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Mental health law, according to Bartlett (2003), is as old as law itself, with the earliest classified reference in the English law book as far back as 1324. This law gave the King authority over persons and property if they were deemed to have mental health problems. It was not until the late eighteenth and predominantly nineteenth century that the insane gradually became subject to legal authority. Although these statutes were the precursors of the Mental Health Act (1983) they were significantly different systems. Much of the nineteenth century saw mental health law in a variety of statutes and each one independent from the other as opposed to a single act. The nineteenth century also saw an array of laws relating to clarification, modernisation and justification in relation to the Royal Prerogative powers. These powers allowed for control over a person and property once they were admitted to an asylum (Bartlett, 2003). Two significant developments in the first half of the nineteenth century saw another strand of legislation termed the Mental Deficiency Acts that began in (1913). This Thomson (1998) and Walmsley et al, (1999) believe provided a legislative framework for care in the community before the Second World War (Thompson (1998), Walmsley et al, 1999). The second development was the Mental Health Act, (1930) which saw the beginning of informal admission, as up to this point there was no distinction between admission to and confinement to a psychiatric facility. It became possible for an individual to be admitted without a compulsory order of admission and it also became possible for an individual to leave; this accounted for almost 90% of psychiatric admissions (Bartlett, 2003). The (1959) Mental Health Act moved control from hospital management of those with mental illness to treatment by General Practitioners (Fennell, 1968). The (1959) Mental Health Act moved the power of the state to a legislative basis, <https://assignbuster.com/the-world-health-organisation-human-rights-law-social-work-essay/>

and it also placed mental disorder and developmental disorder in the same law, which continued until the Mental Health Act (1983) in which confinement became an enforced treatment that was performed on legislative justification and measured by judicial assessment (Bartlett, 2003). The Mental Health Act (1983) was a result of poor legislation concerning the treatment of mentally ill patients' people and as such had very few legal rights and was amended as a result of Human Rights Act (1998). With the exception of sections 7 - 10, section 17 and section 117, the Mental Health Act (1983) is directed towards: the conditions under which people can be detained in hospital against their will; what can be done to them when they are in hospital; and circumstances under which they can cease to be so detained. The mental health act (1983) for England and Wales was based on the UK ' Better Services for mentally ill' white paper (1975) and the UK report of the Butler Committee on mentally abnormal offenders (1975), in which it covered four categories of mental illness: severe mental impairment, mental impairment, psychopathic disordermental illnessUnder the Mental Health Act (1983) an adult can be admitted, detained and treated in hospital against their wishes, this can be done under a number of different sections within the Mental Health Act (1983). Section 2 and 3 are used when someone' needs to be assessed or treated and they are not a danger to themselves or the general public; this is termed a civil admission and can last for 28 days. An adult can be detained under section 4 of MHA if they are a danger to themselves or the public, this section permits a person to be admitted to hospital for an assessment of their mental health for a limited period of time and involves the recommendation of only one doctor. This is dissimilar to section 2 which requires two medical recommendations.

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However, section 5 (2) and 5 (4) of MHA can be used by a doctor and a nurse respectively to prevent a voluntary patient leaving a psychiatric hospital (rethink. org, 2012). The (1983) act was amended by the Mental Health Act (2007), under this new act a host of professionals such as psychologists, mental health nurses and social workers were charged with overall care and treatment of patients. It also allows professionals who are not a registered medical practitioner to complete medical reports that are vital for detention renewal orders (Mental Health Alliance, 2007). A case example of this is Winterwerp v. Netherlands (1979) in which the detention application was accompanied by a medical report completed by a general practitioner, who had only examined Mr Winterwerp for the first time just prior to completing the report. The court approved the temporary detention and did not pursue expert advice or consult with Mr Winterwerp. The European Court on Human Rights indicated that impartial medical expertise is vital in order to determine if the patient has a mental disorder that justifies a detention. The EUHR went on to question whether or not this can be legally be achieved by non-medical professionals (Appendix 1) (Bartlett et al, 2007). Controversially, the new Mental Health Act (2007) for England and Wales allows professionals who are not registered medical practitioners to deliver the medical report that is needed for a detention order renewal. The Mental Health Care and Treatment (Scotland) Act (2003) came into effect in October (2005). It replaced the preceding (1984) act and developed new measures for the detention, care and treatment of individuals with a mental illness or associated conditions, and included brain injury. Principles of the Act are to deliver services to the individual that are suited to their individual needs and limit restrictions on freedom (Appendix 2). (headway. org, 2012). The Mental <https://assignbuster.com/the-world-health-organisation-human-rights-law-social-work-essay/>

Health Order (1986) for Northern Ireland was based on the mental health act (1983) and has not been reformed for over two decades, leading to many considering it outdated. There is also criticism of the MHO (1986) for using stigmatising language and thus disregarding the Human Rights elements that other Mental health laws have taken into consideration in their formation (Mc Parland, 2010). The need for reforming the Mental Health Order Northern Ireland (1986) was recognised by the Bamford Review and the Northern Ireland Executive acknowledges the need for new for legislative reform by delivering the Bamford Vision to include changes to the existing Mental Health (Northern Ireland) Order (1986). This will also include new mental capacity statute and a report on human rights that would be followed by new mental health legislation for (2011) and mental health capacity by (2014). The NI executive also recognises that ideologies that were developed by the Bamford Review should be entrenched in the statute to cover mental health and capacity legislation. The main principle links to autonomy and the rights of the individual to make decisions and act on these decisions. The other central ideologies are: Justice, to apply the law equally and justly; Benefit, supporting the health, welfare and safety of the person, whilst having regard to the safety of others; Least harm, to ensure little harm to other people or persons. These ideologies according to NI Executive will support an all-inclusive framework which will include all mental health provisions and capacity (dhsspsni. gov. uk, 2009). The nature of mental health law is complex and contentious and with the existence of different acts within the United Kingdom can lead to confusion and poor service delivery for the service user. In Northern Ireland for example the Mental Health Order (1986) has no stature for dealing with capacity, whilst in <https://assignbuster.com/the-world-health-organisation-human-rights-law-social-work-essay/>

Scotland the Mental Health Care and Treatment Act (2003) has capacity-based mental health legislation. A debate regarding the issue of capacity was raised in Parliament and the Royal College of Psychiatrists regarding the provisions for England and Wales; where according to Dame Elizabeth Butler-Sloss mental health law should reflect the legal requirements for people with physical illness. Dame Butler-Sloss went on to say that an individual who is capable has the right to refuse treatment even if it leads to their death (Appendix 3). (Zigmond, 2013). The Mental Capacity Act (2005) provides a legal structure supporting people to make decisions for themselves, who may not be able to make these decisions due to illness, injury or disability. It has far-reaching consequences and effects services-users and services-providers, relatives and carers. The Mental Capacity Act (2005) is based on five principles (Appendix 4), and is intended to protect people from decisions made for them that are not in their best interests (mentalhealth.org, 2005) capacity is tested using four questions and any professional can test capacity (Appendix 5). By answering yes to all four questions a person is judged to have capacity, safeguards include contacting a family member, friend or care worker to be present during the questioning. For mental illnesses, the Mental Health Act (1983) is used instead, this permits compulsory treatment even if a person is judged still to have capacity, but they are judged to be a risk to their own or others safety, or so ill that they need the treatment (Yousif et al, 2012). Scotland has a similar act called the Adults with Incapacity Act (2000), this act is designed for adults who lack capacity when making decisions for themselves as a result of a mental disorder or who lack the ability to communicate. This Act sets out the principles that must be adhered to when making a decision to intervene

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(Appendix 6) (hmsa. gov. uk. 2000). In Northern Ireland there is at present no statute on capacity, and medical treatment and care for individuals who lack capacity are made in accordance with common law, and requires decision to be made in the individual's best interest (gmc-uk. org, 2013). Capacity is according to Barlett et al, (2003) is a requirement for consent and in general an essential element for the provision of treatment, but he argues that capacity is really only called into question when the patient is refusing treatment (Bartlett, 2003). The Mental Capacity Act (2005) is there to protect individuals from making poor decisions either directly or as a result of poor advice; however these safeguards, one of which is liberty, are complex and unclear when bordered with existing mental health law, and could prove to be confusing and challenging to clinical teams. Where a person is admitted to hospital under Mental Health Act, Sections 2 or 3, and objects to either admission or treatment. The Mental Capacity Act (2005) Schedule 1A states that the Mental Health Act should be used. This means that objection becomes an important factor for the patient and clinical staff. However, if the patient object to admission or treatment the clinician needs to balance the Mental Health Act and Mental Capacity Act, the later gives the patient more choice that could be lost in the confusion. In the case of H. L v United Kingdom (Application no. 45508/99), where the person was autistic, unable to speak and his level of understanding was limited, the patient was admitted to a psychiatric hospital against his will. The court ruled that he had been unlawfully detained under the mental I disorder (1983) Act (Appendix 7), (Richardson, 2010). There is a balance to be realised between having the means to react to the needs of a person assumed to have a mental disorder and the risk that the use of legislation can pose a risk to a <https://assignbuster.com/the-world-health-organisation-human-rights-law-social-work-essay/>

person's rights to autonomy. Good mental health according to Gable et al (2009) is an important global concern, and is often ignored and undermined by policymakers and politicians. People living with mental disabilities can face significant difficulties such as discrimination, stigmatisation, humiliation and involuntary confinement without just process. These are human rights violations that persist through the lives of people with mental and intellectual disabilities (Gable et al. 2009). In a survey conducted by Social Services Inspectorate England report ' Modernisation Mental Services' Only 39% of service users said that they were always invited to care planning meetings although a further 21% said that this usually happened. Thirty-five per cent reported that they were either never or sometimes invited (Birtwisle, 2002), Governments can improve the mental health of its citizens by improving underlying societal conditions, such as implementing policies that are more inclusive to former service users in future policy making, and having a better understanding of community integration (Bartlett, 2003). In the sociology of medicine most people would see hospitals and asylums are the same, however, according to Goffman, (1961/1991) asylums are total institutions, unlike hospitals where a thread of contact is keep with the outside world. He argues that asylums create a society within a society and when patients are released they can't cope with the outside world (Goffman, 1961/1991). Weber believes that through bureaucracy hospitals have become so efficient that they have lost the ability to adopt to change therefore failing to meet individual needs (Goffman, 1961/1991). Although not a new phenomenon, community care has become more widespread and its purpose is to integrate and provide persons with mental disabilities treatment in a community setting. This would maximise opportunities for <https://assignbuster.com/the-world-health-organisation-human-rights-law-social-work-essay/>

social integration and reduce hospital costs. To achieve this, governments needs to ensure that community mental health services are well-funded and supported (mind. org. uk, 2013). The Mental Act (1930) England and Wales saw the introduction of informal admissions of mental health patients and the importance of aftercare was directed to community. However, overcrowding in the 1950s saw this fall by the wayside. It was the Percy Report (1945) that emphasised the importance of treating patients in the community albeit on the fringes in community housing and day centres (Goodwin, 1990). Community care has been the agenda for successive governments and in 2007 the UK government amended the Mental Health Act (1983) and the Mental Capacity Act (2005) to include Supervised Community Treatment. This is the new supervision process for patients who are discharged from hospital and placed back in the community. An additional amendment is the redefining of the professional roles, which now means that there are more mental health professionals who take complete care of one patient (legislation. gov. uk, 2005). Taking care of a patient completely in the community can have a negative effect on them, as effective treatment with pharmaceuticals requires a strong infrastructure to ensure that medications and other support services are available and affordable. However, underfunding can lead to staff shortages and in turn patients not keeping appointments for medication and according to Gable et al (2009) the sad consequence of these policy changes can result in the number of mentally ill people not receiving their medication. The outcome of this can be agitated patients who are often misunderstood in their community and find themselves homeless, without any access to health services, and in extreme cases can result in patients being jailed, which

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leads to further isolation and the person being deprived of their human rights (Gable et al 2009). Human Rights according to Alcock et al (2012) are linked with freedom that we are all entitled to have. They do not need to be assessed by the respective governments but are the duty of said government to ensure each citizen's human rights are safeguarded (Alcock et al 2012). The Human Rights Act came into operation in the United Kingdom in October (2000), integrating into English law the European Convention of Human Rights, which was initially designed to ensure that there would be no repetition of the atrocities of the second world war. Thereafter any Acts of law including those covering Mental Health were mindful of Human Rights, however pre-existing laws were not affected and this is important in Northern Ireland where the mental health laws have not been reviewed since the 1980s. Human Rights Law incorporates articles of the European Convention of Human Rights into English law; this act allows people with mental health issues to challenge many aspects of their care. Article 5 of the Human Rights Act involves the guarantee of liberty and is central in relation to the detention of mentally ill people (Appendix 8). It ensures that all public bodies (such as courts, police, local governments, hospitals, publicly funded schools) must conform to the Convention rights equalityhumanrights.com, 1998). Recognition of mental health has grown slowly within international human rights law even within the disability rights movement, as mental and intellectual disabilities were historically marginalised while the focus remained on physical disabilities. According to the World Health Organisation (WHO) mental health legislation comes from an increased understanding of the personal, social and economic burdens of mental disorders worldwide. The World Health Organisation estimated that <https://assignbuster.com/the-world-health-organisation-human-rights-law-social-work-essay/>

nearly 340 million people worldwide are affected by depression, 45 million by schizophrenia and 29 million by dementia. There is also a burden of stigma and discrimination that people with mental illness face, which is prevalent in both low and high income countries. Denial of basic human rights, freedoms, civil, political, economic, social and cultural rights; are common place to those suffering from mental illness (who. int, 2005). The Mental Health Act (2007) makes amendments to several pieces of existing legislation but the main changes it makes are to the Mental Health Act 1983 and the introduction of 'Deprivation of liberty safeguards' into the Mental Capacity Act 2005. There are six main parts of the MHA (1983) effected when the MHA (2007) came into force, one of these is supervised community treatment will be shaped through the introduction of a new Community Treatment Order for certain patients (mind. org. uk). This type of care is for people who have been on a treatment order that is deferred when a patient is discharged. However, the person can be recalled to hospital or other NHS premises for treatment if the order is repealed, the patient is returned to hospital on Section 3 of Mental Health Act (1983) (Lester, Glasby, 2005). Enoch Powell a former health minister is said to have favoured community care and he argued that mental hospitals were prisons that prevented a return to normal life. He also believed that community care would be cheaper than hospital care (nhs. uk, 1962). Care in the community and compulsory detention, are areas in community care that can be problematic if the right care and treatment are not in place as was the case in Johnson v UK (1997), 131 (Appendix 9) the European Court held that a discharge could be ordered if the aftercare allows the patient to improve following discharge to be supervised. However, a delay in the release of the patient was not

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unreasonable, but as necessary conditions and safeguards were not implemented and that continued detention could not be justified under art 5(1) (e). Admitting or readmitting adults to hospital for psychiatric treatment without their consent remains a contentious subject and challenges the very foundation of modern day clinical practice—that of informed consent. However, if it is necessary to confine an individual, a legal framework is required to protect them while they receive attention for their illness (tcsw.org.uk, 2010). Foucault believed confinement that began in the late eighteenth century under the supervision of the medical profession was both cruel and controlling, however these institutions were the only place a person with mental health illness could get treatment (Foucault, 2006) To conclude mental health by its definition is a complex and frightening journey and it's estimated that 1 in 4 will experience some kind of mental health problem in the course of a year in UK (Mental Health.org. 2001). Amending mental health acts alone will not change the way services are delivered, policies need to bear in mind the service user and the ultimate goal of curing of controlling the mental illness. Stigma is another problem faced by mental health service user and the need for policy makers to include education regarding mental health from an early age. It is worth noting that treatment of those who are detained under the Mental Health Act should be focused on recovery, support and dignity with a view to enabling people to return to their local communities without prejudice or stigma. The (1983) MHA focused on strengthening patients' rights to pursue independent assessments of their treatment, the MHA (2007) is chiefly focused on public protection and risk management. The amended legislation covers powers of compulsion and introduces compulsory community treatment orders; making patients'

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compliance with treatment a statutory requirement ultimately leaving people with mental health issues very little in the way of choices and confinement is always loitering in the background. In my essay the focus was on mental health law and the impact of changes to mental health acts in England, Wales, Scotland and Northern Ireland. There was also the view that within the UK that are different acts that render the treatment of mental health challenging.