Mental Health Alliance

Exclusions from the definition of mental disorder

This briefing has been produced by the Royal College of Psychiatrists
for the Mental Health Alliance

Clause 3

Page 2, leave out lines 23 to 26 and insert—

"(3) (1) For the purposes of subsection (2) above a person shall not be considered to have a mental disorder as defined in this section solely on the grounds of the following—

(a) his substance misuse (including dependence upon, or use of, alcohol or drugs);

(b) his disorder of sexual preference, excluding paedophilia, or disorder of gender identity
(c) his commission, or likely commission, of illegal or disorderly acts;

(d) his cultural, religious or political beliefs

Purpose of the amendment

(1) To replace the exclusion in the Bill for dependence on alcohol and drugs with a more appropriately worded exclusion which will cover a state of acute intoxication falling short of dependence.
(2) To reinstate the exclusion clause in the 1983 Act to cover sexual preferences
(3) To substitute for the existing exclusion for immoral conduct a more generic clause to protect mental health law becoming used as a form of social control.
(4) to respond to the evidence that people from ethnic communities, particularly the black communities are disproportionately subjected to the Act and to provide a specific exclusion to help to address the problem.

Reasons for the amendment

The broad definition of mental disorder needs to be balanced by a set of exclusions
The Richardson Expert Committee on the 1983 Mental Health Bill and the Joint Scrutiny Committee agreed on this point. The latter stated

> "We conclude that a broad definition of mental disorder in the draft Bill must be accompanied by explicit and specific exclusions which safeguard against the legislation being used inappropriately as a means of social control".[1]

In this Bill mental disorder is defined very broadly as "any disorder or disability of the mind". There is only one exclusion for 'dependence' on alcohol or drugs. It is instructive to compare the amended 1983 Act with mental health legislation in other common law countries. In all cases they have narrower definitions of mental disorder and more broader exclusions. This is discussed below.

As put by Dr Metcalfe from Justice

> The European Court of Human Rights has given a clear judgment stating that the definition of mental disorder must be very clear in order for exercise of detention powers to be lawful. The use of exclusions is a standard feature of most common law jurisdictions in meeting that requirement. They meet the requirements of legal certainty, of guaranteeing individual autonomy and of ensuring that the powers of detention are used no more than strictly necessary[2].

This broad definition has two consequences. First it covers all the diagnoses listed in the WHO International Classification of Diseases10, some of which, even the government acknowledges, may be inappropriate for compulsory powers.

Secondly it potentially covers almost any significant deviation from a "normal" condition of the mind, however temporary. It could cover behaviour that although not listed in ICD10 can be called disordered. There is nothing in the Act that confines the definition to the conditions listed in ICD10 or DSM IV, the American diagnostic manual.

In the Alliance's view there must thus be some limits to guard against the inappropriate use of the clinician's powers of detention as a form of social control.

The Mental Health Commission, in its evidence to the Joint Scrutiny Committee on the 2004 Mental Health Bill, said:

> "For the law to be of value—to patients, State administrators, mental health professionals, the police, the courts or the Tribunal—its meaning cannot rest upon the discretion of those working within its framework. We do not find it difficult to envisage the inappropriate use, however well meant, of mental health legislation for non-medical purposes of social control".

These are limits on power which clinicians welcome. The Royal College of Psychiatrists, the British Psychological Society, the British Association of Social Workers, the Royal College of Nursing and the Occupational Therapists are all members of the Mental Health Alliance who support these policies.

[1] Report of the Joint Scrutiny Committee on the 2004 Mental Health Bill volume 1, page 39:
[2] Informal Oral Hearing on Mental Health Bill , April 17th 2007

The breadth of the new definition

A patient can only be detained for treatment, under the current Act, if s/he suffers from one of the four categories – mental illness, mental impairment, severe mental impairment, psychopathic disorder. The latter 3 are defined. Mental illness is not defined. The courts (W v L 1974) have construed words “mental illness” as “ordinary words of the English language. They …should be construed in the way that ordinary sensible people would construe them. Drunkenness, addiction to tobacco, or religious/ political fanaticism for example, are clearly excluded from such a definition because they would not be considered in ordinary language to be mental illness.

The new definition of mental disorder, ‘any disorder or disability of mind’ by contrast, could include such mental states (and others relating to certain sexual behaviours) It is for this reason that it is said that the scope of the new definition of mental disorder is much broader than under the current Act and why, if the numbers subject to compulsion are not to be markedly, and inappropriately increased, the exclusions are so important.

Why is this so important?

The definition of mental disorder is the linchpin of the 1983 Act. It is the gateway into the compulsory powers in the Act. It (together with the criteria) governs who can be detained, who transferred from prison to hospital or diverted to hospital before trial and who can be placed on the regime of community treatment orders. It limits what treatment can be given without consent and is central to an issue as to whether a person should be discharged.

Protecting the fundamental right to liberty

The liberty of the subject is a pillar of this society, cherished since Magna Carta. The exceptions to it are few –for those who are arrested or convicted of a crime legal principles dictate that every crime must be defined specifically so that people can regulate their behaviour in order to avoid breaking the criminal law. The need for clear and specific boundaries is equally important in mental health law. Exclusions provide that specificity.

Assisting with clinical judgment

From the clinicians’ point of view the exclusions are there so that the right questions can be asked. Faced with a distressed and mentally disturbed person behaving or speaking in a way that is strange to the clinician it is important to consider whether the source of the behaviour is misuse of alcohol or drugs, extreme religious or political beliefs, anger causing disruptive behaviour or simply behaviour that in a different cultural climate would be considered normal or at least comprehensible.

As Lord Alderdice said in Committee the issue of exclusions

> “brings us to the heart of some real difficulties in applying legislation and the law in general to mental illness. It is not like physical illness; it is about the very essence of people and what they are, which is a very difficult issue.

> "without a serious look at understanding issues such as culture, politics, religion, breaking the law, sexual behaviour and so on, we could end up dragging into the net all sorts of people who are not suffering from mental illness in a proper sense and it becomes a question of how we deal with people who are difficult, different or deviant in our society. That is a real problem for colleagues in psychiatry, not least because of a move to diagnosis on the basis of people's behaviour and a set of symptoms, rather then necessarily understanding something more about the depth of the disorder and its likely prognosis".

This move to diagnosis on the basis of behaviour is reinforced in the Bill by the fact that the responsible clinician may come from other disciplines than medicine and that appropriate treatment can include psychological therapies, occupational training and habilitation. While ICD10 is specific about the requisites for a diagnosis of a given disorder, and research follows the same diagnostic criteria, clinicians are a lot less precise about diagnoses and concentrate more on treatment- Thus there is further potential for the boundaries between mental disorder and atypical beliefs, attitudes and life style choices to be further blurred.

Preserving the function of mental hospitals

Baroness Murphy made the following contribution in debates on the clause at Committee Stage.

> Society does not know what to do with other social misfits. One group is those who are persistently addle-headed on drink and drugs. They are very difficult to help. Of course, there are ways to help them, but it is not easy. Paedophiles form another group; the religious fanatics who belong to the Moonie loonies and the like is another. We know that those people are not as we would like them to be; they are not like us; they probably need some help, but how we should help them is rather obscure. No doubt a significant percentage of them suffer, from time to time, with mental disorder which would bring them properly under the scope of the Act, but it is a profound mistake to include all categories of people behaving badly simply because we do not have any other answers.
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> ….I regret that I do not find it difficult to envisage the inappropriate use, perhaps well meant, of mental health legislation for non-medical purposes, for social convenience and control—"Get the paedophiles off the streets". The pressure on services to find solutions to the presently insoluble problems will be massive.

The government response

The government called exclusions "arbitrary obstacles to the use of compulsion "which will cause uncertainty. They consider that redundant material should not be included in Acts both as a matter of good drafting practice and for fear that an unintended meaning will be read into any such words. This simply demonstrates that the government has failed to grasp the purpose of exclusion clauses. Far from being arbitrary they serve a significant purpose.

Other jurisdictions

Irish Mental Health Act 2001: section 2 Definition "mental illness, severe dementia or significant intellectual disability" Exclusions: a personality disorder or "is socially deviant or is addicted to drugs or intoxicants".

Mental Health (Care and Treatment) Scotland Act 2003 section 238 Definition 'mental disorder' means any (a) mental illness; (b) personality disorder; or(c) learning disability. Exclusions sexual orientation; sexual deviancy; transsexualism; transvestism; dependence on, or use of alcohol or drugs; or behaviour which causes, or is likely to cause harassment, alarm or distress to any other person; or acting as no prudent person would act".

NSW Mental Health Act 1990 Section 11Definition: "mental illness" means a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one of delusions, hallucinations, serious disorder of thought form, or a severe disturbance of mood. This includes sustained or repeated irrational behaviour indicating the presence of any one or more of these symptoms.
Exclusion: that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular political religious philosophical opinion, belief or activity, sexual preference or sexual orientation sexual promiscuity, that the person engages in or has engaged in immoral illegal conduct, anti-social behaviour that the person takes or has taken alcohol or any other drug,

Victorian Mental Health Act Definition: section 8 (1A) Mental illness is a condition characterised by a clinically significant disturbance of thought, mood, perception or memory. Similar exclusion to NSW.

New Zealand Definition; An abnormal state of mind shown by delusions or disorders of mood, perception, volition or cognition; Exclusions: That persons political, religious, or cultural beliefs; or that persons sexual preferences; or that persons criminal or delinquent behaviour; or substance abuse; or intellectual disability

The specific exclusions

1. Subsection 3 (a) Substance "misuse" or "dependence"

The Bill provides an exception for dependence on alcohol or drugs. However the Alliance is clear that this is not adequate to deal with the issue. Like the Joint Scrutiny Committee we consider it necessary to exclude people who misuse these substances. People *misuse* alcohol if they become drunk as a result; they misuse illicit drugs just by taking them and other drugs by using them for non-therapeutic (or non-prescribed) purposes.
In both cases this includes a level of intoxication that does not cause lasting harm or dependence. Both misuse and dependence are covered by ICD 10.and are therefore classified mental disorders. It is therefore necessary that the exclusion is worded to cover both so that neither the binge drinker nor the casual consumer of drugs is considered a case for compulsion.

At Committee Stage Baroness Royall said[3]

> "The term "misuse" is used in a variety of ways. If all it means is the use of alcohol or of drugs that have the potential for harm or which are illicit, then the exclusion is unnecessary. Merely using alcohol or drugs is not regarded clinically as a mental disorder, and our understanding is that the same applies to an episode of misuse. However, if "misuse" is intended to mean the consequences of such behaviour, then we profoundly disagree with the suggestion that it be excluded. Many consequences of misuse, from acute intoxication to substance-induced psychosis and withdrawal states, are recognised mental disorders. Any of them, even intoxication in its most severe forms, might, in particular circumstances, warrant compulsory intervention under the Act."

Regrettably the government reasoning is muddled and fallacious. A single episode could come within ICD10. More important, the Bill excludes from mental disorder the more serious level of misuse of alcohol or drugs but covers the less serious forms. This becomes apparent from reading ICD10:

ICD 10 includes at different levels the following-
F10.0 acute intoxication,
F10.1 harmful use of the substance,
F10.2 dependence syndrome and
F10.3 withdrawal state.
F11.0 covers acute intoxication due to use of opiods and F12.0 Acute intoxication due to use of cannabinoids with similar levels and so on.

The Draft Code of Practice states[4] that it is not excluding other mental disorders relating to the use of alcohol or drugs, and the example is given of acute uncomplicated intoxication (drunkenness). The Code therefore creates the possibility that Mental Health Act powers may be used in relation to drunken people, but at the same time states that such a condition would 'only rarely justify the use of powers under the Act.' No explanation is given.

Subsection 3 (b) Disorders of sexual preference and gender identity

This part of the amendment covers both behaviour that is covered by ICD10 and behaviour that is not specifically listed in ICD10 that may be socially unacceptable. What is socially acceptable sexual behaviour is subject to change over time because it is embedded in religious and cultural systems of values – for instance homosexuality was at one time considered unacceptable and a sign of mental dysfunction. It was until recently included as a mental disorder in ICD 10. It is no longer necessary to cover sexual orientation because it is neither listed as a mental disorder or considered in society as a disorder – indeed a person is protected by anti discrimination law and the Human Rights Act against such an approach.

Without this exclusion people with gender dysphoria, transsexualism and fetishistic sexual behaviour will be brought within the Act because they are included in ICD10. Disorders of sexual preference in ICD10 cover fetishistic behaviour, voyeurism, sado masochism and transvestism. The Joint Committee on Human Rights has reported that

[3] H of L Debates , 8th January 2007 Col. 83
[4] Draft Code of Practice para 18.7

> "in order for a non-emergency detention on grounds of unsoundness of mind to conform to the requirements of Article 5(1) (e) ECHR, there must be reliable evidence of a true mental disorder. We are concerned at the possibility that a person with Gender Identity Dysphoria or transvestic fetishism, which are recognised aspects of private life under Article 8, might be detained on grounds of mental disorder without any actual mental disorder such as depression or actual personality disorder. A person with Gender Identity Dysphoria or transvestic fetishism should not be detained unless there is evidence, other than the manifestation of such alternative sexuality or gender identity, that the person suffers from a mental disorder"**.**

Because the government has expressed great concern about whether this exclusion might cover paedophilia and in the wish for a compromise this amendment makes clear that paedophilia is not within the scope of the exclusion.

Subsection 3 (c) Illegal or disorderly acts,
The Bill removes the current exclusion for promiscuity or other immoral conduct. There should be a clear distinction between mental disorders and behaviours and practices which may either be considered unacceptable within a particular society or may cause difficulties for the individual. The Joint Committee on Human Rights expressed its concern on this issue in commenting on the 2002 Bill.

> "The history of the twentieth century demonstrated that psychiatry is capable of being abused: Nazi Germany and the USSR were probably not the only countries in which socially or politically unacceptable behaviour was regarded as a manifestation of a 'disorder of mind ... which results in an impairment or disturbance of mental functioning' (to use the words of clause 2(6) of the draft Bill) and treated accordingly. ……We recommend that an exclusion should be included when a Bill is introduced to Parliament, to prevent mental health professionals becoming the guardians of morality in a way that could lead to a violation of Articles 8 (right to respect for private life) and 10 (right to freedom of expression) of the ECHR".

This view was supported by the Joint Scrutiny Committee on the 2004 Mental Health Bill. In debates at Committee stage Baroness Murphy stated:

> "On illegal or disorderly acts and political beliefs, there should be a clear distinction between people who have a mental disorder and those whose behaviours and practices are simply unacceptable to society in general. There are, after all, lots of people who say that those young British Muslim terrorists who blew themselves and others up were mad—not a far step from thinking that all people who want to see an Islamic state in Britain should be locked up in a mental hospital"[5]

Lord Alderdice also gave the example of a patient who was considered by a psychiatric colleague as "paranoid" because of his fear of entering a particular area of Belfast when that fear derived quite rationally from the patient's political views.

The effect of not having such exclusion is that it further confuses, in the public mind, the role of psychiatry and mental health services, moving it from the proper aim of the assessment and treatment of mental disorder into the area of social control. This further reduces the acceptability and so effectiveness of the service.

[5] Column 78

Subsection 3 (d) cultural religious or political beliefs

Concerns of the BME community

In the diverse and rapidly changing societies of British towns and cities psychiatrists face the challenge of understanding and interpreting the thoughts and behaviour of people from different cultural, religious or political groups. The potential for misunderstanding is demonstrated in the history of the use of compulsory powers against African Caribbean's.[6] Disproportionately high numbers of people from BME backgrounds are still diagnosed with major mental illness and detained in mental hospitals or institutions[7] as the government has most recently reported.[8]

It is well documented that African Caribbean's are more likely to be misdiagnosed and diagnosed with psychotic conditions and treated using medication, which is often of higher dosage[9]. Culturally appropriate and acceptable behaviour has also been wrongly construed as symptoms of abnormality[10] or aggression. While this has been the focus of debate and much research there is little evidence that such concerns have led to significant progress, either in terms of improvement in health status or more positive outcomes for black patients[11]. As Professor Kwame McKenzie has stated,

> *"Given the genetic, cultural and historical differences between African populations and populations of Caribbean origin in the UK it is difficult not to come to the conclusion that their shared high rates of diagnosed psychosis reflect a difficulty that the mental health system has in dealing with people who are black"[12].*

The broad definition of mental disorder has the potential to increase the numbers further raising the hostility with which traditional psychiatric services are viewed and exacerbating the difficulties in providing good care for those who have great need for it.

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[6] Breaking the Circles of Fear, Sainsbury Centre for Mental Health (2002)

[7] Bhui K, Stansfeld S, Hull S, Priebe S, Mole F and Feder G: *Ethnic Variations in pathways to and use of specialist mental health services in the UK: Systematic Review*. British Journal of Psychiatry (2003), 182, 105-116. Morgan C, Mallett R, Hutchinson G, Bagalkote H, Morgan K, Fearon P, Dazzan P, Boydell J, McKenzie K, Harrison G, Murray R, Jones P, Craig T and Leff J: *Pathways to care and ethnicity. I: Sample characteristics and compulsory admission, Report from the AESOP study*, British Journal of Psychiatry, 2005, 186, 281-289

[8] Relative to white patients, BME people were over three times more likely to be detained than white people; black patients were nearly four times more likely to be detained; Asian patients were approximately twice as likely to be detained Ethnicity and the 1983 Mental Health Act – a systematic review,

[9] Sainsbury Centre for Mental Health (2002) 'Breaking the Circles of Fear', SCMH; See also the evidence and sources listed in Supplementary memoranda from the BME Network (DMH 445) Joint Scrutiny Committee on the Mental Health Bill, Vol.II.

[10] See for instance in relation to obsessive compulsive disorder as discussed in NICE Guideline Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder (2005).

[11] K. Chouhan, M. MacAttram, 'Towards a Blueprint for Action: Building Capacity in the Black and Minority Ethnic Voluntary and Community Sector Providing'; Sharpley M, Hutchinson G, McKenzie K, Murray RM 2001 *Understanding the Excess of psychosis among the African-Caribbean population in England. Review of current hypotheses*. British Journal of Psychiatry Supplement 40 vol178 ps60-68.

[12] Supplementary memoranda from the BME Network (DMH 445) Academic Paper By Dr Kwame Mckenzie, Senior Lecturer In Psychiatry, Royal Free And University College Medical School Joint Scrutiny Committee on the Mental Health Bill, Vol.II.

Extensive literature[13] confirms that racism can apply in the practice under the current law – and is even more likely under the broader definition of mental disorder. Research in cultural psychiatry demonstrates how hard it is to diagnose when issues of culture and belief get involved in the mix. The difference between delusional behaviour and hallucinations, and culturally or religiously appropriate beliefs such as belief in and interaction with gods, witchcraft and spirits is often difficult for psychiatrists to define. An exclusion such as this is necessary to delimit the operation of the definition. Such behaviours should be considered in terms of their intensity, duration, their consistency with past behaviour and their effect on the person's social functioning, self-care and other variables. But it would be erroneous, discriminatory, and all too easy, to make assumptions based on different cultural practices alone.

The Joint Scrutiny Committee agreed.

> "an important signal value would be achieved by setting out a specific exclusion of the use of compulsion solely on the basis of behaviour exclusively and directly attributable to cultural or indeed political beliefs."

A simplified definition where exclusions are removed increases the degree to which diagnosis of mental disorder depends on the subjective judgement of clinicians. This is likely to amplify the extent to which race, culture, religion and social perspective are all factors in the interpretation of behaviour and the subsequent identification of mental disorder

Despite calls for an exclusion for cultural reasons the government replied: that the exclusion was inappropriate

> "Cultural, religious and political beliefs and behaviours which are not signs or manifestations of an underlying disorder cannot by themselves be mental disorders – so legally such an exclusion would be of no effect (see draft Code paragraph 1B.5). And if they were excluded from the definition this might imply that, but for the exclusion, they would be mental disorders.

They also consider that the exclusion could be misunderstood and stand in the way of treatment when a person needed it[14]... We do not find that argument convincing"

The Alliance considers the government's position to be untenable given the evidence of the use of the 1983 Act. As part of the **The Race Relations Impact Assessment** *Ethnicity and the 1983 Mental Health Act – a systematic review* was published, reviewing 38 research papers. The result of the study was that relative to white patients, BME people were over three times more likely to be detained than white people; black patients were nearly four times more likely to be detained; Asian patients were approximately twice as likely to be detained.

We note that the government's duty under the 2000 Race Relations Act is not limited to the elimination of discrimination but includes a duty to promote equality. It is unfortunate

[13] National Institute for Mental Health in England (2003) Inside/Outside: Improving mental health services for black and minority ethnic communities in England, Department of Health.[13] Sainsbury Centre for Mental Health (2002) Breaking the Circles of Fear, SCMH,K. Chouhan, M. MacAttram, Towards a Blueprint for Action: Building Capacity in the Black and Minority Ethnic Voluntary and Community Sector Providing, Songhai, written evidence to the Scrutiny Committee, (2004) EV 1060 Harrison , Ethnic Minorities and the mental Health Act Brit Jnl of Psychiatry (2002)210

that they have not seen fit to respond to the legitimate concerns of the BME community, a shortcoming this amendment will overcome.