover future treatment of a mental disorder

is based on admission to hospital. Should any new act be based on admission to a service instead? The government's rejection of the proposal by the Royal College of Psychiatrists for a community supervision order¹¹⁻¹⁴ reflects, at least in part, recognition that such an order would probably be judged unlawful by the European Court of Human Rights. In contrast, supervised discharge orders¹⁴ would use existing rules for admission under the Mental Health Act combined with a discharge agreement with the patient to establish, according to the government, a legal framework for community care. However, supervised discharge orders would have little influence on patients beyond that already contained in current guardianship order provisions under section 7: the only additional power would be to convey a patient to a mental health care facility, where he or she might then again refuse treatment (the basis for redetention would remain exactly as currently provided for in the 1983 act).

Of course, it can be argued that a legal framework for care in the community is already provided under section 117 of the act, albeit grossly underresourced and therefore ineffective. Without further resources, using the legal framework of supervised discharge orders in community care will probably do little more than identify the responsibility of the “key worker” (who may then be made a scapegoat). Lucy Scott-Moncreiff, a lawyer, challenged the need for any extension of power over patients in the community, arguing cogently that there was no evidence to support the government's view that there were about 3000 “revolving door” patients for whom additional community legal provision was required.¹⁴

The “compulsion in the community” debate reflects a more fundamental debate of principle underlying calls for legislative reform. Hence, it can be argued that if it is moral to have a compulsory right of treatment of some patients in hospital then improvement of their care by moving the locus of care to the community does not affect that morality. Alternatively, it can be argued that if a patient is well enough to be in the community compulsion must be wrong. Supervised discharge orders represent a fudged compromise that does

Supervised discharge order

- Community treatment agreement with patient before discharge, initiated by mental health team
- Somewhat similar to guardianship order
- Identified key worker
- Patient default on agreement requires key worker to call immediate case review
- Decision to redetain based on existing criteria of the Mental Health Act
- No additional powers to treat in the community

not move the Mental Health Act towards greater congruence with community care. They represent tinkering with a law essentially designed for hospital care. Indeed, supervised discharge orders may have little effect other than to concentrate the allocation of scarce community resources towards the small group of patients to whom the orders are applied. Patients may be able to gain community resources only by showing reluctance to accept treatment before discharge.

Psychopathic disorder

Continued inclusion of psychopathic disorder in the Mental Health Act is controversial¹⁵ because it defines disorder largely by behaviour and because it represents the border between “madness” and “badness” and between the appropriateness of treatment and of punishment. The fact that its use is almost entirely restricted to hospital orders made by courts emphasises the civil rights issue. Dr Bridget Dolan argued that there is no scientific basis either for retention or for removal of psychopathic disorder from the act on the grounds of demonstrated (un)treatability.¹⁶ The recent legal decision that a psychopathic patient must be discharged if he or she is deemed untreatable¹⁷ will make unlawful the preventive detention of dangerous patients and will certainly focus a previously sterile debate.

Psychopathic disorder

- A legal category not equivalent to any specific personality disorder diagnosis; defined largely by behaviour; covers borderline between “madness” and “badness”
- Used as a basis for “sectioning” almost solely by courts
- Has been used as a basis for effective preventive detention in spite of untreatability; untreatability now implies tribunal must discharge
- Psychiatrists divided on continued inclusion in the Mental Health Act
- “Hybrid hospital order” proposed for psychopathic disorder defendants

Forensic psychiatrists are divided on continued inclusion of psychopathic disorder in the act.¹⁸ Drs Coid and Chiswick proposed a compromise “hybrid hospital order,” which would link a fixed punishment tariff with alternatives of hospital care or prison. The debate on psychopathic disorder will probably become largely irrelevant if the recent judgment¹⁷ stands on appeal since courts will then substantially reduce detention under this legal category.

Mental health review tribunals

Mental health review tribunals offer apparent rights of redress to detained patients. Since “due process” is not applied, however, they may sometimes be little more than legalised case conferences,¹⁹ applying an odd mix of investigative and adversarial approaches. Judge Woods appeared to suggest a move towards greater application of courtroom due process when he proposed that, in cases of Section 41 restriction orders, the home secretary should be represented at tribunals so as to avoid tribunal members (often the judicial president) inappropriately having to cross examine the independent psychiatrist called on behalf of a patient—as he said, “those that go down into the arena must expect to get dust in their eyes.” However, he refused to extend his own suggestion towards truly increased due process by rejecting a call for removal of the

medical member from the tribunal, who is seen by many as an unfair "silent medical witness" who cannot be cross examined by the patient's lawyer.

Judge Woods also argued for increased powers of tribunals to direct transfer of patients to (usually less secure) hospitals when all parties except the Home Office agreed. However, such transfers are probably blocked more often by lack of resources—that is, the shortage of regional secure unit beds.²⁰ Indeed, reform of section 39 of the act to the effect that a court could require a district purchasing authority to purchase a hospital bed for a defendant (instead of currently merely requiring the authority to explain why a bed has not been provided) would do more to advance services for mentally disordered offenders than any other single legal or administrative manoeuvre.

Doctors and the law

All doctors should have knowledge of general medical law. The power of doctors, especially psychiatrists, to make medical recommendations that have the effect of removing the civil liberties of psychiatric patients means that knowledge of mental health law specifically is an ethical imperative. Currently, the Royal College of Psychiatrists does not formally examine in mental health law (because of a dispute with Irish candidates who have objected to examination in English law). Further, there is no requirement for demonstration of either training or competence in mental health law before recognition by regional health authorities under section 12(2) of the act. Both inadequacies are in stark contrast with the requirement that social workers undergo approved social work training in mental health law. The lack of commitment shown by professional medical bodies in requiring doctors to acquire detailed knowledge of mental health law is likely to increase division with and criticism by civil rights pressure groups. This will be particularly damaging with regard to reform of mental health law that is needed to make it more congruent with care in the community. The Royal College of Psychiatrists and the BMA should commit themselves to developing a principle of reciprocity which recognises that the right to infringe a patient's civil liberties must be matched by a duty to maintain detailed knowledge of the enabling law.

Conclusion

Legal reform should be radical (as was argued by almost all of the speakers at the conference). It should not only address civil detention but also introduce statute law to fill gaps relating to incapacity to consent to treatment for physical disorders and relating to patients' private property and their public protection. In relation to treatment for mental disorders, legal provisions should be designed specifically for a "mixed economy" of care between hospital and community. The conference has opened a debate which must go beyond narrow arguments about extending persuasion or compulsion into the community with supervised discharge orders or community supervision orders.

Above all, legal reform must enshrine the principle of reciprocity. Society has no right to remove civil liberties from patients for the purpose of treatment (whether in hospital or in the community) if resources for that treatment are inadequate. It has no right to

legislate solely in the interests of the protection of society from nuisance or even violence. A new mental health act should continue legal provision for compulsion or persuasion of patients, whether in hospital or the community, only if the state also offers specific rights to treatment that go beyond the ineffective general rights to treatment offered by primary NHS legislation. Psychiatric patients are distinguished from all others by virtue of their condition, which potentially renders them liable to civil detention. Even if specific rights to treatment cannot, for reasons of public financial prudence, be given to all NHS patients they must be given to psychiatric patients. Infringement of individual rights requires acceptance of social duties.

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Corrections

Summary of 1993 World Health Organisation-International Society of Hypertension guidelines for the management of mild hypertension

An editorial error occurred in this article by the Subcommittee of the WHO/ISH Mild Hypertension Liaison Committee (11 December, pp 1541-6). On page 1544 the first sentence under the subheading *Oral contraceptives and hormone replacement therapy* should have started, "Alternative methods of contraception should be considered for women with hypertension [not hypotension]. . . ."

American and European recommendations for screening mammography in younger women: a cultural divide?

A printer's error occurred in this article by Ismail Jatoti and Michael Baum (4 December, pp 1481-3). The legend to the picture should have read, "[The benefits of mammography screening from age 40 remain unproved improved]."