Response from the Northern Ireland Council for Ethnic Minorities (NICEM) to the DHSS&PS on the review of mental health legislation, policy and provision.

Despite the apparent commitment of professionals and managers to provide '*ethnically sensitive and culturally appropriate services'* for mental health, the overall experience of psychiatric services by ethnic minorities in the UK remains '*largely negative and aversive'*.[1] Attempts to innovate for ethnically responsive services notwithstanding, the disparity between ethnic minority groups and others in service usage, satisfaction and outcome persists.[2] The indictment that *'...there is no single aspect of contemporary psychiatric care within which Black or S. Asian people are not disadvantaged.'*[3] suggests that attempts to develop ethnically responsive services in the UK have largely failed to address problems with race and psychiatry and moreover, it has been suggested that the more fundamental task of addressing racism within psychiatry has been neglected. [4]

It is in the experience of contemporary psychiatry by minority ethnic groups in Western Europe that the ethical dilemmas of psychiatry and the contradictory ideologies within mental health are made most explicit.[5] The following evaluation identifies a number of concerns within the context of the current mental health provision before assessing existing mental health law and considering it in the light of proposed legislative reforms which have recently emerged from a parallel review in other UK jurisdictions.[6]

1. Discrimination and mental health

Issues of race and culture in relation to psychiatry are rarely addressed except in the most marginal terms. The evidence attesting to the discriminatory nature of psychiatric care in the UK and the corresponding overwhelmingly negative experience of psychiatry by persons of ethnic minority is incontestable[7] and the message from research is unambiguous - minority

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[1] Sashidharan SP 'Institutional Racism in British Psychiatry' Psychiatric Bulletin 2001; 25: 244-47

[2] King et al 'Incidence of psychotic illness in London: comparison of ethnic groups. BMJ 1994; 309: 1115-9

[3] supra at 1

[4] ibid. and Minnis et al. Racial stereotyping: a survey of psychiatrists in the United Kingdom. BMJ 2001; 323: 905-6. As with a number of public bodies and other societal groups, British psychiatry has admitted to a major problem of institutional racism within the profession itself. Following the Macpherson enquiry [Home Office 1999] there was an emerging sense of urgency in tackling racism within public bodies such as the NHS. Since the enactment of the Race Relations Amendment Act this has begun to change and mental health services are obliged to give serious consideration to the perceptions and experiences of ethnic minority groups.

[5] Davies et al 'Ethnic differences in risk of compulsory psychiatric admission among representative cases of psychosis in London' BMJ 1996; 312: 533-37; Bhugra and Cochrane 'mental illness and ethnic minority groups' In Psychiatry in multicultural Britain. London: Gaskell, 2001: 137-150; Ethnicity, social inequality and mental illness (Editorial) BMJ 1998; 316: 1763-70

[6] Report of the Expert Committee established by government in 1998 to advise on reform. Review of the Mental Health Act 1983 (London: Dept of Health, 1999). Draft Mental Health Bill (Cm 5538-I)

[7] Cochrane & Sashidharan, 1996. The negative experiences of psychiatry for ethnic minority ethnic groups were first documented in the early 1960s when research indicated the over-representation of Black people within

ethnic groups are represented within psychiatric settings in a different way, both quantitatively and qualitatively from the white ethnic majority.[8]

A recent survey of UK psychiatrists suggests that racial stereotyping still occurs.[9] Involuntary admissions of young black men are more common than those of young white men[10] and schizophrenia is more commonly diagnosed in young black men even though the *prevalence* in the community is no different for black and white.[11] Other groups report an increased *incidence* of schizophrenia in several ethnic minorities in the UK[12] which does not seem to be explained on the basis of biological risk factors. Reports from the US have demonstrated an association between the proportion of an ethnic minority living in an area and their admission rates for mental illness in general.[13] These indicate the need to consider social risk factor/s for the increased rate of schizophrenia reported in non-white ethnic minorities in the UK.[14] The claim that the ethnic variations are merely products of differential disease burden is presently unsustainable. Thus the academic agenda of contemporary psychiatry must move beyond the search for a genetic predisposition to examine and appreciate how psychiatric institutions and practices impinge upon disadvantaged or marginalised groups in society in general and minority ethnic groups in particular.[15]

Under the RR(NI)Order 1997 and S75 of the NI Act 1998, the disadvantage experienced by members of ethnic minority groups must be considered and used as a means of quality monitoring for policy planning. The requirement for health needs assessment as central to provision of health care supports the mainstreaming of needs of ethnic minority communities. Ethnic monitoring must be in-built to the policy planning and service delivery of all public bodies and impact assessment will identify any gaps in the service needs. Part of this is the provision of interpreters and translation but equally important is that those planning and providing for these groups have the competence to understand the cultural or religious

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institutional settings. Since then a wealth of data have emerged to confirm that discrimination against ethnic minority groups extends to all aspects of psychiatric care.

[8] There are three ways of addressing this discrepancy in the representation of ethnic minority groups within psychiatry; either the pattern of service usage reflects disease variability or that European psychiatry discriminates against ethnic minorities or a combination of both.

[9] Minnis *et al supra* at n 4.

[10] Davies et al. Ethnic differences in risk of compulsory psychiatric admission among representative cases of psychosis in London. BMJ 1996; 312:533-37; Koffman et al. Ethnicity and use of acute psychiatric beds: one-day survey in North and South Thames regions. BJPsych 1997; 171: 238-41

[11] Nazroo JY. Ethnicity and mental health: findings from a community survey. London: Policy Studies Institute, 1997. Racial stereotyping occurring at the first interview is insufficient explanation for the inequalities seen in secondary care and urgent exploration is required to identify the source of such inequalities.

[12] Boydell et al 'Incidence of schizophrenia in ethnic minorities in London: ecological study into interactions with environment' BMJ 2001; 323: 1336

[13] Halpern D Minorities and mental health Soc Sci Med 1993; 36: 597-607

[14] What seems to be important is the concentration of people from the non-white ethnic groups in the immediate vicinity. It is speculated that stressful factors such as exposure to discrimination, and perceived alienation and isolation. Reduced protection from the effects of such stresses could be associated with decreased social networks or social buffers in small or dispersed ethnic minority populations.

[15] Commander et al. 1997: In relation to black and other ethnic minority groups in the UK conventional epidemiological and clinical studies repeatedly point to the discriminatory nature of the psychiatric care received by them

obligations which may make it difficult or impossible for them to engage with traditional services. Mechanisms for overcoming such issues must be established including the recruitment of staff from ethnically and culturally diverse backgrounds where appropriate.

2. The pathway into mental health care

Studies have shown that although initial pathways into care are similar for different ethnic minority groups, the subsequent care given to many of these is more coercive and their service related outcome poorer.[16] The increased risk of coercive psychiatric interventions in the pathway into psychiatric care, the discrepancies between ethnic groups in assessment and identification of needs and risks, the nature and location of psychiatric treatment and differential outcome have all been identified repeatedly and continue to be the subject of a number of local and national enquiries and reports.[17] Unfortunately in the recent review in England, minority ethnic groups were largely ignored in the opportunities available at the time of the new National Service Framework for Mental Health to develop a coherent set of principles or standards. A commitment to developing a coherent and overarching regional strategy for mental health in minority ethnic groups with a clear mandate to tackle institutional racism within mental health services should be one of the first step in the reformed NI mental health agenda.[18]

3. Mental health and the elderly

The growing number of elderly people from ethnic minority groups and in particular the relative neglect to date of their mental health needs also requires recognition.[19] Up to 15% of elderly people are known to suffer from depressive symptoms of whom 1/3 have an illness requiring treatment. The under-representation of ethnic minority groups in use of psychiatric outpatient services parallels a similar observation in the younger ages.[20] Elderly people from ethnic minority backgrounds are heterogeneous communities. The assumptions about community strength, extended families and informal support *may* be false and 'triple jeopardy' has been used to describe the three-fold challenge of racism, agism and socioeconomic deprivation which they may face.[21] Unravelling the triple jeopardy of aging/old age, discrimination and limited access to health care among ethnic minority groups

[16] King *et al.* Incidence of psychotic illness in London: comparison of ethnic groups. BMJ 1994; 309:1115-9; Bhugra and Cochrane 'Mental illness and ethnic minority groups' In Psychiatry in multicultural Britain. London: Gaskell, 2001: 137-150

[17] National Schizophrenia Fellowship, 2000; Warner et al 2000

[18] as part of and linked into a broader national strategy for managing mental health problems in ethnic minorities

[19] This is increasingly recognised as a major public health issue in E&W for the 21st century

[20] Saxena *et al.* Socioeconomic and ethnic group differences in self reported health status and use of health services by children and young people in England: cross sectional study. BMJ 2002; 325: 520

[21] 'Age, ethnicity and mental illness: a triple whammy' Editorial, BMJ 1996; 313: 1347-8

will require transdisciplinary investigation with a broad focus on physical, mental, social and economic determinants of perceptions of health and the occurrence of disease.

4. Methodological obstacles to accurate assessment and diagnosis

Western ideas of distress and symptoms are not necessarily true for other ethnic groups and it is difficult to translate emotions into English even with good language skills or an interpreter present - and most existing instruments for screening for depression and dementia were developed for use in the indigenous white population. Without valid instruments the necessary assessments cannot be performed in ethnic minority communities and without such assessments the size of the problem will remain hidden. For instance, cultural limitations of Western measures of mental illness may explain the increased likelihood of suicide in young Asian women despite the findings that they were found to be no more likely to feel suicidal than other ethnic sub-groups.[22] Methods for assessing cognitive function depend greatly on literacy and educational attainment and seem to be culturally biased however instruments have been developed that overcome this limitation.[23] The Policy Studies Institute, in a study commissioned by the Department of Health has begun to tackle these complexities and openly address the difficulties in cross-cultural assessment of mental illness.[24] Drawing on existing NHS research development and validation of screening tests for depression and dementia in elderly subjects from ethnic minorities for example, will allow the provision of services that are appropriate to actual need[25] - and from the perspective of patient satisfaction and in the context of more efficient longer term resource management - it is essential that such tools are not limited to crisis management. Both the UK government and NI assembly have stated their commitment to improving the health of minority communities[26], to the creation of health action zones to tackle health inequalities with the overarching objective of targeting social exclusion. Further and substantive efforts are required to meet these objectives if they are to be more than merely aspirational. Priority being given to the recognition and treatment within primary care of common mental disorders among ethnic minorities in recognition of the important and fundamental interactions between mental illness, ethnicity, gender and social inequality.

Strengths and weaknesses in current[27] Vs proposed mental health provisions[28]

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[22] Results of the Policy Studies Institute survey in 'Ethnicity, social inequality and mental illness' BMJ 1998; 316:1763-70

[23] Jitapunkul et al. 'Chula mental test: a screening test developed for elderly people in less developed countries. Int J Geriatr Psychiatry 1996; 11:715-20

[24] Nazroo JY *supra* at f 15

[25] Jitapunkul *supra* at f 22

[26] Although the overall the proportion of ethnic minorities in NI population is significantly lower at 1.3%, under the RR(NI)Order 1997 and S75 of the NI Act 1998, the disadvantage experienced by members of ethnic minority groups must be considered and used as a means of quality monitoring for policy planning.

[27] Mental Health Act 1983 + Common Law

[28] under the Draft Mental Health Bill (Cm5538-I)

UK mental health law is particularly inconsistent and discriminatory in the way it deals with questions of competence and patient autonomy with regard to mental disorder. Unlike many other European and Commonwealth jurisdictions, the UK makes no special statutory provision for substitute decision making in the field of health care generally on behalf of those adults who lack competence.[29] The law in NI as in E&W governing the provision of medical care in the case of adults with incapacity and the provision of care and treatment for mental disorder presents serious problems for the principle of patient autonomy and has correspondingly weighty implications for the individual's Convention rights under Articles 5 and 6 as incorporated into the Human Rights Act 1998.

The adult with incapacity has no competence either to consent or to refuse medical treatment but the law provides no statutory structure for substitute decision making on that adult's behalf. On the other hand the law does allow a person with mental disorder to be treated for that disorder despite his/her competent refusal.[30] The current programme for reform of UK mental health law is set against the background that for some persons in the UK, irrespective of ethnicity, the common experience of mental disorder for some leads to a reduction in mental competence and an inability to make decisions about health care and treatment – for others decision-making competence will be unimpaired. In the first event it might be expected that the law would provide for substitute decision-making in the affected person's best interests' while in the second it might be assumed that the person's competent decisions might be respected. Legal reality fails to match these simple expectations and assumptions. The provision of health care and treatment for incompetent adults in general is left to the uncertainties of the common law wherein there is no formal structure for substitute decision-making. Special statutory provision is available only for the care and treatment of mental, not physical disorder and here special principles apply which permit treatment to be given against the competent wishes of the patient. Unfortunately the proposed legislative reform does little to dispel the confusion engendered by the current approach to adult incapacity in general and mental disorder in particular.

- The current statutory framework re treatment for mental disorder does not consider patient autonomy. The MHA 1983 permits a person suffering from a mental disorder of the necessary degree of severity to be detained and treated for that disorder against his/her competent wishes.[31] No assessment of competence is required. The shift in the criteria for use of the statutory framework proposed by the new bill causes this shift further from patient autonomy in the cause of public pressure for social protection and in contravention to A5 rights. It has been suggested that the paternalistic justification for this statutory

[29] Mental Incapacity (1995) No 231, Report of the Law Commission E&W
[30] The nature of these inconsistencies have been examined in a comparative report by Richardson. Autonomy, guardianship and mental disorder, MLR Vol 65 Set 2002 p 702 ff
[31] MHA 1983 s 3

approach originated in the now contested belief that mental disorder equates to loss of judgement.

- Like many other jurisdictions, that in E&W and NI singles out mental disorder and imposes special restrictions on the autonomy of those who suffer from it, whether justified or not. The MHA 1983 only provides for the compulsory care and treatment of those whose mental disorder fulfils the relevant statutory criteria. The vast majority of those who suffer from mental disorder are not treated under such powers, the aim being to restrict the use of compulsory powers to those for whom there is no alternative means of providing care. Thus the vast majority of mental health patients receive care under common law principles. This distinction between formal and informal patients can give rise to practical difficulties including the issue of coerced consent; arguably this issue is unavoidable once any power to treat in the absence of consent is provided.

Proposed restructuring of the law and provision of mental health services under the draft Mental Health Bill, June 2002.

There is no doubt that existing mental health legislation requires review and in some areas reform is long overdue however, some of the proposed measures suggested in recent draft legislation add further human rights challenges to those already existing.[32] Of particular concern is (i) the proposed introduction of detention without trial of people with untreatable personality disorders who are deemed to pose a risk to others; and (ii) the forcible treatment of mentally ill people who are living in the community. The problem of lack of beds, forensic staff, drug/alcohol services, community health services and lack of comprehensive evaluative study of problem prisoners, delays to Mental Health Review Tribunal hearings caused by under-resourcing not only present major problems but are often in breach of A5(4) and A6 of the ECHR.[33]

Under the MHA 1983, people are prevented from compulsory hospital detention unless medical treatment can at least prevent their condition from deteriorating. In response to public pressure however, the government has in its draft legislation proposed to extend the meaning of medical treatment to include every type intervention[34] but without any requirement that the patient should benefit thus paving the way for preventive detention of non-offenders.[35] It has been widely observed that a number of the proposals in the bill would recast mental health professionals as jailers and agents of social control.[36] The bill widens the diagnostic net to

[32] In regard to the draft Mental Health Bill, it has been said that as a result of its main provisions the government has forged an 'unbreakable bond' between lawyers and doctors united in its condemnation. Professor Eastman speaking on BBC Radio London, June 2002. [Legal Action, August 2002 p 7 – 8]
[33] *R (KB and others) v MHRT and Secretary of State for Health* [2002] EXHC 639 (Admin).
[34] including education and social skills training
[35] a response which harks back to the Criminal Lunatics Act, 1800 which allowed any person suspected of having a 'derangement of mind and a purpose of committing some crime' to be detained indefinitely.
[36] Legal Action, August 2002, p 3

include alcohol or drugs dependency within the definition of mental disorder and widens the net of compulsion by allowing enforced treatment of outpatients.

(A) *Some of the provisions are commendable including*

- The care plan is now to constitute a key part of the powers to detain (constructed and revised within a strict time frame) and a mental health tribunal must approve the care plan when making either a an assessment or treatment order.
- Patients receiving increased information and explanation and have the facility to challenge proposed care plans
- All patients will have the right to an advocate to help them access information and the right to challenge and the use of compulsory powers.[37]
- Compliant incapacitated patients do not have to be detained under the MHA 1983 to be treated. Government have accepted that these patients, generally those with dementia or severe learning disabilities have no statutory safeguards. This is addressed in part 5 of the Bill which sets out a separate statutory scheme to provide some incapacitated patients legal safeguards without sectioning them.[38] The patient and the nominated person have to be consulted in the making of that plan and when the plan is approved sent a copy of it. The care plan will have to be reviewed, the first after 12 months.
- It is now clear since the *Bournewood* decision[39], that not only were the inadequacies of the safeguards provided by the common law evident but it was also suggested that even those provided by the MHA 1983 are insufficient. While the statutory safeguards may be more accessible they offer no real protection in relation to the stage I competency decision.[40] Under the proposed legislation, the structure of consultation, certification and notification and the facility for the patient or his/her representative to apply to the proposed tribunal *could* provide adequate safeguards. While the process of consultation etc. should help to protect the patient's interests, the real safeguard will be provided by the tribunal. Its details are not fully clear however, it is presumed that it will be able to consider both

[37] It offers the possibility of mental health advocacy services to be made available to all those receiving compulsory treatment and the new mental health tribunals with the responsibility for authorising all compulsory treatment beyond the first 28 days, regular review of the orders and the requirement to provide reasons for all their decisions are welcome. However given the broad criteria for compulsion and the lack of sufficient trained staff this may be problematic.

[38] however, only patients who pass a six-fold test will qualify for the safeguards a patient who resists treatment or is at risk of committing suicide or causing serious harm to other persons, will fail the test and have to be detained formally.] If they do pass the test, the clinical supervisor will have to prepare a care plan, which has to be approved by an adviser from the new expert panel of the tribunal.

[39] *R v Bournewood Community and Mental Health Trust, ex parte L* [1998] All ER 319

[40] Buller T 'Competence and risk relativity' 2001; Bioethics 15: 92; Richardson G 'Autonomy, guardianship and mental disorder: one problem tow solutions. Modern Law Review 2002; 65:5. In Ch 6 of the White Paper, the government outlined a set of safeguards to apply to compliant patients with long term mental incapacity, at least with regard to the provision of treatment and care for mental disorder. It estimates that there are as many as 44,000 such people at any one time and is proposing that in these cases the patient's clinical supervisor will have to arrange a full assessment and develop a care plan to cover all aspects of the patient's care and treatment including steps taken to restrict liberty.

whether the patient does in fact suffer from 'long term mental incapacity' and whether the care and treatment described in the care plan is in his/her best interests. If the proposed new mental health tribunal is in practice empowered to investigate *both* of these questions *rigorously*, then it will certainly provide a better safeguard at both stage I and II[41] than is currently available under common law. In cases where the care plan involves detention, the requirements of A5(4) of the ECHR should serve to ensure that the tribunal applies the necessary rigour. *However*, until a comprehensive framework for adult incapacity is introduced it only applies to those who require care and treatment for serious mental disorder who will receive these safeguards. All other forms of care and treatment for adults who lack competence will continue to be delivered under common law.

(B) *Behind the sensational headlines there are numerous recommendations some of which will seriously erode the civil rights of patients and the fair adjudication of patient's detainability.*

- The draft Mental Health Bill introduces a much wider definition of mental disorder: 'any disability or disorder of mind or brain, which results in an impairment or disturbance of mental functioning'[42] and incarceration is proposed on the basis that they *might* commit a crime.[43] Thus, in clear breach of A5 and A6, the bill allows indefinite detention without trial of 'dangerous' non-offenders with *untreatable* personality disorders.[44]
- Attempts to comply with the right to a fair trial in the case of patients subject to compulsory treatment includes importantly the requirement to explain the decisions of the new Mental Health Tribunal to patients. However, the consensus is that in the face of the 'absurdly wide'[45] new grounds for detention and compulsory treatment, the legislative protection offered is illusory.
- The bill also provides for an 'community injection order' whereby patients may receive compulsory out-patient treatment. The potential for forcible removal of patients from home to clinic/hospital to receive treatment will further erode patient trust in mental

[41] Buller 2001, *supra*
[42] clause 2(6). Under new proposals any disorder described in psychiatric reference books could be included.
[43] It has been estimated that in order to prevent each homicide found to have been committed by a person deemed to have a severe personality disorder, at least 5,000 people would need to be in preventive detention. Zigmond T, Psychiatrist at Leeds NHS Trust. Others argue that this is a conservative estimate. Eastman N, Forensic Psychiatrist, St George's Hospital.
[44] A principle quite different from the MHA 1983 wherein the treatability test is required – to become defunct under the proposed new legislation. The new definition of mental disorder has far reaching implications to the extent that the legislation could be used for non-therapeutic purposes and at its most extreme as a mechanism of social control. If people are to be detained for a mental disorder there should be more certainty over what it is and is not; without the certainty of definition how would it be possible to challenge detention successfully. Additionally, without an exclusion clause it will be possible to impose detention on the basis of addictive disorders or the demonstration of immoral behaviour. For the powers to challenge detention successfully a precise definition with exclusions is fundamental.
[45] The rights balance, Legal Action August 2002 p 7-8

health professionals and place patients at risk.[46] According to the Mental Health Alliance[47] the policy will drive patients away from services.

The consensus from psychiatrists, lawyers and service-users has been unanimous condemnation of the government's proposals to widen the criteria for compulsion. Following the introduction of the HRA'98, the lowest common denominator must be to make Mental Health Law compatible with the Convention which requires careful balancing of the rights of the individual with those of society as a whole. Existing law encourages compliance without physical coercion whereas the new powers could breach patients liberty rights under the Act[48] with the additional risk that police officers and medics involved in enforcing such orders will be accused of assault on patients, the precedent for which already exists.[49]

(C) *The government have responded constructively to some of the criticisms:*

- the addition of clause 1(3)(c) means that *restrictions* imposed on patients should be the *minimum necessary* to protect them or others.
- Also the previous appointment of nearest relatives has been changed to the broader use of 'nominated persons'. One of the significant deficiencies of the MHA 1983 provision for nearest relative is its failure to introduce a remedial order to prohibit perpetrators from acting as nearest relatives. Following the case of *JT v UK*[50] the government in the draft bill have eventually moved to remedy provisions of the MHA 1983 which *continues* to allow a patients nearest relative to include someone who has abused the patient as a child.
- The detention under common law, of compliant, but mentally incapable adult patients provides a potential violation of A5 of the convention. This current lack of safeguards under existing legislation[51] has been remedied under the new bill, which allows patients who are effectively deprived of liberty in hospital[52] to make applications to the new mental health tribunals.[53] However, the introduction of an explicit provision authorising psychosurgery on a patient without capacity[54] on the authority of a High Court judge and various experts[55] must be condemned as barbaric.[56]

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[46] Anyone who is subject to a treatment order and refuses to co-operate with it could be taken to hospital and forcibly medicated. Such powers would discourage people with mental health problems to seek medical help. In keeping with its emphasis on coercion the bill proposes emergency powers which would allow the police to enter a home without a warrant and remove a person to a 'place of safety'.
[47] a coalition of MIND and other mental health groups
[48] HRA 1998
[49] Precedents exist for this more recently in *R (Wilkinson) v RMO, Broadmoor Hospital* [2001] EWCA Civ 1545, 22 Oct 2001, where the Court of Appeal recognised that a patient's refusal to consent to taking anti-psychotic medication and the subsequent forcible injection placed the patient in grave potentially mortal danger.
[50] Appl no 26494/95
[51] highlighted in *R v Bournewood Community and Mental Health NHS Trust ex p L* [1998] 3 All ER 289, HL
[52] but not those 'on section' under the MHA 1983
[53] clause 136
[54] ie who is 'not capable of consenting'
[55] clauses 112-116; if it is deemed to be in their 'best interests' and they are 'unlikely to resist'

Conclusion

Mental Health has become one of the key priorities within the NHS.[57] New legislation was apparently intended to update the service in view of changing patterns of treatment and care however the draft bill serves to largely undermine this strategy, responding to society's preoccupation with dangerous persons and the threat they pose to the community has led to the introduction of new 'draconian' measures to detain people who have severe personality disorders irrespective of whether they have committed any offence. It will be hugely expensive to operate extended powers of compulsory treatment which are likely to cause mentally disordered people to avoid all contact with mental health professionals and perhaps even increase the chance of violent incidents. Current proposals under new draft legislation demand emphatic rejection from anyone involved in caring for and supporting people with mental illness.

There is currently no statutory framework - either existing or proposed - for the provision of substitute decision-making on behalf of adults with long-term incompetence. Omission of a framework from the draft legislation exacerbates some of the problems already arising from the demarcation of mental disorder. Although it is suggested that the lack of an express statutory framework covering incapacity in general, together with the breadth of the diagnostic categories falling under the 1983 Act, may have combined to protect mental disorder from attracting even greater stigma; in the long-term however, if the law is really to help dispel negative attitudes towards mental disorder, it must introduce a comprehensive statutory framework for the provision of substitute decision-making. Such a framework would have to deal with the provision of medical treatment for all forms of disorder, mental and physical, on behalf of all those who lack competence for whatever reason.

At the time of this position paper, the reform of mental health legislation in England & Wales is well advanced and the criteria for the use of compulsory powers contained in that Bill pay significantly less regard to the demands of patient autonomy that was contained in the white paper.[58] If the Bill goes through as drafted, those with mental disorder and (for the reasons previously elaborated) persons belonging to ethnic minorities in particular, will continue to suffer discrimination at least equivalent to that under existing legislation.

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[56] Boast N, Consultant Forensic Psychiatrist, Redford Lodge Hospital, London

[57] with the appointment of a mental health 'tsar' and increased investment in community teams

[58] The proposals in the draft legislation stand in contradiction to the report of the Expert Committee established by govt in 1998 to advise on reform. Than Committee was anxious to pursue the goal of non-discrimination on grounds of mental disorder and to that end recommended a legislative framework which was designed to afford greater respect to the principle of patient autonomy. Accordingly it proposed that lack of decision-making capacity/ competence on the part of the patient should become one of the criteria for the use of compulsory powers. Review of the Mental Health Act 1983 (London: Dept of Health, 1999). The government have been singularly unconvinced by the Committee's emphasis on patient autonomy, favouring the 'degree of risk' in the face of which questions of capacity 'may be largely irrelevant'

Paper produced by Dr Angela O'Rawe, for the Northern Ireland Council for Ethnic Minorities, December 2002.