Invited commentaries on: Mental health legislation is now a harmful anachronism†

Replacing the Mental Health Act 1983? How to change the game without losing the baby with the bath water or shooting ourselves in the foot

George Szmukler and Frank Holloway's (1998) challenging paper raises a number of timely issues. The continuing stigmatisation of mental illness, its identification in the public mind with dangerousness and the alarming rise in involuntary hospitalisations, are matters of grave concern. But are they right that the current framework of mental health law reflects and reinforces discriminatory attitudes towards those with mental disorders? Are they right that we would be better served by generic legislation covering incapacity and dangerousness? In short, are they right that specifically mental health law is an anachronism and should be abandoned?

I want to consider three readings of this claim: that mental health law as such is discriminatory; that our current mental health law, in particular the Mental Health Act, 1983, is discriminatory; and that the concept of mental disorder is discriminatory.

Is mental health law discriminatory?

Specifically mental health law is certainly divisive. It divides mental disorders off from disorders of other kinds. But is it discriminatory? Does it discriminate unjustly against those with mental disorders as Szmukler & Holloway imply? After all, if division as such means discrimination, there should be no distinct Royal College of Psychiatrists. The College's anti-stigma campaign should focus on a merger with the Royal College of Physicians.

In arguing for generic legislation, therefore, to replace our current structure of specifically mental health law, Szmukler & Holloway are at risk of changing the name without changing the game. The 'game' is discriminatory attitudes towards those with mental disorders. If the Mental Health Act 1983, reflects these attitudes, then it is discriminatory. But it is the attitudes that are discriminatory not the distinct mental health law.

Is the Mental Health Act 1983 discriminatory?

Few would disagree with Smukler & Holloway that the Mental Health Act 1983, important and innovative as it was in its day, is long overdue for a radical refit if not honorable retirement. *L.* v. *Bournewood*, as they point out, has highlighted a particularly discriminatory aspect of the Act, namely that while a capacity-competent adult can be treated for a bodily disorder only with their consent, the 1983 Act allows the same capacity-competent adult to be treated for a *mental* disorder *without* their consent. In 1983, when clinical decisions were still taken largely by doctors on behalf of their patients, this may have been acceptable. But 15 years has seen a shift in ethos from medical paternalism to patient autonomy. In 1998 the expectation is that doctors and other health care professionals will share their decisions with their 'users'.

Since Szmukler & Holloway's article was written, the House of Lords has overturned the *L.* v. *Bournewood* judgment (2WLR, 764, 1998). Case law moreover has gone some way towards narrowing the legal gap (Dickenson & Shah, 1998). But the original Appeal Court judgment, as Szmukler & Holloway argue, remains a clear signal of the discrepancy between bodily disorders and mental disorders in matters of consent.

If we are not to abandon specifically mental health legislation altogether, then, is there not a case for either restricting the powers of the 1983 Act or replacing it with a new Act which gives equal treatment to mental disorders and bodily disorders? This more modest reading of Szmukler & Holloway's claim would amount to a real change of the game. There is a difficulty, though, a difficulty which, if it is not faced square on, could result in (mixing my metaphors shamelessly) throwing out the baby with the bath water.

The difficulty is this. Any proposal for equality of treatment of consent-incompetent adults

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between mental disorders and bodily disorders (whether under generic mental incapacity legislation or a revised mental health law) depends on equality of criteria for judging incompetence. For the game to be the same the 'diagnostic hurdle' (this is the Law Commission's own term, see e.g. para 3.8 of the 1995 report) must be the same. But there are grounds for believing that the diagnostic hurdle is considerably more complicated for mental disorders than for bodily disorders.

We can get an indication of the complications here by going back to some of the ground work for the 1983 Act in the findings of the 'Butler' Committee (Butler, 1975). Chapter 18 of the Butler report dealt with the diagnostic difficulty. It recommended that only severe mental disorders should be regarded as incapacitating in the relevant legal sense and it defined 'severe' operationally by the presence of one or more of a list of specific psychotic and cognitive symptoms.

This was a clear and workable recommendation. It is broadly consistent with custom and practice (Fulford & Hope, 1993). Yet it failed to find its way into the 1983 Act. Why? Well, because it was felt that it failed to get us over the diagnostic hurdle. A narrower definition of mental disorder might help to exclude those who should be excluded. But by the same token it could result in excluding those who should be included. In the 1983 Act therefore we find a broad definition of mental disorder combined with a range of provisions aimed at ensuring that professionals, and notably doctors, will use the powers it confers on them in an appropriately narrow way.

Szmukler & Holloway are sanguine about the diagnostic hurdle. The Law Commission (1995) they suggest, has given us a "workable" definition of incapacity. This may be so for bodily disorders. But it is far from clear that the Law Commission's definition is as "workable" for mental disorders as Szmukler & Holloway claim. The Commission's self-set terms of reference excluded mental disorder, after all. Their report gives it a good many column inches none the less. But we can get an indication of their failure to get us over the diagnostic hurdle from the table at the end of Szmukler & Holloway's paper. It is suggested there that delusion, perhaps the central case of a legally incapacitating mental symptom, incapacitiates by making people "unable to exert their will". Even if this were true, imagine being asked to justify *that* diagnosis in court or to a mental health review tribunal!

I do not mean to trivialise this issue. The assessment of competence is an enormously complicated matter even in relation to bodily disorders. The Law Commission's proposals are important and innovative; there have been a growing number of psychiatry-sensitive discussions of capacity (chapter 12 of the joint British Medical Association/Law Society guidance is especially helpful practically, British Medical Association, 1995); and this is an area where, as Eastman & Peay (1998) have cogently argued, new research is urgently needed. It should be no surprise, then, that the "broad definition–narrow use" solution has been adopted not only in the UK 1983 Act but uniformly across Europe in a raft of more recent mental health legislation right up to 1995 (Fulford & Hope, 1996).

Szmukler & Holloway's proposals should not be judged on whether they have solved the diagnostic difficulty, therefore. But they *should* be judged on whether they take it seriously. If we underestimate this difficulty, if we assume that judgments of incapacity can be made with no less difficulty for mental disorders than for bodily disorders, then we will be at risk of either including those who should be excluded or excluding those who should be included. Szmukler & Holloway are concerned about the former danger, of over-inclusive legislation. This, they rightly argue, discriminates against those with mental disorders. But the latter danger, over-exclusive legislation, is equally discriminatory, for it excludes from treatment (and other resources) those who most desperately need it.

Is the concept of mental disorder discriminatory?

Szmukler & Holloway are not alone in failing to take the diagnostic difficulty seriously. Bioethicists, lawyers and, indeed, many psychiatrists, have failed to take the diagnostic difficulty seriously (Fulford, 1993). I have argued elsewhere that this reflects a discriminatory attitude towards the concept of mental disorder (Fulford, 1989). Mental disorder, this attitude assumes, is a mess; bodily disorder is not; hence we can sort out the mess of mental disorder by modelling it on bodily disorder.

This is not only discriminatory it is ill founded. Mental disorder is no more of a mess (ethically or scientifically) than bodily disorder, it is just a lot more difficult to deal with (ethically and scientifically). A well-founded strategy must therefore be based on taking the difficulties seriously. In the case of judgments of incapacity this will include embarking on the range of empirical and legal research indicated by Eastman & Peay (1998). But it will also include coming to a better understanding of the nature of conceptual difficulties and how we should tackle them. I want to finish by looking briefly at one aspect of what this would involve.

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Users of services and the use of concepts

Conceptual difficulties are, essentially, difficulties of meaning. Clinical work and research in psychiatry have benefited considerably from our attempts, through the work of Kraepelin, Jaspers and others right up to the DSM and ICD, to define our terms more carefully. But satisfactory explicit definitions as a way of resolving questions of meaning are the exception rather than the rule. In general, we are better at using concepts than defining them (try defining 'time' if you doubt this!). It follows, therefore, that a difficulty of definition is not in itself a barrier to the effective (reliable and valid) use of that concept.

As a general observation about concepts, the priority of use over definition goes back to the work of the Professor of Moral Philosophy in Oxford after the Second World War, J. L. Austin. His ideas are important to us in psychiatry in a number of respects (Fulford, 1990). His methodological message was that concept-use could be exploited as a guide to meaning: this offers rich returns in descriptive psychopathology, for example (Fulford, 1989). In respect of the diagnostic difficulty, the J. L. Austin message is that we should be concerned not just with the criteria adopted (i.e. with definitions of the concept of capacity) but with the processes by which these criteria are applied in practice (i.e. with the way the concept of capacity is actually used).

This takes us right back to the changes in mental health practice over the past 15 years which lie behind the 1983 Act rapidly becoming a square legal peg in a round clinical practice hole. The key change, you will recall, was the shift from paternalism to autonomy, or, with a convenient homonym, from patients to users. Nowadays, users (of mental health services) are as much users (in J. L. Austin's sense) of the concept of capacity as are professionals. Hence any changes in the legislation governing consent to psychiatric treatment must incorporate users in the processes by which judgments of capacity are made alongside professionals.

Again, there are deep difficulties here, not least the problem of insight. But as Szmukler & Holloway note in a different context, relevant mechanisms are already under active discussion – advance directives, continuing powers of attorney, advocacy, and so forth. We have a lot to learn. But the bottom line is clear. As Dr V. Y. Allison-Bolger has put it (personal communication), autonomy in psychiatry means people with mental disorders having a say not just in how their problems are treated but in how they are understood.

Conclusions

Szmukler & Holloway's proposals are driven by the desire, shared by users and professionals alike, for a stigma-free world. I have argued that neither abandoning specifically mental health legislation nor radical reform or replacement of the Mental Health Act 1983, will be sufficient to achieve this unless we face the diagnostic difficulties involved in assessing mental capacity square on.

Szmukler & Holloway, I have suggested, fail to do this. They assume that the Law Commission's definition of incapacity, although developed primarily with bodily disorder in mind, will be equally 'workable' for the conceptually far more difficult case of mental disorder. This assumption, I have further suggested, reflects a stigmatising attitude towards mental disorder, widespread among not only lawyers and ethicists but psychiatrists themselves, which equates the conceptual difficulties posed by mental disorder with conceptual confusion. If we collude with this stigmatising attitude, therefore, by failing to take the diagnostic difficulty seriously, we are at risk of shooting ourselves in the foot.

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