

REVIEW OF THE MENTAL HEALTH ACT 1996 – Submission by RANZCP (WA Branch)

The competing views of many interested parties presents considerable problems for those given the task of reviewing the *Mental Health Act 1996*. How does one, like Odysseus, sail between the Scylla of the autonomy and rights of the mentally ill, and the Charybdis of the health and safety of the mentally ill and the safety of others. The Western Australian Branch of the Royal Australian and New Zealand College of Psychiatrists is pleased to be able to make the following submission. **This submission is entirely concerned with adults and not with children and adolescents; the Office of Mental Health Act Review is referred to the submission of Dr Paul Hudman, Consultant in Child and Adolescent Psychiatry,**

The Branch believes there are a number of principles of a general nature that should be considered before attending to the details of an Act.

1. The Principle of Reciprocity.

“Reform should be based on principle not 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”.¹ These resources include:

- i. Adequate bed numbers to allow appropriate time in hospital so that discharge to the community occurs at the right time and not too early. In the UK it was found that “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).”²
- ii. A range of treatments for this severely ill group. This means not just relying on medication but there being time for talking to the patient, for adequate facilities for psychological and social treatments, and appropriate rehabilitation facilities.

“Paul Applebaum's fine book, *Almost a Revolution (1984)*, stated that he found that changes in the law had less impact than anticipated on the practice of mental health services. The advocates of reform did not have their hopes fulfilled, and the critics who prophesied dire consequences also turned out to be wrong. Psychiatric services changed less than expected. It is a conclusion that is both reassuring and depressing”³.

However, as Fisher states, “Legislative powers cannot in the end substitute for good quality services staffed by skilled workers”⁴. “Ultimately, mental illnesses (like any other illnesses) are treatable only through clinical means, and the quality of mental health care is dependent upon professional skill and resources. **The Branch would agree with these statements.**

2. A central importance for ‘incapacity’.

In their report, Review of the Mental Health Act 1983⁵, the Expert Committee, chaired by law Professor Geneva Richardson, "argued that where a patient lacks the capacity to consent to care and treatment for mental disorder then society should have the power to provide that care and treatment even in the absence of the person's consent. ... It is 'compulsory' essentially because it empowers mental health professionals to

¹ Eastment N. Mental health law: civil liberties and the principle of reciprocity. *British Medical Journal* 1994; 308:43-45.

² Ibid.

³ Grounds A. Reforming the Mental health Act. *British Journal of Psychiatry* 2001; 179:387-389.

⁴ Fisher M. Guardianship under the Mental Health Legislation: a Review. *Journal of Social Welfare Law* 1988; ?:316-327

⁵ Department of Health. *Review of the Mental Health Act 1983; Report of the Expert Committee.* Department of Health 1999

intervene in the absence of consent, whether passively or actively displayed.”⁶ “There is, of course, a further sense in which the structure is compulsory. In certain circumstances society is also justified in intervening in the face of a clear refusal to consent to treatment for mental disorder on the part of a person with the capacity to make that choice. ... [T]he precise extent of the circumstances in which such a denial of an individual's autonomy is felt to be justified within a health statute is ultimately a matter of moral judgement.”⁷

One of a person's rights is the right to medical treatment; where a person is incapable of giving consent to this treatment his right to treatment requires that treatment to be given as an involuntary patient.

The *Mental Health Act* 1996 discusses informed consent in Sections 95, 96, 97 and 98. there is a considerable number of patients in hospital and nursing homes who do not have the capacity to fully give informed consent but who passively comply with hospitalisation and with the treatment given. This group has been labelled “detained voluntary patients” by the Ombudsman in her submission to the Review. In a well known case in the England and Wales jurisdiction, called the “Bournewood Case”, the Court of Appeal determined that “the right of a hospital to detain a patient for treatment for medical disorder was to be found only in [the *Mental Health Act 1983*] the provisions of which applied to the exclusion of the common law principle of necessity ... The right to admit a patient informally [i.e. as a voluntary patient] applied only to a person who consented to his admission”⁸. Thus the detention of a person who was unable to consent as a voluntary patient was held to be unlawful in England and Wales. By a majority decision, the House of Lords later overturned the finding of the Court of Appeal stating that “the basis upon which a hospital was entitled to care for and treat such compliant incapacitated patients was the common law doctrine of necessity”⁹ since they were not detained under the Mental Health Act. Lord Steyn, one of the dissenting Law Lords, observed that “[d]iagnostically there is usually no or virtually no difference between [the] ... compliant incapacitated patients and patients compulsorily admitted under the Act”¹⁰ However, by excluding the “detained voluntary” or “compliant incapacitated patients” from being involuntary patients they were also excluded from the protective provisions of the mental Health Act such as the Mental Health Review Board and the Council of Official Visitors. Lord Steyn called this “an indefensible gap in our mental health law.”¹¹ The Ombudsman has drawn attention to a situation that is still somewhat unresolved as to the legal authority for detaining and treating the ‘detained voluntary’ patients under Western Australian Law and this needs to be resolved in a new Mental Health Act.

The Branch recommends that the Chief Psychiatrist investigate the current practise; it also recommends that this group of patients have access to the Council of Official Visitors if they so wish.

3. The meaning of the words “mental illness”.

Definition of “mental illness”. UN Principle 4.1 states that “a determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards”. Others state that the court should have regard to ordinary community understanding of mental illness, for example Professor Brenda Hoggart’s (Hon Lady Justice Hale’s) “the man-must-be-mad” test.

The Model Mental Health Legislation¹² states that ““mental illness” means a condition that seriously impairs, either temporarily or permanently, the mental function of a person in one or more of the areas of thought, mood, volition, perception , orientation or memory and is characterised by one or more of the following:

⁶ Ibid. para 4.1.

⁷ Ibid. para 4.2.

⁸ *R v Bournewood Community and Mental Health NHS Trust, Ex parte L* [1998] 2 W.L.R. 764.

⁹ *R v Bournewood Community and Mental Health NHS Trust, Ex parte L* [1998] 3 W.L.R. 116.

¹⁰ Ibid. 122.

¹¹ Ibid. 124.

¹² Model Mental Health Legislation Volume 1. Commonwealth Department of Human Services and Health 1994.

- (a) delusions
- (b) hallucinations
- (c) serious disorder of stream of thought
- (d) serious disorder of thought form
- (e) serious disturbance of mood

or by sustained or repeated irrational behaviour which indicates the presence of at least one of those symptoms.

The model legislation then goes on to state that “a determination that a person has a mental illness must be made in accordance with accepted medical standards.

The Branch strongly recommends that the diagnosis of mental illness remains a medical function.

4. Review of involuntary patient status

“The power to take and convey is a form of psychiatric arrest, and for such an arrest to be lawful under the Convention [of Human Rights and Fundamental Freedoms] the person concerned must be reliably shown to be of unsound mind of a nature or degree warranting detention, entailing ‘the establishment of a true mental disorder before a competent authority on the basis of objective expertise’” [as held in *Winterwerp v The Netherlands*]¹³. This “objective expertise” is by way of a medical examination and report.

Compulsion was seen as being appropriate under defined circumstance both in hospital and in the community. “The view was expressed that if a broad diagnostic criterion, such as mental disorder, is adopted it becomes essential that other criteria are sufficiently demanding to prevent the inappropriate use of compulsion, and possibly guarantee compliance with the ECHR”¹⁴. The expert committee recommended, “that the criteria be drafted in such a way as to include the following.

- i. a person may be made subject to compulsory assessment if there are objective grounds to believe:
- ii. that the person is suffering from a mental disorder requiring care and treatment under supervision of specialist mental health services;

and

- iii. that in the interests of the patient’s health or safety or for the protection of others from serious harm or for the protection of the patient from serious exploitation, the mental disorder requires assessment;

and, either

- iv. that the patient lacks the capacity to consent to care and treatment for mental disorder;

or

- v. that the patient fulfils the criterion described at para 5.95.v¹⁵;

and

- vi. that adequate assessment cannot be conducted in the absence of compulsory powers.”¹⁶

“The early introduction of independent decision making is central to the Committee's recommendations in this area. We are convinced that such a step will bring significant benefits in terms of the protection of patient's rights and thus compliance with the requirements of the ECHR, the consistent application of compulsion, improvements to the therapeutic relationship between patient and care team and the acceptability and thus effectiveness of the of compulsory structure.”¹⁷

¹³ *Winterwerp v The Netherlands* [1979] 2 E.H.R.R. 387. para 39.

¹⁴ *Ibid.* para 5.17.

¹⁵ *Ibid.* para 5.95.v states “that in the case of a patient who has capacity to consent to the proposed care and treatment for his/her mental disorder, there is a substantial risk of serious harm to **the health or safety of the patient or to** the safety of other persons if s/he remains untreated, and there are positive clinical measures included within the proposed care and treatment which are likely to prevent deterioration or to secure an improvement in the patient’s mental condition.”

¹⁶ *Ibid.* para 5.18.

¹⁷ *Ibid.* para 5.43.

The European Convention of Human Rights states in its Articles “that everyone has the right to liberty and security of person. No-one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: (e) the lawful detention ... of persons of unsound mind ... (Article 5(1))”, and that “everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful (Article 5(4)).”¹⁸

According to Thorold¹⁹, following the principles established in *Winterwerp*²⁰ and *X*²¹, for someone to be deprived of their liberty on account of mental illness, the following should be met:

- (a) valid detention requires prior objective medical expertise;
- (b) the disorder must be of a nature or degree warranting detention;
- (c) detention must last no longer than the disorder of this quality exists;
- (d) the patient must have access to a judicial body independent of the executive, with “court-like” attributes;
- (e) the judicial hearing must be attended by certain basic guarantees.

Thorold observes that the Court in *X v United Kingdom* regarded the Mental Health Review Tribunal as having appropriate “court-like” attributes. The basic guarantees possibly open to challenge he mentions are:

- i. Universality of access
- ii. Speed of access
- iii. Legal aid
- iv. Discharge criteria
- v. Tribunal powers

In 1994 the Model Mental Health Legislation was drawn up in a report for the Australian Health Ministers’ Advisory Council National Working Group on Mental Health Policy²². This model legislation was to be consistent with the human rights contained in the United Nations *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* and the *National Mental Health Statement of Rights and Responsibilities*²³. The model legislation gives as the criteria for involuntary admission on the grounds as mental illness as –

- (a) the person has a mental illness; and
- (b) as a result of that mental illness the person requires treatment which is available at the mental facility to which he or she is to be, or has been, admitted;
- (c) as a result of that mental illness the person is likely to cause imminent harm to him or her self or others, or is likely to suffer serious mental or physical deterioration, unless admitted to, or detained at, a mental facility and treated; and
- (d) the person lacks the capacity to give informed consent to treatment for his or her mental illness or the person has unreasonably refused treatment for his or her mental illness;
- (e) there is no less restrictive means of ensuring that the person receives appropriate treatment for his or her mental illness.

Each of these five grounds for involuntary admission must be satisfied before the patient is detained.

The UN Principles themselves contain two different sets of grounds for involuntary detention:

¹⁸ Horne J. *Mental Health Review Tribunals*. School of Law, University of Northumbria 2000.

¹⁹ Thorold O. The Implications of the European Convention on Human Rights for United Kingdom Mental Health Legislation. EHRLR Issue 6 1996.

²⁰ *Winterwerp v The Netherlands* [1979] 2 E.H.R.R. 387.

²¹ *X v The United Kingdom* [1981] 1 B.M.L.R. 98.

²² Whiteford H. Letter accompanying distribution of Report to the Australian Health Ministers’ Advisory Council National Working Group on Mental Health Policy on Model Mental Health Legislation Volume 1. Commonwealth Department of Human Services and Health 1994.

²³ Mental Health Branch, CDHFS. *National Standards for Mental Health Services*. Canberra/Australian Government Publishing Service 1997.

- 1) preventative detention grounds – the person has a mental illness and because of that mental illness there is a serious likelihood of immediate or imminent harm to that person or to other persons.
- 2) best interest grounds –
 - the person has a severe mental illness, and
 - the person’s judgement is impaired, and
 - failure to admit that person to a mental health facility as an involuntary patient is likely to lead to serious deterioration in his or her condition, and
 - failure to admit that person to a mental health facility as an involuntary patient will prevent the giving of appropriate treatment, which can only be given by admission to a mental health facility in accordance with the principles of the least restrictive alternative.

The diagnosing of the presence of a mental illness in the person undergoing review is a medical function; it is then up to the Board whether it is accepted or not by the Board.

The Mental Health Review Board is currently required to conduct a review after the making (a) of an order for a person to be admitted to, and detained in, an authorised hospital as an involuntary patient (where that person has been continuously detained), or (b) a community treatment order²⁴, under the following circumstances:

- (i). Initial review must occur “as soon as practicable after the initial order is made, and in any event not later than 8 weeks after that time”²⁵.
- (ii). Periodic review must occur “not later than 6 months after a review in respect a person has been carried out under section 138 or this section”²⁶
- (iii). Application for review “may be made at any time except within 28 days after the Board has made a determination the making of which involved a consideration of substantially the same issue as would be raised by the proposed application”²⁷

Up to 56 days (8 weeks) may be an unbearably long period of time for some one to be detained in an authorised hospital to wait for their situation to be reviewed. They can make an application but this requires an action on their part, and may still result in some delay that they consider unreasonable before their application is heard by the Board. To routinely reduce the maximum time before review would result in many more detained persons being reviewed when previously they would have been discharged from the Act in the normal evolution of their illness. To deal with the greater number of reviews that would result would require increased resourcing of the Board, both financially and in personnel. With the increase number of reviews being scheduled at these earlier times again the resources of the psychiatric facilities would have to be diverted to the writing of more reports, arranging the reviews and attending the reviews by consultant or registrar psychiatric personnel to the detriment of clinical work unless extra resources were made available. **With the proviso that sufficient additional resources are made available, the Branch supports an earlier initial review of involuntary detention (such as at 14 or 21 days).**

Schedule 2 of the Act states that a person “may be represented in those proceedings (before the Board) by counsel or, with leave of the Board, by any other person”²⁸. There is no mention of that representation being free or otherwise. The Schedule does state that “the Board may arrange for a person to be represented in proceedings before it if the person wishes the Board to do so.”²⁹

The choice to be legally represented at a review should be a right. An increase in the number of reviews, by bringing forward the review date, will further increase the resources required by the Mental Health Law Centre or Legal Aid.

²⁴ *Mental Health Act 1996* Section 138(1) Western Australia.

²⁵ *Ibid.* Section 138(2).

²⁶ *Ibid.* Section 139(1).

²⁷ *Ibid.* Section 142(3).

²⁸ *Ibid.* Schedule 2(3)(1)(b)

²⁹ *Ibid.* Schedule 2(3)(2).

The Branch would recommend that , having been received into hospital under the Act by the use of a Form 1, that these persons have access to the Council of Official Visitors during that time, as well as subsequently if they are admitted under the Act.

5. Should the Board have the power to interfere in treatment of the patient?

This might be through the Board having to approve treatment plans that are put in place after the initial period of assessment following the patient being detained, or after the drawing up of a community treatment order. For this to have any meaning consideration would be needed as to how it would be carried out. If it should occur by, say, confirming or recommending change in a proposed treatment plan this might improve the therapeutic relationship between the patient and the psychiatrist as it would be the Board that would be seen as the body *imposing* unwanted treatment and detention. And would the Board carry the clinical responsibility for the treatment ordered including modifying that treatment in the light of response or side-effects. How would they do this? For something like this to occur the Board would have to attend extremely promptly after detention to prevent unacceptable and perhaps inhumane delay in the initiation of treatment. In addition, how could the Mental Health Review Board be seen by anyone as an *independent* review body if they become so actively involved in the treatment process? This does not seem to be an option.

The question of the Board directing the treating team to make a community order would be open to the same comments of actively involving itself in the treatment of the patient.

The Branch strongly maintains that questions of treatment remain with the treating team who have the most detailed appreciation of the issues involved. The views of the patient and carers should be part of this appreciation where appropriate. A second opinion should be available to the patient if the treatment plan is contested by him/her.

6. Appeals against decisions of the Board are by appeal to the Supreme Court³⁰.

Appeals to the Supreme Court are expensive and may be daunting. Appeal for judicial review by a lower court might be used more frequently and would clarify “law and fact” as it relates to the operation of the Mental Health Act. Further appeal to the Supreme Court would still be an option. This would build up a history of precedent.

7. The State Administrative Tribunal.

The Mental Health Review Board is to be subsumed under the State Administrative Tribunal. What form it will take is as yet unknown. It is suggested that it will be “more legalistic” whatever that means. It is most important that it serves the needs of the patient and the community for the benefit of the patient. It is important that how the review is conducted does not destroy the therapeutic relationship between patient and psychiatrist, and become an experience that is non-therapeutic for the patient. The expertise of the current Board took some time to develop and it would not be in the patients’ best interest if that experience should be thrown away.

Without knowing the details of how the review body will function as part of the State Administrative Tribunal, the Branch is concerned the process that might be proposed.

8. Should there be a separate Mental Health Act.

³⁰ Ibid. Section 149(1).

In considering new mental health legislation, the question has to be asked should specialist mental health legislation be abandoned and replaced by generic health legislation? At this stage in a review it would not be possible to address this question. It would require an extensive debate as to whether to abolish specific mental health legislation in favour of a more general health act incorporating the same needs that have made a mental health act so essential. A wide-ranging debate would probably only occur if the government set the agenda. A thorough debate leading to the possibility of a Medical Incapacity Act would take considerable time and consultation to cover all the clinical, ethical and legal conundrums that would arise.

However, the Branch would recommend that a more long term view is taken to this particular question. Eastman and Peay quote a personal communication from Professor Norman Sartorius, recent President of the World Psychiatric Association, and describe him as “a powerful advocate for the view that we should be working towards the abolition of specialist mental health legislation (as stigmatising and problem-inducing rather than problem-solving) whilst putting physical and mental health problems on the same footing.”³¹ They also quote Gordon³² who argued in 1993 that recent legislation reflected “a false dichotomy – care and treatment vs. rights and liberties – which deflects attention away from a more critical issue: *the pursuit of resources necessary to facilitate the creation and use of the most effective but least restrictive way of providing care and treatment for patients, and as chosen by patients whenever possible* [emphasis added]”. “When patients lack capacity psychiatrists rely on the authority of the Mental Health Act to assess and treat them whereas other doctors rely on common law.”³³ Zigmond asks “why should there be a difference?”³⁴ For the small but problematic group of competent patients who pose a real risk to others but who refuse treatment, then protective laws analogous to public health laws for infectious diseases could be developed. Zigmond advocates that the medical colleges should together “campaign for a Medical Incapacity Act. This would provide for medical treatment, both medical and physical, for those who lack capacity from any cause. It would establish a statutory framework offering the same protections to *all* patients who are unable to consent to medical intervention. ... Such intervention may be within or outside hospital.”³⁵ He puts forward the view shared by many that such a generic act would reduce the stigma of mental illness.

Similarly Campbell³⁶, a professor of law, and Rosenman³⁷, a psychiatrist, have argued against specialised mental health law. Campbell argues for separating the ‘paternalistic’ need for detention from the ‘protectionist’. “In the case of paternalistic detention the rationale must involve (1) a need of treatment, (2) proven efficacy of that treatment and (3) the inability of the individual to apprehend the need for treatment. ... If we are prepared to accept paternalistic intervention in the case of mental illnesses then there can be no justification for not applying the same criteria to other people.” He also argues that “the creation of distinct institutional arrangements for making decisions about preventive detention which covers all citizens is a first step in correcting the distorting effects of mental illness prejudice in this area [of dangerousness]. Probably dangerousness provides the sole relevant grounds for preventive detention”. Rosenman argues that special mental health law stigmatises people with mental illness and degrades their treatment. He is in favour of substituted consent being provided by a guardian to protect both the patient and the treatment provider, and that custody to protect others should remain with the courts where individual rights to freedom may be more carefully protected.

Szmukler and Holloway also put forward a similar argument in response to “the increasing use of coercion in an attempt to alleviate society’s fears of the dangers posed by the mentally ill in the community”³⁸. They

³¹ Eastman N. Peay J. *Law Without Enforcement*. Oxford/Hart Publishing 1999 page 35.

³² Gordon R. Out to Pasture: A Case for the Retirement of Canadian Mental Health Legislation. *Canadian Journal of Community Mental Health*. 1993; 12:37-55.

³³ Zigmond AS. Mental incapacity act. *Psychiatric Bulletin* 1998; 22:657-678.

³⁴ Ibid.

³⁵ Ibid.

³⁶ Campbell T D. Mental health law: institutionalised discrimination. *Australian and New Zealand Journal of Psychiatry* 1994; 28:554-559.

³⁷ Rosenman S. Mental health law: an idea whose time has passed. *Australian and New Zealand Journal of Psychiatry* 1994; 28:560-565.

³⁸ Szmukler G, Holloway F. Mental health legislation is now a harmful anachronism. *Psychiatric Bulletin* 1998; 22:662-665.

argue that specific mental health legislation discriminates against patients with mental illness and reinforces prejudice against them. They argue that “dismantling mental health legislation may be the single most important action we can take to finally give equal rights to persons with mental illness and to eliminate stigma”³⁹.

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³⁹ Ibid.