Mental Health Alliance

Impaired Decision Making (IDM)

Page 2, line 26 at end insert the following new Clause -

"( ) Impaired Decision Making; admission treatment

( ) The 1983 Act is amended as follows -
( ) In Section 3 (admission for treatment) after subsection (3)(a) insert –
"( ) That because of his mental disorder, his ability to make decisions about the provision of medical treatment is significantly impaired.". "

Purpose of the amendment

This amendment ensures that people who are fully able to make their own decisions about treatment for their illness cannot have their decisions overruled by a doctor who disagrees with them. It restores the Lords amendment in a more limited form. It only applies when a 6 month treatment order is being considered.

Section 2 patients

The amendment passed by the House of Lords would have inserted the test into section 2 which allows the detention of patients for assessment for a period of 28 days. The concern raised in the Committee stage in the Commons that IDM test might prevent patients being detained because of uncertainty about whether they met the test has led the Alliance to a compromise position. If the patient can be detained for assessment irrespective of his/her decision making ability it will give the patient and the clinician time to deal with a crisis and time to decide if in the long term the patient needs to be detained and whether their decision making ability is impaired.

This briefing covers the case for IDM and then deals with the government objections raised in debates so far. As this test would enshrine in the law a fundamental ethical principle the Mental Health Alliance considers that it deserves serious consideration and hence full explanation in this briefing.

1 An untested concept?

There is much high level support for this change to the Mental Health Act. Nor is it as the government claims an untested concept.

The Expert Committee on the 1983 Act recommended an approach to compulsion based on capacity.

> *"Whatever the initial difficulties in refining the concept the Committee is convinced that the notion of capacity has an independent value and meaning the core of which is accepted by all those involved in the operation of mental health legislation. The introduction of capacity in place of the current test of 'appropriateness' should lead to a more precise and objectively justifiable use of compulsory powers".*

The Joint Scrutiny Committee on the 2004 Bill recommended that it should include a condition. that by reason of mental disorder the patient's ability to make decisions about the provision of medical treatment is significantly impaired".

> *"A large proportion of the evidence received by our Committee favoured a capacity-based approach as the starting point for a new Act, although some proposals were more radical than others….We believe that compulsory powers should only ever be used as a last resort when people are very seriously ill, and we do not agree that a person would become too seriously ill before an impaired decision-making criterion is met".*

The professional bodies in the Alliance and the British Psychological Society have publicly supported the test.

International trends

There is clear recognition of the importance of an impaired judgment standard in statements from the Joint Committee on Human Rights[1] and in international standards. They include statements by

- the World Psychiatric Association[2]and
- the World Health Organisation[3]
- the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment[4]
- UN General Assembly

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[1] The Committee, scrutinising the 2002 Mental Health Bill "Where a patient is suffering from a condition **which seriously impairs his or her mental capacity to choose whether to accept treatment,** [our emphasis] there seems to us to be a rational and objective justification for treating that person differently, in relation to decisions about treatment, from someone whose mental capacity for decision-making is not so seriously impaired" Joint Committee on Human Rights, 25th Report. Para 20.

[2] The World Psychiatric Association approved at the General Assembly, August 25, 1996. Article 4 "When the patient is incapacitated and/or unable to exercise proper judgment because of a mental disorder, the psychiatrists should consult with the family and, if appropriate, seek legal counsel, to safeguard the human dignity and the legal rights of the patient. No treatment should be provided against the patient's will, unless withholding treatment would endanger the life of the patient and/or those who surround him or her. Treatment must always be in the best interest of the patient".

[3] WHO MENTAL HEALTH CARE LAW: TEN BASIC PRINCIPLES WHO/MNH/MND/96.9 These include the right to self determination covering the need for consent to medical treatment.

[4] A report in August 2000, 8–General Report reads:

"Patients should as a matter of principle, be placed in a position to give free and informed consent to treatment… Every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances

The General Assembly Resolution **Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care** provides that a person could be admitted to compulsory detention if there is either a serious likelihood of immediate or imminent harm to that person or to other persons; or

> "in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition"…

The Mental Health (Care and Treatment) (Scotland) Act 2003 has the same criterion as in the amendment, albeit for the assessment stage as well as the treatment order Anecdotal evidence from psychiatrists and social workers in Scotland suggests it is not causing dilemmas for clinicians. The principle has been recommended for Northern Ireland and is a criterion for admission in other jurisdictions, for instance, in Ireland[5], New South Wales, North Carolina, Israel, Saskatchewan.

The General Medical Council

"The requirement that a person's decision-making ability must be significantly impaired before they can be detained and treated without their consent is consistent with the guidance the GMC issues to doctors, in which we make clear that doctors are expected to respect the wishes of patients who have capacity to make their own decision (about treatment or care or disclosures of confidential information), and to act in the best interests of patients who lack such capacity. **These are fundamental principles of good medical practice which we would expect to see applied to decisions involving patients with mental disorders in the same way as those suffering from physical conditions**".

2. The case

Respect for patients

Respect for autonomy, personal integrity and personal responsibility are fundamental values of our society which are trumped in mental health legislation by risk. In the view of the Alliance there needs to be a better balance between the two to be consistent with modern understanding of mental health and ethical standards.

The Mental Health Act authorises the detention of the patient in hospital for 6 or 12 months and requires him/ her to submit to a course of treatment with which s/he disagrees. Although it is good practice for a psychiatrist to take account of the patient's views and wishes they are legally speaking immaterial. This contrasts with the position for those with a physical illness[6], a fact illustrated by the following case

[5] Irish Mental Health Act s. 3because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission

[6] The legal position relating to physical treatment was recently spelt out by Dame Elizabeth Butler-Sloss in the case of Ms B (2002*):"A competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even when that decision may lead to his or her death".* Although the judge did not state it, this principle does not apply to the patient with a mental illness.

C was a detained patient with schizophrenia who had a gangrenous leg. His surgeon advised that his leg needed to be amputated in order to save his life. He refused to consent and, because he retained decision-making capacity, his refusal had to be honoured. His leg recovered. However his ability to make decisions in relation to treatment for his mental disorder does not entitle him to refuse his doctor's advice as to medication for his mental illness. (*re C* [1994] 1WLR 290)

> "A competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even when that decision may lead to his or her death". (Dame Elizabeth Butler-Sloss in the case of Ms B (2002).

A mental health patient is not so different from the many patients with diabetes who fail to check their blood sugar before driving and therefore endanger others as well as themselves or from the cancer patient who declines chemotherapy because of its side effects. If both people have a full capacity (that is a full understanding of their illness and the consequences of taking or not taking their medication) there needs to be some clear justification for the distinction in the law.

A belief that physical and mental disorders are different in kind – driven by a popular misconception that mental illness cannot coexist with powers of judgment or insight, and concern for the protection of others are likely reasons.

Who are the patients who this amendment will protect?

The Mental Health Act is very broad. People are detained under section 3 on the grounds of it "being necessary for their health, or safety, or for the protection of others". (This low threshold was recognised by the government in the 2004 draft Bill with its higher threshold: 'interests of health' was removed and 'safety' was replaced with 'prevention of suicide or serious self harm'). The scope of the power to detain has been expanded by the new definition of mental disorder.

The breadth of the law contrasts with those in most other countries where seriousness of the condition or serious of the harm are essential criteria for detention[7]. We see the criterion of impaired decision making as providing a preferable alternative to a seriousness criterion in the 2004 Bill because it is more specific and directs the clinician to the correct issue of patient choice and patient autonomy.

The vast majority of people with mental illnesses (similarly to those with a physical illness) retain fully their ability to make their own decisions throughout their illness; and are treated by GPs or psychiatrists without being detained. Of those who are detained under the Mental Health Act some will also retain their capacity. A recent study found that a 15% of detained patients, particularly those who had been detained on a previous occasion retained their capacity[8]. The authors also found that a capacity test worked with a high

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8 "Prevalence and predictors of mental incapacity in psychiatric in-patients" CAIRNS, MADDOCK, BUCHANAN,DAVID, HAYWARD, RICHARDSON, SZMUKLER and HOTOPF BRITISH JOURNAL OF P SYCHIATRY (2 0 0 5), 18 7, 3 7 9 ^ 3 8 5

level of reliability. Given that the IDM test imposes a lower threshold and given the test does not apply to Section 2 patients we believe that with this test in law the percentage would be much lower.

Patients who find themselves in disagreement with their psychiatrist over their treatment and when they become ill are detained even though they retain full capacity.

What are the consequences of failure to take account of a person's decisions when they have insight into their condition and are full capable to choose?

1. Patients with full capacity come to resent their psychiatrists and avoid the services for fear of being forced to have treatment they don't want. They may then get more ill
2. Patient outcomes are damaged.
3. patients may be harmed by unnecessary treatment
4. Stigma is increased

Harm to patients

The inappropriate use of the Mental Health Act may do harm. The process can involve the attendance of police, the use of restraint to admit the patient to hospital and force to inject him/her with drugs. For a patient who disagrees strongly with the admitting psychiatrist it can cause a "lingering sense of grievance"[9]. It can and does destroy a vulnerable person's trust in the medical profession on whom they rely for mental and for physical health. Large numbers of service users wrote to the Joint Scrutiny Committee on the Mental Health Bill 2004 to express that view.

> *"I fully accept that there are some individuals who do need compulsory treatment. However unless one has been through this experience it is quite impossible to express how degrading and terrifying it is".*[10]

Detention in hospital is, inevitably, a major disruption to a person's life. In the context of the 'blame' culture, where every tragedy caused by a patient can potentially be attributed to a psychiatrist's misjudgement, psychiatrists often feel required to section patients, perhaps against their better judgement or the best interests of the patient.

Drugs may do harm and be unnecessary. People may live with episodes of mental illness for many years and develop knowledge of what works best for them when the illness flares up. This may include choosing coping mechanisms that do not give the immediate relief of drug treatments. For some the prospect of long term use of powerful and potentially harmful drugs is deeply unpalatable. Psychiatric drugs still have seriously debilitating side effects which include: serious weight gain leading to obesity (with the associated health risks); impotence; diabetes; disabling, embarrassing, and at times painful, movement disorders and lethargy and feeling 'drugged-up' all the time. A recent major study by the Disability Rights Commission attributed the relatively poor physical health of people with mental illness to the effects of the medication[11].for their illness.

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[9] "What I needed was an arm around my shoulder not a shot in the arm" Joint Committee on the Draft Mental Health Bill Vol II Evidence 736 Eric Stark

[10] Memorandum from Victoria Hanson, Vol II Joint Committee on the Draft Mental Health Bill Evidence 735

[11] Equal Treatment: Closing the Gap, Formal Investigation into Physical Health Inequalities of People with Learning disabilities and/or mental health problems' , DRC 2006

Memorandum from Ronald Archer (DMH 53)

I was placed on medication and eventually released on supervision; the medication had an adverse affect of sexual dysfunction, acute apathy and paranoia. My personal hygiene began to suffer to the extent that social services arranged for a home visit by the psychiatrist who placed me on further medication that affected my ability to urinate. I eventually stopped medication as I was having such difficulties and over two years I gradually improved.

People will stay away from services

The predictable consequence of the law is that people with full capacity stay away from the psychiatrist because of a justified and rational fear of being detained. In this sense the law is totally counterproductive.

> *"Enabling people to feel able to seek help early, to talk about their fears and difficulties, without fearing scorn, humiliation or loss of status, freedom, job and friends is the best way to bring about improvement in their health"*[12].

Users are often faced with no choice of psychiatrist and therefore no choice of prescribing practices. Psychiatrists vary widely between the extremes of medical model and social model. It is difficult to change psychiatrists because of the shortage of psychiatrists coupled with geographic allocation of patients to doctors. It is also often difficult to get to see a psychiatrist quickly. This means that a user is usually stuck with one psychiatrist's prescribing practices, with little possibility of changing their medication regime.

However, a user may wish to use medication differently from how their psychiatrist wishes to prescribe it. For example, there is a currently accepted practice, used by many of the highly successful assertive outreach and early intervention teams, of varying medication to provide a rapid response to early warning signs, and tapering off the medication to a minimum dose or even no dose as soon as possible after a crisis begins to fade. This is in contrast to more common prescribing practices. A user who is at odds with their psychiatrist over prescribing practices may well be faced with ignoring a CTO, (with the possible punishment of incarceration in a mental hospital even if not unwell), or to disengage. I myself would prefer to disengage.

Patient outcomes

As in other areas of medicine the best outcomes are achieved when patients engage early, when they take a full and active role in their treatment and have trust in their psychiatrist or other professional. As the Nice Guideline on anxiety puts it

> "Involving individuals in an effective partnership with healthcare professionals, with all decision-making being shared, improve outcomes**"**[13]**.**

[12] Dr Anthony Zigmond, Vice- President , Royal College of Psychiatrists, Joint Committee on the Draft Mental Health Bill Oral Evidence, 27 October 2004.

[13] NICE Guideline Anxiety Management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care.

Modern principles of the NHS, and other NICE Guidelines[14] on mental health support this [15] Detaining patients with full capacity distorts that important principle.

Stigma and discrimination

Another reason for limiting the use of compulsory powers is the stigmatising effect of the law on a group who are already acknowledged to be the most stigmatised and disadvantaged group in society[16].

Stigma has increased over the last decade[17]. We would have hoped that a government, which has worked so diligently to address this issue, would consider its significance in the context of mental health legislation[18] Stigma is a serious social and medical problem that contributes to the vicious circle of poverty[19], homelessness, isolation and illness for too many of our patients. The Report on Social Exclusion and Mental Health cited stigma above poverty, isolation and homelessness as the main source of social exclusion. Its impact is likely to be felt most by those from ethnic minority groups who are already disproportionately subject to the Act[20].

Being detained under the Mental Health Act contributes to stigma and discrimination.

A recent case reported to the Alliance concerned a young man who committed suicide He lived in a Welsh village. His family and the approved social worker were both reluctant to have him detained because of the stigma in a small community that would brand him for life. This was a tragic but understandable mistake.

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[14] For instance the NICE Guideline on treatment for bipolar disorder commences *"Healthcare professionals should establish and maintain collaborative relationships with patients and their families and carers (within the normal bounds of confidentiality), be respectful of the patient's knowledge and experience of the illness, and provide relevant information (including written information) at every stage of assessment, diagnosis and treatment (including the proper use and likely side-effect profile of medication)".*

[15] " Our health, our care, our say: a new direction for community services", DH 2006

[16] Findings of the Mental health and Social Exclusion Unit. Adults with mental health problems are one of the most disadvantaged groups in society. Although many want to work, fewer than a quarter actually do, the lowest employment rate for any of the main groups of disabled people. Over 900,000 adults in England claim sickness and disability benefits for mental health conditions. This group is now larger than the total number of unemployed people claiming Jobseeker's Allowance in England. Mental health problems can have a particularly strong impact on families, both financially and emotionally.

[17] The Department of Health's study of public attitudes to people with mental illness found that "levels of fear and intolerance of people with mental illness have tended to increase since 1993" and that "attitudes …have become less positive between 2000 and 2003"

[18] The Mental Health Act Commission reports, "*Of all mental health patients, none are so stigmatised as those who receive treatment under compulsory powers, because of widespread ignorance and fear regarding the purpose and usual causes of detention under the Mental Health Act 1983.*" MHAC 9th Biennial Report p 72, Para 6.34

[19] Mental Health and Social Exclusion , Citizen's Advice Bureau; 2004

[20] Findings from the first national census of psychiatric wards revealed African Caribbean's are 44% more likely to be detained under the 1983 Act. They are three times more likely to be admitted to psychiatric hospitals, 50% more likely to be put in seclusion and 29% more likely to be forcibly restrained than the rest of the population despite having the same rates of mental ill health as other ethnic groups. Commission for Healthcare Audit and Inspection (2005) Count Me In, Results of a national census of inpatients in mental health hospitals and facilities in England and Wales,; National Centre for Social Research (April 2002) EMPIRIC Report.

A young woman, a member of an Alliance service user group, used to go to work from hospital where she was a detained patient but she was too fearful to tell anyone. When the time for the ward round was changed she was unable to get to work as early and rather than let her employer know that she was detained in hospital and seek flexible working hours she resigned her job.

Government views

The government has objected that this amendment might leave out people who need treatment.. That is true but it is alarming to think that the state has reached the point that everyone who is deemed to "need treatment" should be detained if they disagree. **Dr. George Szmukler, Dean of the Institute of Psychiatry stated to an informal Committee hearing on the Bill**

> People who argue against a capacity based or impaired decision-based criterion say that it will miss people who need treatment. That poses an interesting dilemma for me: how do they know that those people need treatment? What are the criteria that they are using to determine that? We need to start with the principles about who should be eligible for compulsory treatment and then worry about whether it is being applied properly rather than start with a view about for whom it is appropriate, based on vague suppositions and then try to manipulate the rules to give that particular answer.

The effect of the test on homicide and suicide

We do not hold to the view that the clinician should stand by and allow a person to commit suicide or be a danger to others if their wish to die or to kill is a consequence of their mental disorder. We are clear that in no circumstances would a person with a mental disorder whose condition is serious enough to be regarded as dangerous to others or suicidal because of their mental disorder, be construed as excluded from the Act for this reason. A wish to die or to kill is itself a symptom of their disorder.

If a person is seriously unwell <u>because of</u> a mental disorder they make A patient with anorexia who believes she is fat clearly has disordered thinking and as a result has impaired decision making ability. A depressed patient who thinks she is too unworthy to socialise with other people has her judgment impaired by her mental disorder. These connections are regularly made by clinicians now when they decide how and whether to treat them.

Difference from the Mental Capacity Act

The government argues that it will be confusing to have two tests in the two Acts and that at least a capacity test would be "honest". However there are several other examples of different but related concepts in these acts. Clinicians regularly work with capacity to consent to treatment and with notions of "insight" into illness. The concept could be explained in the Code of Practice just as the government proposes for its much more uncertain concepts such as "appropriate" treatment.

The notion of “significantly impaired decision-making” is explained in detail in the Scottish Executive’s Document: Code of Practice[21] It states

> “This concept is separate to that of 'incapacity' […] However, when assessing a person’s decision-making ability, it is likely that similar factors will be considered to those taken into account when assessing incapacity. Such factors could involve consideration of the extent to which the person’s mental disorder might adversely affect their ability to believe, understand and retain information concerning their care and treatment, to make decisions based on that information, and to communicate those decisions to others.
>
> One difference between incapacity and significantly impaired decision-making ability arguably arises out of the fact that the latter is primarily a disorder of the mind in which a decision is made, but is made on the basis of reasoning coloured by a mental disorder. Incapacity, by contrast, broadly involves a disorder of brain and cognition which implies actual impairments or deficits which prevent or disrupt the decision-making process. […] A person’s decision making ability should not be considered to be significantly impaired by reason only of a lack or deficiency in a faculty of communication. Similarly, it should not be taken as equivalent to disagreeing with the opinions of professionals”.

The capacity test as set out in the Mental Capacity Act may have too high a threshold. It would be unfortunate if the deliberately high threshold in legislation which is about empowering people to make their own decisions was devalued through an interpretation in legislation which the courts are likely to see as having a very different function (to protect people from the consequences of their illness) .It would cause confusion around if different approaches to the same concept were used in different contexts or for different groups of patients..

The capacity test is seen to be most problematic when it comes to those who are at risk of causing harm to others. At the level of principle it is clear. Why should people with mental health problems, who know what they are doing, be detained because of a potential risk of harm to others more readily than those who are intoxicated with alcohol? The latter are not detained in case they drive recklessly or beat their wife even if on past record it is likely to happen. The criminal law is there to restrain them or to punish them after the event. The difference of approach to mental health patients is rightly resented by mental health patients. A person’s failure to take treatment may be serious for friends and family or the public at large in other situations - people who infect others with serious illnesses such as tuberculosis or AIDS can cause harm arising from physical illness but when the AIDS epidemic arose it was not suggested that AIDS sufferers be detained. Nor is it suggested that compulsory attendance at addiction clinics be required of people with alcoholism who are the major cause of harm to others.

Nevertheless, bearing these points in mind the Lords’ decided in favour of a less demanding test of impaired decision making. This goes some way to meeting the point about risk but also puts down as a bottom line a principle of non- discrimination to protect those who should in no circumstances be subject to the compulsory system.

Part III patients

[21] Code of Practice for the Mental Health (Care and Treatment) (Scotland) act 2003, Volume 1; 31.March 2004; Chapter 1, paras 33 – 38

Concerns raised by the forensic psychiatrists in the Royal College of Psychiatrists led the Alliance not to favour a condition of impaired decision making ability for those patients who are offenders or defendants under Part III of the Act. This condition would significantly restrict the possibility of using detention in hospital or CTOs for forensic patients who might otherwise remain in secure institutions or receive a criminal justice disposal. It would remove the possibility of transferring a patient to hospital or on to a CTO rather than sending him/her to prison if the patient's decision-making was not impaired. Such patients cannot choose informal admission to hospital. This view was accepted by the House of Lords and the amendment which they passed covers only civil patients