

Principled mental health law?

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A set of principles which might underpin mental health law across the world is discussed, and one particular difficulty is highlighted.

There is, unfortunately, a long, ignoble history, across the world, of using mental health services to rid a family, community or state of people who are embarrassing, inconvenient or dissident. In an attempt to stop such practices and to uphold human rights for patients suffering from mental disorder, many countries have introduced mental health legislation. The provisions vary. Is it possible to agree on a set of principles which should underpin all mental health legislation?

Both mental disorder and physical illness can have serious, even fatal, consequences. Having different grounds for the non-consensual treatment of the two types of disorder is illogical. In England, risk is the basis for intervention in relation to mental disorder (under the Mental Health Act 1983), while lack of capacity is applicable for physical illnesses (under the Mental Capacity Act 2005). Thus, a person who suffers from depression and cancer, but who retains decision-making capacity in relation to both, is entitled to refuse treatment for the cancer but not for the depression. A patient with schizophrenia and a potentially fatal gangrenous leg was forcibly treated for the former but legally permitted to refuse recommended treatment for the latter (and did so) (*Re C (Adult refusal of medical treatment)* [1994]).

Is the risk to others presented by some people with a mental disorder a good reason for having laws based on different principles from those that apply to the rest of the population? There are circumstances in which people with physical conditions may present serious risks to others (e.g. a person with epilepsy or diabetes who neglects to take medication or to monitor blood sugar but continues to drive). They would be dealt with through the criminal justice system.

Mental health law is not just about making it lawful to deprive patients of their liberty or to give them treatment without consent. It also includes safeguards for their protection against abuse or overzealous intervention. Again, one must ask, are patients with mental disorders necessarily more at risk from medical staff or institutions than are people who have a physical infirmity?

Should patients ever be detained in hospital solely for the protection of other people, that is, without the patients themselves gaining any health benefit? In England and Wales the law regarding the non-consensual treatment of people with a mental disorder changed in 2007, with an amendment to the Mental Health Act, so that the criterion

that 'treatment is likely to alleviate or prevent a deterioration of the condition' was removed and replaced with 'treatment which is for the purpose of alleviating, or preventing a worsening of, a mental disorder or one or more of its symptoms or manifestations'. Is 'purpose' good enough, or should a patient be detained in hospital, or forced to accept medical treatment, only if there is a real prospect of health benefit? The law for those with physical illnesses requires such benefit for the patient.

If there is to be just one law, what should be its basis – risk or capacity? It might be argued that intervention without consent should be permitted on the basis of incapacity with regard to self-harm but that risk should be the basis when the potential harm is to other people.

Principles of mental health law

- 1 Every country should have a clear legal process, in accord with accepted international standards, regulating the detention and medical treatment of patients in the absence of their consent.
- 2 Criteria for detention and treatment must conform to internationally accepted values and be confirmed by examination of the patient by appropriately qualified medical practitioners.
- 3 All patients subject to detention or compulsory treatment should have a legal hearing within a reasonable period.
- 4 The least restrictive alternative should be preferred.
- 5 Detention and treatment should be permitted only when likely to be of therapeutic benefit for the patient and given for that purpose.
- 6 When patients are deprived of their liberty for the purpose of receiving a particular medical treatment, then they must be provided with that treatment. If they are put in a position where they cannot fend for themselves, then they must be provided with food, shelter and protection.
- 7 The person must suffer from a mental disorder.
- 8 Patient autonomy must be respected.
- 9 The law must be equitable. Everyone should be equal under the law and the law should apply equally to all citizens regardless of race, gender, age or disability.

Young people, under the age of 18, may in part require different principles. This article does not address the requirements for minors.

Principles 1–6 should not be contentious, although details require discussion. For example, should application of principle 2 be the preserve

solely of suitably qualified professionals, after gathering information and taking advice from a variety of sources, or should relatives have some formal authority? How long is 'reasonable' in relation to principle 3? Should detention have judicial authority from the start (other than in an emergency) or is 'clinical' authority, with judicial review, sufficient? The European Convention on Human Rights requires that someone accused of committing a criminal offence must *have* a hearing, while a person with a mental disorder who is detained has only a *right* to a hearing. Is the 'right' to a hearing sufficient, given that many severely ill patients may not understand their 'rights' and so never apply?

Rather more complex issues arise in relation to the three remaining principles.

Principle 7 (the presence of mental disorder) may seem to be a necessary prerequisite for the application of a mental health act. However, some countries include personality disorders as grounds for detention and compulsory treatment (e.g. England), while others specifically exclude such disorders (e.g. Ireland). Furthermore, many countries are so concerned that their legislation should not be used for social or political detention that their laws specifically exclude detention of particular groups on such grounds (e.g. sexual orientation, substance misuse or a person's political or religious beliefs).

Principle 8, respect for autonomy, is not compatible with a 'mental disorder' requirement as a principle. No one would be forced to accept medical intervention against their capacitous wishes. If principle 9 is accepted, then the basis for medical treatment without the patient's consent, whether deprived of liberty or not, is solely that the patient lacks the mental capacity to make the necessary decisions. In many countries this is the basis for the non-consensual medical treatment of patients deemed to have a 'physical' illness but not for those with a 'mental' disorder.

Principle 9 is also not compatible with most mental health legislation. The United Nations High Commissioner for Human Rights has said in relation to the UN Convention on the Rights of Persons with Disabilities (2006):

Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished.... This should not be interpreted to say that persons with disabilities cannot be lawfully subject to detention for care and treatment or to preventive detention, but that the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis. (United Nations High Commissioner for Human Rights, 2009)

As Dawson & Szmukler said as long ago as 2006:

a single legislative scheme governing nonconsensual treatment of both 'physical' and 'mental' illnesses ... would reduce unjustified legal discrimination against mentally disordered persons and apply consistent ethical principles across medical law. (Dawson & Szmukler, 2006)

Should 'disability' be added to race, gender and age (other than children) as grounds which must not be used for legal discrimination? Should 'mental illness or disorder' be removed as a requirement for mental health legislation and replaced with 'lack of capacity to make the necessary healthcare decision'?

Principle 9, if accepted, might result in respect for autonomy and lack of decision-making capacity as the only basis for non-consensual medical treatment. However, respect for autonomy (principle 8) would not be necessary in order to uphold principle 9 if a state decided that preservation of life and health should override personal wishes no matter what the patient's disorder: no one, whether suffering from schizophrenia or cancer, would be entitled to refuse medical treatment deemed necessary by a doctor. This would be equitable. Indeed, principle 9 would not be breached by having two laws, one in relation to risks to the patient and another for risks to other people, so long as they were indeed based on risk, not nature of the disability. Abiding by principle 9 would stop people with mental disorders being lesser citizens and might lead to a clearer debate as to the relationship society wishes to have for its citizens between respect for autonomy on the one hand and life and health on the other.

The central questions

Assuming there is agreement that people should be protected by law from unwarranted detention or compulsory treatment, an international framework could be agreed. There remains, however, a fundamental question. Should countries have one law to regulate the care and treatment of patients, or two? Is it principled, assuming proper legal safeguards for all, to have a capacity-based law for the non-consensual treatment of patients with a diagnosis of a physical illness and a risk-based law if the diagnosis is of a mental disorder? And if the law is to be the same for all patients, should it be based on capacity or risk?

References

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- United Nations High Commissioner for Human Rights (2009) *Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General (A/HRC/10/48)*. United Nations.
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