CHAPTER 1

Mental Health Legislation

Opportunities to make substantive changes in mental health legislation occur infrequently. In England and Wales the 1890 Lunacy Act confirmed and established legalism; that is, admissions to mental hospitals and treatment in those hospitals were to be governed at all times by statute and controlled and supervised by government bodies such as the Board of Control. The emphasis was on the legal rights of the patient (see Bean, 1980). When legalism was found to be unworkable, mainly because of the stigma said to be associated with mental hospital admissions and the manner in which legalism prevented patients entering mental hospitals except by the courts, the 1930 Mental Treatment Act was introduced. That Act allowed some patients to enter hospital voluntarily, that is without certification. Thirty years later legalism was swept away, to be replaced by a medical view of mental disorder, the terms and definition of which were provided by the Royal Commission preceding the 1959 Mental Health Act (HMSO, 1957). That commission saw mental disorder generally and mental illness in particular as being the province of the medical profession. It was, said the commission, the task of the medical profession to diagnose and treat such conditions and inappropriate for the lawyer and the courts to impose and dictate their terms of reference. The commission's view has now been refined. In the manner in which the 1930 Mental Treatment Act softened legalism, so the 1983 Mental Health Act has softened the medical view. If the history of mental health legislation is anything to go by, England and Wales ought not to expect new legislation before the end of the century, although it appears organisations such as MIND are eager to promote changes at a rather faster rate.

To talk of the medical view of mental disorder is to talk generally. The 1959 Mental Health Act (called the 1959 Act from now on) represented the medical view, yet sustained the powers of the courts in some areas of the civil commitment procedure. Indeed, the Royal commission preceding the 1959 Act (The Percy Commission) spent a considerable time justifying the use of legal powers (see Bean, 1985). When we talk of the medical view, or the medical model, we are talking of a view which was dominant rather than exclusive. To use such terms is to claim a form of academic licence or academic convenience. In this context the medical view means support for the statement of intent made by the Percy Commission; that is mental illness is an illness like any other, that mental patients should be admitted to mental hospitals (or their equivalent) on the basis of psychiatric diagnosis rather than on the decision of the courts, that treatment is primarily if not solely a matter of clinical judgment, and the method and means of detention (where required) is also primarily a clinical matter. In contrast, to say that the 1983 Mental Health Act (called the 1983 Act from now on) or indeed other comparable legislation represents legalism is to say that one or more of those features described above is controlled by statute emphasising the legal rights of the patient.

The 1983 Act has had a short but eventful history (details of which are given in a note at the end of this volume).[1] It was influenced by the recommendations of a number of government committees, notably the Report of the Committee on Mentally Abnormal Offenders (HMSO, 1975) (The Butler Report) and the judgment of the European Commission of Human Rights on 5 November 1980 (X v. United Kingdom) together with various research reports and the activities of certain influential pressure groups, notably MIND (National Association for Mental Health). The 1983 Act is a consolidating Act, having been preceded by the 1982 Mental Health (Amendment) Act. It has been followed by numerous Government Regulations, some of which will be cited throughout, and by Codes of Practice from the newly formed Mental Health Act Commission. At the time of writing (1985) most of the regulations have come into operation, as have a few Codes of Practice.

The Act does not seek to produce new principles, rather it seeks to alter those contained in the 1959 Act. The Parliamentary Under-Secretary of State made such a point, and worth quoting in full.

> The Mental Health Act 1959 was a landmark in the development of care for the mentally disordered. It established many important principles. Among them are those which require that where care and treatment in hospital are needed they are given upon a voluntary basis wherever that is possible and that in those few cases

where compulsion does prove necessary it must be subject to strict controls. I doubt whether anyone would challenge those principles today; this Bill seeks to amend the 1959 Act but it does not challenge those principles. On the contrary it seeks to ensure that they are more perfectly implemented.

Parliamentary Debates (1.12.1981), p. 933.

What changes have then taken place? According to Lord Elton, the Parliamentary Under-Secretary of State, they are as follows:

. . . that except in particular circumstances people should not be admitted to detention for treatment in hospital if their condition is not treatable; the provision of much more frequent access to mental health review tribunals; the more stringent regulations of the use of treatment without the consent of the patient; the institution of a special health authority, with particular responsibility to oversee the powers to detain and treat patients under the Act; the institution of interim hospital orders, the powers to remand to hospital for assessment; and I think the limitations of the powers of a guardian to apply only to people over 16 years of age . . .

Parliamentary Debates. (1.12.1981), p.935.

That seems to be a fair summary of the Act and of the government's intentions. Where modifications have occurred, they have as a general rule been with a bias to the rights of the patient. This is not entirely true, for some changes have been made which benefit the professionals to the detriment of the patient. Some changes seem entirely neutral; that is, they are aimed at improving an administrative system. There are some changes where it is claimed the patient will benefit yet as far as I can see, do nothing of the sort; they may even make matters worse. (for example, procedures which allow nursing staff to detain informal patients, see Chapter 3). Perhaps a pastiche of effects was to be expected, for legislation is never likely to satisfy everyone.

Mental health legislation in England and Wales is widely based. It includes those (who we can call patients from now on, to make it easier; and, for convenience sake, we can also refer to the patients as male) who would fit into the broad rubric of the mentally disordered. It includes too such matters as the patient's right to vote, the administration of mental health services, and the removal of patients overseas. Generally speaking, the legislation is concerned with two basic questions: first, how should patients and staff (that is, medical and allied workers) be regulated in the manner in which patients make contact with psychiatric services; second, how should patients and staff be regulated in the manner in which psychiatric treatment is provided. These are timeless questions yet are required periodically to be updated and reviewed according to changes in contemporary conditions. In the first the government said it aimed to provide as much opportunity as possible for patients to seek treatment on a voluntary basis. Where

voluntary treatment is not forthcoming then, subject to certain conditions (and including offenders and non-offenders alike) compulsory treatment should by provided. In the second, that is in the manner in which the extent and type of treatment provided should be regulated, the Act attempts to balance the demands of the patient's condition with the types of treatment to be imposed.

All societies are faced with these questions and all answer them in their own fashion. In England and Wales non-offender patients are compulsorily admitted as a result of medical recommendations together with an application from a social worker or a relative. Some countries use the courts, others not. In England and Wales some limits are imposed on the clinical freedom of the medical profession, elsewhere this is different. There does not appear to be a pattern, or perhaps even a logic, in the way societies operate; those insisting that the court should determine admission, on the grounds that liberty can only be taken by the judiciary, appear not to see it as important to restrict clinical freedom. Some countries mix offender and non-offender patients in the same system, others not. Of course things are not as haphazard as this, though they may appear so to the outsider. Each society grapples with the problems in its own way, some dictated by the availability of resources, others affected by geographical factors and so on. The provision of mental health services in remote areas of Canada, for example, places burdens which do not exist in a densely populated urban society in England and Wales. In some Third World countries, primary psychiatric care does not exist, and complex mental health legislation becomes somewhat inappropriate. In England and Wales, which has a long history of mental health legislation, historical precedents have been created and built up, mixed with a tradition where the types of services produce a unique national flavour. To understand why, say, social workers are involved in compulsory admissions in England and Wales we need look to the origin of social work. The same is true of guardianship and so on.

We can go some way towards answering the first question, that is the manner in which patients make contact with the psychiatrist, by asking about the legal classification of patients. That is, who are the patients under the 1983 Act and how does that legislation classify them? The second major question is much wider and will be dealt with throughout many of the chapters that follow, more particularly in Sections II and III.

Types of patients

England and Wales, in common with many other countries, have experienced a steep decline in the numbers of compulsory patients and of beds in

mental hospitals. There has been a drop in aggregate and percentage of compulsory admissions for non-offender patients from about 19% in 1960 to about 10.1% in 1979 (DHSS, 1981). The trend is downward except for patients detained under Section 136 of the 1983 Act; that is where a police constable detains someone deemed to be suffering from mental disorder in a public place (see Chapter 4). Some details of inpatients at one hospital are given at the end of this chapter.[2] Alongside this, at the end of 1954, there were 344 beds per 100 000 of the population; this was halved to 171 per 100 000 by 1978. The total number of mental hospital beds was reduced from 160 000 to 80 000 during the same period. This reduction was due in part to the discharge of certain long-stay patients but, to a greater extent, to a decrease in the patients' average length of stay (Roth, 1985).

To speak of formal and informal admissions in this way where one is contrasted with the other is misleading. I deal with this point in greater detail later (in Chapter 3). For the present however two points can be made; first in my view, Thomas Szasz is entirely correct when he says the presence of legal controls makes a mockery of the term voluntary, for legal controls can always be used as a threat to secure a voluntary admission (Szasz, 1970). (The ancient Latin phrase *coactus voluit*, 'at his will although coerced', sums it up nicely.) Second, there are some patients (the mentally impaired child or the demented elderly) who may not be admitted under a formal order but whose detention is equally real. That they may not require a formal order matters little, for being unaware of their surroundings and unable to do anything about it makes the order unnecessary. It does not alter their predicament. That only 3% of the mentally impaired are formally detained may, on the face of it, appear satisfactory but only if one sees detention in formal legal terms. It takes no account of the social reality of these patients.

Moreover to speak of a drop in the number of hospital beds is also misleading for it could imply that the mental hospital was the sole institution for the detention and treatment of the mentally disordered. Yet not everyone in the mental hospital is disordered, and not all the disordered are in a mental hospital. Mentally disordered patients are dispersed throughout other institutions, whether they be prisons, the so-called special hospitals (by that I mean those hospitals which are controlled by the Secretary of State where admission is only by approval of the Secretary of State, see Chapter 6), and even old peoples' homes. To illustrate this point consider the research study conducted by Dr Irene Ovenstone and myself on admissions to old peoples' homes in Nottingham in 1977 (Ovenstone & Bean, 1981).

A total of 272 people were admitted of whom 117 (or 43%) were from the local geriatric hospitals and 155 (or 57%) from the community. All were

Residents admitted to old peoples' homes in Nottingham and their medical, psychiatric and behavioural assesssment[a]

	Patients ($N = 272$)	
	Admitted from hospital	Admitted from the community
Per cent (and number) of total	43(117)	57(155)
Per cent (and number) who had undiscovered medical condition on admission	44(51)	81(126)
Diagnosis of psychiatric condition: per cent (and number)		
Dementia	56(66)	48(74)
Functional mental illnesses	16(19)	14(22)
Mixed conditions	7(8)	12(19)
No psychiatric condition	21(24)	26(40)
Total	100(117)	100(155)
Behavioural assessment for both groups: percent (and number)		
Severely disabled	6(16)	
Moderately disabled	77(210)	
Independent	17(46)	
Total	100(272)	

[a]I am grateful to the *British Journal of Psychiatry* for granting permission to reproduce these data.

given extensive medical and psychiatric examinations together with a thorough behavioural assessment. The results are best illustrated by a table (above).

That 79% of those admitted from hospital and 74% from the community were diagnosed as having a psychiatric condition illustrates the point that many mental patients, or patients suffering from mental conditions are elsewhere than in mental hospital. (That 44% had undiscovered medical conditions, and those of a serious nature, who were admitted from hospitals says much of the quality of care in general hospitals!) Bearing in mind that old peoples' homes were designed to cater for the eldery in a manner like that received by those who wished to pay for their care, it is not suprising then that old peoples' homes have never been equipped or staffed to deal with the mentally disordered. There were 17 homes, each catering for between 45 and 50 residents, in three of the homes there were three qualified nursing staff, in four there were two, and in the remainder none at all. From the data given above it is clear that old peoples' homes have become surrogate psychogeriatric hospitals, and that they lack the necessary facilities to perform their newly acquired role. We may say with some degree

of satisfaction that the long-stay patients in mental hospitals are living in less overcrowded conditions than hitherto but this may have been achieved by causing other institutions to take mental patients. A detailed study of these auxiliary institutions is long overdue; the evidence suggests that more mentally disordered are living in less-than-suitable conditions, receiving less-than-adequate care. This point of course is often made by critics of contemporary forms of community care (see Scull, 1983). What is given less attention however is the mode of referral. That a patient should go to an old peoples' home rather than elsewhere seems often to be a matter of chance and the facilities available at the time rather than part of a coordinated public policy.

Legal classifications

The architects of the 1983 Act spent a great deal of parliamentary time debating the nature and types of mental disorder. Sadly their deliberations have hardly led to an improvement, some critics believing that things are worse now than before. No doubt the complexity of the subject matter made it difficult to provide adequate legal definitions but, even so, some definitions verge on the tautological and others are pedantic and obscure. Here I wish to describe the legal terminology rather than to examine it in detail, for the aim is to provide the necessary platform for later discussions.

To summarise: the Act makes two distinctions. First, the generic term 'mental disorder' is used where admission is for assessment (Sections 2 or 4) or the patient is to be removed to a place of safety (Sections 135 or 136). For those sections providing for longer periods of detention, the Act requires that the patient must have one of the four specific forms of mental disorder: that is, mental illness, mental impairment, severe mental impairment or psychopathic disorder. Second, and over and above this, the specific forms of mental disorder can themselves be further classified into major and minor types of disorders: the major ones being mental illness and severe mental impairment which justify admission even if hospital treatment is unlikely to do the patient good, while the minor disorders of psychopathic disorder and mental impairment justify admission only if treatment is likely to make the patient better, or (if not) then to stop him from getting worse.

The definitions are contained in Section 1. Section 1(2) says

> In this Act –
> 'Mental disorder' means mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind and 'mentally disordered' shall be construed accordingly:
> 'Severe mental impairment' means a state of arrested or incomplete development of

mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and 'severely mentally impaired' shall be construed accordingly;
'mental impairment' means a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned, and 'mentally impaired' shall be construed accordingly;
'psychopathic disorder' means a persistent disorder of disability of mind (whether or not including significant impairment or intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned;

Section 1(3) adds a caveat.

Nothing in subsection (2) above shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder, or from any form of mental disorder described in this section by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.

Mental illness, one of the major forms of mental disorder is not therefore defined in the 1983 Act nor was it under the 1959 Act. The current omission is regrettable. It represents a lost opportunity which would have forced greater attention on the nature of the psychiatric task. As things now stand there remains the suspicion that mental illness defies definition, needlessly providing the sceptics and the anti-psychiatrists with much to cling to.[3] For, in spite of imperfections, the DHSS had earlier produced a definition which could have formed the basis of further discussions and possibly been included in the legislation. The DHSS said mental illness means an illness having one or more of the following classifications:

(i) more than temporary impairment of intellectual functions shown by a failure of memory, orientation, comprehension or learning capacity;
(ii) more than a temporary alteration of mood of such degree as to give rise to the patient having a delusional appraisal of his situation, his past or his future or that of others or to the lack of any appraisal;
(iii) delusional beliefs, persecutory, jealous or grandiose;
(iv) abnormal perspectives associated with delusional misinterpretations of events;
(v) thinking so disordered as to prevent the patient making a reasonable appraisal or having reasonable communication with others DHSS (1976).

This definition is not without its flaws yet it remains superior to many others currently available. The Butler Committee, for example, defined mental illness as 'a disorder which has not always existed in the patient but has developed as a condition overlying the sufferer's personality' (HMSO, 1975, para. 1.13). In Canada (Alberta) mental illness includes alcoholism,

and in the USA (Indiana) it includes mental retardation, epilepsy, alcoholism and addiction to narcotic and dangerous drugs (Curran & Harding, T. 1978, p 36). It is also superior to the definition found in case law where Lawton (L. J.) said the term mental illness had 'no legal significance'. It was 'an ordinary word of the English language' and 'should be construed in the way ordinary sensible people construe such words. I ask myself what would the ordinary sensible person have said about this patient's condition . . .? In my judgment such a person would have said "Well this fellow is obviously mentally ill."' (W.V.L. (1974) Q.B. 711, 719, C.A.).

One wonders incidentally why Lawton (L. J.) used the term 'mentally ill'; from the tone of his statement 'mad' would have been as appropriate. Indeed, Hoggett slips unwittingly into this by referring to this judgment as the 'man-must-be-mad-test' (Hoggett, 1984,p. 46). From the perspective of an academic lawyer, Hoggett (1984, p. 46) sees Lawton (L. J.)'s judgment as 'denigrating to the patient and to those who have given the matter careful and considered thought in recent decades' and also as a lost opportunity where the courts could have provided a working definition of mental illness, thereby making it likely that statute law would be forced to follow. Whether so or not one can see why Lawton (L. J.)'s definition fails to please the academic lawyer, presumably because it offers so little by way of a recognition of the complexity of the task.

It is all the more strange then that the DHSS definition should have been withdrawn, and for the most curious of reasons (namely that 'a lack of definition has not led to any particular problems', DHSS (1978) para. 1.17). For whom has it not led to any particular problems? Those who operate the Act or those at the receiving end? Generally speaking, definitions or the lack of them are of little consequence and often remain matters of convenience (except, of course, in legal matters). Legal definitions help determine entry into certain types of facilities or determine who shall receive this or that type of punishment. They also exclude those failing to meet the definitional requirements. The need to include and exclude is equally important if rights (and, in this case, the right to treatment) are to be matched with rights to remain free from coercion. As matters now stand, mental illness – the most common form of mental disorder, and the form most often used in compulsory admissions – remains undefined and, in the 1983 Act by implication, therefore a matter solely of clinical judgment.

Turning to 'severe mental impairment' and 'mental impairment', it will be remembered that severe mental impairment is a major form of mental disorder, that is it justifies admission even if hospital treatment is unlikely to do the patient good. 'Severe mental impairment' and 'mental impairment'

replaced 'severe subnormality' and 'subnormality' in the 1959 Act, which were defined primarily in cognitive terms. As a result it was said that subnormality and severe subnormality had come to be regarded as pejorative, causing offence and distress. These earlier terms were also criticised as taking no account of social functioning. The DHSS in 1978 suggested they be replaced by 'mental handicap' and 'severe mental handicap' (DHSS, 1978, para. 1.21) but 'mental impairment' and 'severe mental impairment' were preferred eventually. (The differences between the levels of impairment are whether the person is 'severely' impaired or 'significantly' so; a difference almost impossible to determine yet, also to be a matter for clinical judgment.) Whether 'impairment' – in its severe or significant form – will be seen as less pejorative is of course doubtful. Some critics, MIND in particular, see the new terms as producing their own set of prejudices and alienation and rejection, others that the terms imply the patient had been reduced somehow from a hitherto higher level of functioning (quoted in Jones, 1984). Yet it is difficult, perhaps almost impossible, to find other acceptable or suitable terms which are or will themselves remain free of pejorative overtones.

When we look at what constitutes the legal definition of mental or severe mental impairment however, additional problems arise. We are told in the 1983 Act impairment means 'a state of arrested or incomplete development of mind which includes impaired intelligence and social functioning, significant or severe and is associated with abnormally aggressive seriously irresponsible conduct'. Yet 'social functioning' can include matters of taste, based on personal evaluations of various forms of morality. What does 'arrested or incomplete development of mind' mean? What does 'associated with' mean in this context? It was pointed out in the parliamentary debates (11 May 1982) that 'associated with' could be construed as being related to any event that has occurred at any time in the past. The official reply was interesting. The Secretary of state said 'associated with' had the effect of asking people to determine the current state of the patient when deciding whether to detain him. They should be asking whether his state of mind makes him liable to be violent or seriously irresponsible unless a detention order is made. The patient's past conduct, said the Minister 'may be highly relevent as evidence as a way of appraising his current conduct and state of mind'. Even so, it does not meet the criticism that there is a lack of precision in the terminology.

I do not wish to be overly critical here for I recognise there is some merit in the use of the term 'impairment' derived as it is from the International Classifications of Impairment, Disabilities and Handicaps and meaning