

Editorial: Reforming the mental health act. Making a reality of reducing coercion

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Reforming the mental health act: Making a reality of reducing coercion

On a number of occasions, we have written in the pages of *MHSI* about the discriminatory nature of the 1983 Mental Health Act ([Perkins and Repper, 2014, 2018](#)). On 4th October 2017, then Prime Minister Theresa May announced an independent review of the Act, specifying that this should address what can be done to reduce compulsory detention and the disproportionately large number of Black people detained under the Act. We argued that:

This review offers a real opportunity to move beyond discriminatory mental health legislation and create new generic “fusion” legislation that replaces both the 1983 Mental Health Act and the 2005 Mental Capacity Act. Legislation that moves from a “diagnosis, disorder and risk” paradigm to one that puts impaired decision-making capacity and the person’s will and preferences at the heart of all compulsory treatment and intervention. A law that applies to everyone who has a problem with decision making, whether the diagnosis is physical or psychiatric, and in any setting. ([Perkins and Repper, 2018](#), p. 3)

Since we wrote this in 2018, the final report of the Mental Health Act Review was published in December 2018 ([Independent Review of the Mental Health Act, 2018](#)) and, subsequently, in January 2021, a white paper “Reforming the Mental Health Act” taking forward the recommendations of the review ([Department for Health and Social Care, 2021](#)).

This white paper is based on a laudable set of “guiding principles” and proposes a number of positive changes (such as Advance Choice Documents, revised detention criteria based on “therapeutic benefit” and “least restriction” and more rights to challenge detention) designed to

[...] drive a more person-centred system, in which the choices made by patients have weight and influence, where care must have therapeutic benefit, and where the powers of the Act are only used when absolutely necessary[...]. (Secretary of State for Health and Social Care, 2021, p. 20)

“The new principles are:

- *Choice and autonomy* – ensuring service users’ views and choices are respected.
- *Least restriction* – ensuring the Act’s powers are used in the least restrictive way.
- *Therapeutic benefit* – ensuring patients are supported to get better, so they can be discharged as quickly as possible.
- *The person as an individual* – ensuring patients are viewed and treated as individuals”.

(Secretary of State for Health and Social Care, 2021, p. 20).

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The white paper argues that “Together with the other legislative reforms set out [...] these principles will help redress the balance of power between patient and professionals” (Secretary of State for Health and Social Care, 2021, p. 20). But will this really be the case?

The proposed reforms do little, if anything, to change the fundamental imbalance of power and the discriminatory nature of mental health legislation and the primary ways in which it deprives people with mental health challenges of the rights enjoyed by other citizens – rights enshrined in the United Nations Conventions on the Rights of Persons with Disabilities. In particular:

- Unlike any other citizen who may be at risk of causing harm (for example, habitual spousal abusers or those who are drunk), someone diagnosed with a mental disorder can still be detained because they might be a danger to themselves or others.
- Separate rules exist for those with physical and mental illness. If you have a physical illness you have the right to refuse treatment, even if this may endanger your life; if you are diagnosed with a mental illness you do not. The law relating to mental illness is one based on a “disorder, diagnosis and risk” model, whereas the law relating to physical illness is based on a “capacity and best interests” model (Szmukler, 2017). If you are physically ill you have the right to refuse treatment providing you are able to understand what you are told about your condition and treatment and the consequences of accepting or refusing it.

Justice requires that all people posing equal risk would be equally liable to preventive detention [...] [and] the law must be generic: namely that it applies to everyone who has a problem with decision making, whether the diagnosis is physical or psychiatric [...] (Szmukler in Szmukler and Weich, 2017).

In 2018, we expressed the fear that the review of the 1983 Mental Health Act would “continue to tinker around the edges of intrinsically discriminatory mental health legislation” (Perkins and Repper, 2018, p. 4). It appears that our fears have been realised.

However, at the time of writing, the white paper is still open to consultation, and some progress may still be possible.

Within the white paper, there is a clear desire to reduce compulsory detention and to decrease the overrepresentation of people from Black, Asian and minority ethnic (BAME) communities subject to compulsion:

The Government has serious concerns about the rising rates of the use of the Act. Between 2006 and 2016 the number of detentions rose by 40% and we are now detaining tens of thousands of people each year. (Secretary of State for Health and Social Care, 2021, p. 9)

We are concerned that too often patients are detained for longer than is needed, and beyond the point of therapeutic benefit to the individual. (Secretary of State for Health and Social Care, 2021, p. 28)

We will take action to tackle the disproportionate number of Mental Health Act detentions of people from black, Asian and minority ethnic backgrounds. (Secretary of State for Health and Social Care, 2021, p. 13)

Similarly, a desire to reduce other coercive practices (restraint, seclusion and segregation) is evident:

The CQC has raised concerns about the use of restrictive practice when caring for people who use mental health or learning disability and autism services; high numbers of people continue to be restrained and are subject to restrictive practice. Research has also demonstrated that people from black, Asian and minority ethnic backgrounds experience excessive use of

seclusion and that restraint is used disproportionately on people from these backgrounds. (Secretary of State for Health and Social Care, 2021, p. 13)

The proposals designed to achieve this within the white paper focus on changes in process. History, especially in the field of equalities, is littered with a focus on processes – what we should do – at the expense of outcomes – what we must achieve. We believe that to achieve these desired reductions in compulsory detention and treatment, and other forms of coercion, there needs to be added a focus on outcomes.

This might usefully take the form of a requirement to monitor coercion in all its forms and to achieve a decrease in its use as well as a decrease in the overrepresentation of people of BAME origin. Monitoring is not only important in providing data about the impact of different processes and interventions. It is also an intervention in and of itself. The reactive effects of monitoring have long been recognised – if people monitor something then it produces changes in behaviour (see, for example, [Nelson and Hayes, 1981](#)).

There is a wealth of evidence and learning which shows that it is possible to achieve reduction in compulsory detention and other forms of coercion (see World Psychiatric Association Task Force, 2020) and many approaches that have proved fruitful, but all share the requirement to monitor its use and central leadership towards change with a clearly articulated goal of reducing coercion (see, for example [National Technical Assistance Center, 2005](#); [Care Quality Commission, 2017](#)).

The World Psychiatric Association specifically includes “detention and treatment without consent” among those coercive practices that must be reduced. However, to date, many attempts to reduce coercion in the UK have focussed on use of restraint (physical, chemical – rapid tranquilisation and mechanical) and seclusion within inpatient settings. Examples include the Reducing Restrictive Practice collaborative [1] and the Restraint Reduction Network [2]. Such initiatives are important but need to be extended to include detention and treatment under the Mental Health Act. Leadership and a clearly articulated philosophy of care that embraces a reduction in all forms of coercion need to be specified and required in the Mental Health Act itself.

We would therefore suggest that the Mental Health Act requires providers of services where people can be detained and treated without consent be required to achieve at least a 10% per annum [3] overall decrease, and at least a 10% per annum decrease in the overrepresentation of people from all BAME communities, in:

- detentions under the Mental Health Act;
- use of CTOs; and
- use of restraint, seclusion and rapid tranquilisation (as defined by the Reducing Restraint Collaborative [4]).

A focus on outcomes as well as process is important. The addition of clear targets for reduction of use of coercion in all its forms in the Mental Health Act would provide the leadership necessary to both assist in the achievement of its stated goal of reducing detention and other coercive practices and stimulate innovation into ways of making this a reality.

Notes

1. www.rcpsych.ac.uk/improving-care/nccmh/reducing-restrictive-practice
2. <https://restraintreductionnetwork.org/>
3. 10% reduction was the figure set, and largely achieved in a large scale initiative in the Netherlands [Noorthoorn et al. \(2016\)](#).
4. www.rcpsych.ac.uk/improving-care/nccmh/reducing-restrictive-practice

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