An Exploration of Sectioning under the Mental Health Act:
Failure of the Current (Medical) Model to Protect Patient Rights

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Sections 2 and 3 of the Mental Health Act 1983 (as amended) (MHA) allow individuals to be civilly detained for assessment or treatment without their consent. With Article 5 of the European Convention on Human Rights providing a 'Right to Liberty', though not an absolute right, the MHA represents extreme interference with human rights. As will be shown, the MHA s 2 and s 3 operate under the medical model.

The traditional medical model approach purports a 'focus on biological cure or management of the condition or person' and 'involves a power imbalance in the relationship between professional and patient' with 'diagnosis and classification functioning as ends.' Within mental health law 'a medicalised model of disability has been prominent,' and the most recent MHA intended to move away from this and encourage patient involvement. However, whether this is the case in practice shall be explored whilst taking into consideration the Act, its Code of Practice, and case law. These sources will determine whether the medical model is still prominent in practice – but the words of the act and some realities reflect different models; hence, an evaluation is necessary to determine whether this is the most effective way forward for mental health law.

What is the Medical Model?

The controversial medical model has varying definitions;[1] Clough's take of it being a 'narrow lens' which 'focuses attention on control, care, and treatment as a consequence of the mental disorder and defines these responses in a medicalised way'.[2] The control element is characterised as a 'paternalistic style of interaction'[3] meaning that the doctor acts as sole decision-maker. This 'doctor-knows-best mentality' follows the 'A-B-C paradigm' where 'when problem A needs treatment B to achieve outcome C... This results the belief that causes are attributable to biological factors, and not social,'[4] and the 'disease [can] be fully accounted for by deviations from the form of measurable biological (somatic) variables'.[5] This means that the illness is seen to derive wholly from the body, and not the mind. The medical model manifests in two forms: in beliefs about disease and in the attitudes towards patients. They feed into one another, and 'can turn the patient into an objective of scientific enquiry who presents a problem to be solved'.[6]

Other commentators incorporate more encouraging criteria into their definitions of the medical model; in relation to the illness doctors are 'informed by the best available evidence. Doctors advise on, coordinate or deliver interventions for health improvement. It can be summarily stated as 'does it work?' – Causation being a core concept here.[7] Whilst on the front of behaviour towards patients, Shah and Moutain champion the medical model for 'patient empowerment,' reminding of how it is not about doctors' power but more on patients being 'active participants.' They note the focus should be on doctors helping patients to 'take charge of their recovery by whatever means available'.[8]

[1] Premal Shah and Deborah Mountain, 'The Medical Model is Dead – Long Live the Medical Model' (British Journal of Psychiatry 2007) 191, 375-377.
[2] ibid.
[3] ibid.
[4] P Beresford and others, *Towards a Social Model of Madness and Distress? Exploring What Service Users Say* (Joseph Rowntree Foundation 2010)
[5] George L Engel, 'The Need for a New Medical Model: A Challenge for Biomedicine' Science (Vol 196, No. 4286 1977) 129-136.
[6] Premal Shah and Deborah Mountain (n 2) 86.
[7] ibid.
[8] ibid.

The traditional medical model appears to hold the key themes that there is an asymmetry between doctors and patients, and they are treated more as objects, whilst the illness is seen as a cause-effect scenario. Sections 2 and 3 shall be judged against the traditional medical model, versus a future alternative medical model.

Detention processes under the MHA

Section 2 allows for a twenty-eight-day detention for the purpose of an assessment and detention is not renewable; they must be released, continue as an informal patient or be admitted for treatment under section 3. Section 3 allows the individual to be detained for treatment for up to six months initially. Only the most relevant sections in relation to the medical model shall be evaluated.

i. Medical input and interviewing patients

Two medical recommendations are required to support the application of the Approved Mental Health Professional (AMHP) or nearest relative; a section 12 approved doctor (who is trained in the use of the MHA) which is usually a psychiatrist, and then, if practicable, another that knows the patient (which is usually a GP).

The second doctor, who 'has previous acquaintance' with the patient, allows for another -more personal - social perspective which moves away from the traditional medical model. In *Ann R (By Her Ligation Friend Joan T)* it was held that the statute only requires the acquaintance to be minimal.[9] The GP in this case had only just accepted R as a patient and their first meeting was concerning the potential confinement. This constituted prior acquaintance as the statute did not require prior 'personal' acquaintance. The judiciary here are failing to see the value in knowing the patient's personal background – but the court purported this very medical model approach to be sufficient.

The interview of the patient that must take place no more than 14 days prior to making the application (section 11(5) MHA). What seems to stray from the medical biological model is that all circumstances must be taken into account when deciding upon detention (section 13(2) MHA). In *M v Managers, Queen Mary's Hospital,* due to various extenuating circumstances the doctor and AMHP went to the hospital for the interview but M refused to speak to them.[10] It was not obvious that the interview could not be rescheduled, but the Court of Appeal held that the duration and form of the interview were not stated in the MHA and shall be decided by professional discretion. The court has eroded patient safeguards and given doctors immense power in this situation, which is in line with the traditional medical model.

ii. Nature and degree

The mental disorder that the patient must be suffering from in either section 2 or 3 must be of a 'nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by treatment).' It has been held that 'nature' and 'degree' do not have the same meaning. *R v MHRT for South Thames Region. Ex p Smith [1999] COD 148* held that 'nature' regards the disorder itself, which incorporates features of the condition and prognosis, whereas 'degree' is in reference to the current state of the illness.[11] The court believed that these were stated separately for a reason and therefore Smith could be confined based on the nature of his condition, despite the current degree not warranting it. This excessive leniency towards medical discretion has caused a lot of criticism, especially when it involves a patient that stopped taking their medication sometime in the past, and will be detained based on this.[12] Although the Code of Practice (CoP) encourages the current circumstances to be looked at, this is, again, only advisory (as in *R v Munjaz* the Code is only advisory but clinicians must be able to give a reason for departing from it) and case law allows the detention based on nature.[13]

> Since 'nature' would appear to refer in the section to the disorder itself, not to the patient's intentions regarding treatment compliance. If that is the case, even patients with no history of ceasing treatment might have disorders of a nature, but not degree, warranting confinement.[14]

The safeguards against excessive use of the medical model are weakened after Smith.

iii. Appropriate treatment

One aspect, that only concerns section 3, is that appropriate treatment must be available for an individual to be confined. With little statutory guidance, the CoP adds that it must be 'for the purpose of alleviating or preventing a worsening of the patient's mental disorder or its symptoms or manifestations'.[15] While this seems to take account for the individual patient and does not seem to be too excessive towards the medical model, the case law tells a different story.

MD v Nottinghamshire Health Care NHS Trust[16] held 'the milieu of the ward both for its short-term effects and for the possibility that it would break through the defence mechanisms and allow him later to engage in therapy'.[17] Hence, 'this case comes perilously close to finding that detention, itself, is appropriate treatment'.[18] This means that another safeguard has been weakened and a patient could be detained, simply to be confined. Whilst there may be merit to this approach for some patients, it may not work for all and it puts a lot of faith in doctors and their discretion - especially when the same treatment is not afforded to criminals before they commit a crime.

[9] Ann R, (By Her Ligation Friend Joan T) v Bronglais Hospital Pembrokeshire and Derwen NHS Trust [2001].
[10] [2008] EWHC 1959.
[11] [1999] COD 148.
[12] W Armstrong, "Nature or Degree' in the Mental Health Act 1983' (1999) 2 Journal of Mental Health Law 154.
[13] [2003] EWCA Civ 1036.
[14] ibid 251.
[15] Department of Health, Mental Health Act 1983, Code of Practice (2015).
[16] [2010] UKUT 59 (AAC).
[17] Department of Health, Mental Health Act 1983 Code of Practice, (2015) para 39.
[18] ibid 255.

However, a less medical model approach was taken by the *Upper Tier Tribunal in DL-H v Devon Partnership NHS Trust and Secretary of State for Justice,*[19] which encouraged doctors to ask questions like 'What precisely is the treatment that can be provided? What discernible benefit may it have on the patient? Is that benefit related to the patient's mental disorder or to some unrelated problem? Is the patient truly resistant to engagement?' to push for a more individualised decision. If this was procedurally ensured, there could be a greater enforcement of patient rights.

iv. Nearest relatives

All of the previous issues stated may not be of such concern if there was a robust process where someone could stand up for the patient. The nearest relative is meant to bring this element to the decision-making process. Under section 2 the nearest relative is to be informed, but under section 3 the nearest relative is to be consulted and can make an application for admission. The application is almost always made by the AMHP,[20] which could save family tensions and therefore purports a more social approach. All of this diverges from the medical model.

The first major issue is there is no requirement of reasonable diligence when the AMHP appoints a nearest relative[21] so this safeguard, which aims to ensure a more well-rounded detention decision, is not ensured. A person who is wholly inappropriate or who does not know the patient could be chosen, so the safeguard of the patient's rights is weakened.

The most concerning issue regards replacing the nearest relative. If the AMHP applies to replace, the question is whether the relative is 'suitable.' Does this mean that they are uncritical of the treatment team's proposals, or is it that they are suitable because they pose a challenge to it? Ground (c) is used 'almost exclusively'[22] and notes 'the nearest relative of the patient unreasonably objects to the making of an application for admission for treatment' (section 29(3)). *W v L (1974)* established the test for the unreasonableness of the relative's objection at an objective standard – what would the reasonable person in this situation do?[23] It seems counterintuitive and illustrates excessive medical deference since the subjective approach is exactly what a relative is meant to bring to the discussion. Due to the objective test this individuality no longer remains because any objection to the proposed treatment plan would seem unreasonable. This was criticised heavily by Hale LJ:

> [this gives] rise to the greatest possible sense of injustice on the part of patients... it illustrates the overriding of views of the nearest relative, and in practice how difficult is it for the nearest relative to avoid being found unreasonable if his views differ from those of the hospital...Relatives must in those circumstances wonder why they have any role at all.[24]

In all of these instances, the legal framework has created 'medical freedom with the appearance of legal control'[25] which in reality defers to the traditional medical model.

Does it matter that sections 2 and 3 employ the medical model in practice?

The issue with using the medical model to exclude patients is that patients are left feeling like they did not have say in the process and that no one is advocating for them – essentially 'dehumanising'[26] the patients. It is questionable whether this is helping the patients. As previously mentioned, patient empowerment is an important part of the process of getting better.[27] 'Classifying mental illness is a more subjective endeavour' than physical illness, meaning that a wider section of variables such as 'behavioural components as well as biological components' need to be taken into account, which only comes with increased patient involvement.[28] This benefits the improvement of mental health treatment since, as David Adams so aptly put it, 'only a fool or a liar will tell you how the brain works'.[29] Treatments are constantly contradictory; with anti-depressants and corresponding research being based on serotonin, the neurotransmitter,[30] and others finding that depression can be linked to anhedonia (a lack of pleasure),[31] which is a totally different part of the brain. The key point being that the medical model does not take into account the multiplicity of causes. The brain can be treated as any other organ – 'the same basic principles apply'[32] – but the brain is difference because of the mind. 'The extended mind' is the theory that the existence of the mind goes beyond the physical brain that encapsulate experiences.[33] Hence, listening to a patient's behaviour and views is important to look into the causes of mental health. Practically, this is possible if the medical model is looked at more broadly with the core principle of 'does it work?'[34] If a more abstract concept of illness has to be explored to find answers, that is what the law must encourage doctors to do.

With regard to patient treatment, 40-50% of civilly confined patients do not know they have been

[19] Upper Tier Tribunal in DL-H v Devon Partnership NHS Trust and Secretary of State for Justice [2010] UKUT 102 (AAC).
[20] George L Engel (n 5) 247.
[21] Re D (Mental Patient: Habeas Corpus) (2 FLR 848 2000) para. 15.
[22] Peter Bartlett and Ralph Sandland, *Mental Health Law: Policy and Practice* (3rd Edn, Oxford University Press 2007) 266.Bartlett and Sandland (n 5) 266.
[23] QB 711 at 717-8.
[24] [2000] EWCA Civ 3025.
[25] Peter Bartlett and Ralph Sandland (n 22) 9.
[26] Giles Newton-Howes and Richard Mullen, 'Coercion in Psychiatry Care: Systematic Review of Correlates and Themes' (2011) 62 Psychiatric Services 465.
[27] Premal Shah and Deborah Mountain (n 6).
[28] Kirsten Weir, 'The Roots of Mental Illness: How much of Mental Illness can the Biology of the Brain Explain?' (2012) 42(6) American Psychological Association 30.
[29] David Adam, '*The Man Who Couldn't Stop: The Truth About OCD*' (Picador 2014).
[30] Alexander Neumeister, Theresa Young and Juergen Stastny, 'Implications of Genetic Research on the Role of the Serotonin in Depression: Emphasis on the Serotonin Type 1 Receptor and the Serotonin Transporter' (2004) 174(4) Psychopharmacology 512.
[31] Lindsey Sherdell, Christian E Waugh and Ian H Gotlib, 'Anticipatory Pleasure Predicts Motivation for Reward in Major Depression' (2012) 121(1) J Abnorm Psychol 5.
[32] Rupert Sheldrake, 'The Extended Mind' (Jul-Aug Issue of The Quest 2003).
[33] ibid.
[34] Premal Shah and Deborah Mountain (n 6).

detained,[35] and situations like this have led to no more than 40-50% of persons compelled later considering their detention justified.[36] Creating an environment where patients feel the stark power asymmetry has led to 'even those who considered their admission to have been justified...not chang[ing] the way they felt about it. Those that were angry were still angry'.[37] Correspondingly, studies found that there is 'little improvement among patients to offset the negative experience of coercion'.[38] Hence, when using a medical model where doctors' discretion far outweighs that of patient, it results in limited patient progress. This is especially because of the nature of mental illness, since the mind is much more than a purely biological organ, but is made up of individuals' experiences too. Hence, the broader medical model that encourages patient empowerment[39] would seem to serve a more effective purpose than the current, more traditional model.

Alternative models

Gostin depicts 'a pendulum swinging between two opposing schools of thought- legalism and professional discretion'.[40] 'Traditional legalism is founded upon the application of a body of law to individual cases so that relatively consistent and fixed results accrue from reasonably equivalent factual circumstances'[41] as opposed to trusting medical discretion. The difficulty with legalism is exemplified by the MHA 1983 since on paper it is a move towards better legal safeguards for patients' rights. However, because of legal formalism, medical discretion is still at the heart of the Act, instead of patients' rights.[42] Critics of legal intervention argue that such a structured framework cannot regulate complex issues relating to human behaviour well enough.[43] Legalism is necessary to ensure consistency and provide safeguards against unfettered medical discretion[44] but there is a need for this to be approached with acknowledgement of its shortcomings.

Noting this, the social model is yet to be undertaken legally.[45] It 'believes that people with disabilities aren't disadvantaged because of their bodily or mental state, but because of society imposing such disadvantages'.[46] Disability, from the medical model perspective, is seen as an 'unfortunate state of functioning and being'[47] and that 'the issues caused by disability [are] coming from the person's impaired body or mind'.[48] The concern put forward is that, in fact, 'one of the most prominent factors preventing disabled people from enjoying human rights is the prevalence of the medical model'[49] since 'the very notion of disability evokes the idea of being 'less' than others, at least in a biological sense'.[50]

Relating this to another theory – the core (mis)understanding of what mental health is as a concept. Szasz critiques on the grounds that 'we use one set of laws to explain sane behaviour, which we attribute to reasons (choices), and another set of laws to explain insane behaviour, which we attribute to causes (diseases).' This purports the idea that a mentally healthy person is viewed as an active agent and can make decisions, whereas someone with mental illness is treated more as a passive object that is the victim of processes happening to his/her body.[51] This creates a negative view of the mentally ill, and may be preventing the finding of the true causes of such behaviours. Szasz uses the example of a Schizophrenic pushing someone in front of a train, point out that it is not just because of the schizophrenia, but something that made the person do this at that time – because there are millions of mentally ill people who are not violent.

Although this is an abstract proposal, it allows us to look to the heart of why these occurrences are happening and recognise the individuality of circumstance within each person. It is not incompatible with the current conception of illness because the key theme here and in the medical model is causation – but this just redefines it. This looks to a third way – 'recognising that bodies are lived in, but in the social spaces that they inhabit'.[52]

By encouraging a bio-psychosocial model (a model which considers biological, psychological and social elements to health and their complex interactions), patients are seen as active agents instead of victims defined by illness. This could encourage recovery – since the mind has so much to do with outside experiences and not just biological processes. Further, this approach would help to change attitudes towards mental health patients and ensure that medical discretion takes account for social and biological causes and remedies.

Additionally, the vast majority of homicides are committed by people without mental illness,[53] meaning that by recognising that causes result in violence, and not illnesses, it would allow for better prediction and prevention. This step would make sense since mental

[35] Rainer Goldbeck, Donald McKenzie and Peter Bennie, 'Detained Patients' Knowledge of their Legal Status and Rights' (1997) 8 Journal of Forensic Psychiatry 573.
[36] Stefan Priebe et al, 'Patients' Views and Readmissions 1 Year After Involuntary Hospitalisation' (2009) 194 British Medical Journal 49.
[37] William Gardiner et al, 'Patients' Revisions of Their Beliefs About the Need for Hospitalisation' (1999) 156 American Journal of Psychiatry 1385.
[38] Lindsey Sherdell, Christian E Waugh and Ian H Gotlib (n 31).
[39] Premal Shah and Deborah Mountain (n 6).
[40] Lawrence O Gostin, 'Cotemporary Social Historical Perspectives on Mental Health Reform' (1983) 10(1) Journal of Law and Society 1.
[41] ibid 48.
[42] ibid 47.
[43] ibid 48.
[44] Premal Shah and Deborah Mountain (n 1) 10.
[45] ibid 2.
[46] Sara Goering, 'Revisiting the Relevance of the Social Model of Disability' (2010) 10(1) Am J Bioeth 54.
[47] Jennifer Nedelsky, *Law's Relations: A Relational Theory of Self, Autonomy and Law* (Oxford University Press 2012).
[48] Colin Barnes and Geof Mercer, *Implementing the Social Model of Disability: Theory and Research* (Leeds, The Disability Press 2004) 2.
[49] Gerard Quinn and Theresia Degener (eds), 'Human Rights and Disability: The Current Use and Future Potential of United Nation Human Rights Instruments in Context of Disability' (Office of the United Nations Commissioner for Human Rights, Geneva 2000).
[50] Premal Shah and Deborah Mountain (n 1) 3.
[51] Thomas Szasz, 'Mental Illness: Psychiatry's Phlogiston' (2007) 27 Journal of Medical Ethics 297.
[52] Dan Goodley, 'Disentangling Critical Disability Studies' (2013) 28(5) Disabil Soc 631.
[53] Pamela J Taylor and John Gunn, 'Homicides by People with Mental Illness: Myth and Reality' (1999) 174 British journal of Psychiatry 9.

illness is an unreliable indicator,[54] and therefore the mentally ill can also cease to be discriminated against in this manner.

In practice, a more abstract model may be difficult to implement, but one place to start may be in line with the fusion approach where capacity is a key factor in detention, hence it depends if the mental disorder impairs decision-making.[55] Although it seems to be less directly discriminatory against the mentally ill, it raises difficulties on whether the decision would be to consent to admission or to treatment, and how much patients would have to know about their condition. The UN Convention on the Rights of Persons with Disabilities takes this one step further by removing disability as a factor, which would seem fairer as we do not detain people without mental disabilities, when there is stronger evidence of dangerousness among such people than among people with mental illnesses.[56] Nevertheless, due to the possibility of abuse of this system, the CRPD model may need to just focus on the severity of people's behaviour with harm to themselves, since this likelihood significantly increases when someone has a mental illness,[57] despite how politically difficult this may be to implement.

Conclusion

When considering the merits of each model, legalism is needed but in a much more intricate way in order to take account for medical and judicial discretion. Further, it needs to be backed up by a change in the stance of doctors which must be driven by self-regulation of the medical profession. This must be accompanied by changes in attitudes from the judiciary and parliament in order to ensure that whatever discretion is in fact exercised, is used in line with the intentions of the act. This would ensure greater consistency between the aims of the act and the reality.

With regard to the medical model theoretically, as long as there is account taken for the social model too, a fused approach between all of the models' benefits would seem to care for patients the most.

On paper, the MHA 1983 seems to lean away from the traditional medical model. However, even when the CoP encourages a more patient-centred approach, case law and the flaws practically make it very clearly still a medical model. The extent to which this is damaging for patients depends on whether doctors focus on patient empowerment and a bio-psychosocial model of disease when considering mental illness and the treatment of patients.

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