

# What We Should Consider When We Next Amend the Mental Health Ordinance of Hong Kong

Following the recent amendments to the UK Mental Health Act (MHA) 2007,<sup>1</sup> it may be time to examine the Mental Health Ordinance (MHO) of Hong Kong (HK) for any areas we may also consider amending. This editorial summarises our recommendations based on views expressed at the College Symposium on Forensic Psychiatry held on 12 April 2008.<sup>2</sup>

## Overview of the Mental Health Ordinance

The entire MHO may be viewed as legislation seeking a balance between paternalism and patient autonomy. We think that there may be *room for further extension of paternalistic care* to those who need it, subject to the approval of society, and prevention of abuse. (Rationale — there are still significant numbers of patients with mental illness who remain untreated in society because of lack of insight. On the other hand, there is no evidence of excessive infringement of human rights by the execution of the MHO in HK up to this moment.)

## Part I — Preliminary

### Section 2(1)

- (i) The *definition of the term mentally incapacitated person (MIP) should be restricted* to “a person who is incapable, by reason of mental incapacity, of managing and administering his property & affairs”. (Rationale — at present, the definition of the term MIP is too broad, as it also covers any mentally disordered or mentally handicapped person, irrespective of his mental capacity. Under the current definition, a paradoxical situation may arise in which a MIP may not in fact be mentally incapacitated, which creates a lot of confusion with communication.)
- (ii) *The present broad definition of the term mental incapacity can then be replaced by the term mental disorder*, which can be defined as “any disorder / disability of mind including mental handicap”. (Rationale — the current separation of mental handicap from mental disorder does not in fact result in any material change of practice, since a person suffering from a mental handicap can still be detained in a psychiatric hospital if he exhibits abnormally aggressive or seriously irresponsible conduct.)
- (iii) *The requirement that a relative be aged 18 or above* should also cover “any person with whom the MIP resides or has resided”. (Rationale — at present a co-resident below 18 can act as a relative of the MIP. It is illogical that a blood relative below 18 is excluded from the MHO, but a co-resident below 18 who may not even be a relative in the ordinary sense can be included.)

- (iv) We may consider adopting 2 new terms created in the recent amendment of the UK MHA: — “*Approved Clinician*” to replace “registered medical practitioner”, and “*Approved Mental Health Professional*” to replace “approved social worker”. (Rationale — given the increasingly important contributions by different disciplines in psychiatric teams, it may be operationally appropriate to open some powers under the MHO to other disciplines like community psychiatric nurses, occupational therapists, clinical psychologists — e.g. as applicants for Form 1 or guardianship.)

### Section 2(2)

*A medical practitioner approved under this section should be extended* to cover S.44A (Guardianship Order [GO]), S.44D (Supervision & Treatment Order [S&TO]), S.45 (Hospital Order [HO]), S.54 (3) (HO), Criminal Procedure Ordinance (CPO) S.75 (Fitness to be tried), CPO S.76 (HO). (Rationale — at present the required qualifications of medical practitioners for various purposes are extremely inconsistent, e.g. a HO under S.45 or S.54 (3) requires only a medical officer in the public service with any qualification, whereas a HO under the CPO requires 2 psychiatric specialists. While the former requirement is too low, the latter may be too high, and the inconsistency is creating confusion. Section 2(2) approved practitioners may have the appropriate qualification levels for all purposes.)

### Section 2(5)

*“Sexual deviancy” and “dependence on alcohol or drugs” may be removed from the exclusion items* in the definition of mental disorder. (Rationale — these 2 items are accepted psychiatric diagnoses, and excluding them from the legal definition of mental disorders has created confusion among clinical professionals. On the other hand, “immoral conduct” can legitimately remain on the exclusion list.)

## Part II — Management of Property and Affairs of MIP

### Section 7(3)

*A friend should also be allowed* to apply. (Rationale — sometimes a MIP has no relatives, but a friend may act as his advocate.)

## Part III — Reception, Detention and Treatment of Patients

### Section 30

- (i) The *category of voluntary patients may be repealed*,

by converting all of them into informal patients. (Rationale — by categorising all voluntary patients as “formal” patients under the MHO, the ordinance has created the false impression that most psychiatric patients in hospitals are involuntary whereas in actual fact the involuntary patients constitute a minority of the patients inside psychiatric hospitals.)

- (ii) If the above proposal is adopted, we may need to give the hospital staff a period of **statutory holding power to prevent an informal patient from leaving** when he wishes to leave hospital against medical advice. (Rationale — this is to allow the staff the time required for arranging a Form 1/2/3 or Form 7 [certifying the patient] where necessary. Such a statutory power is available at present for voluntary patients.)
- (iii) On the other hand, if the voluntary patient category is preserved, **for a patient between age 16 & 18, either he or his parents should be allowed to sign the Voluntary Form.** (Rationale — in the current MHO, a loophole concerning our control over a patient between age 16 & 18 exists, because his parents can neither sign the Voluntary Form for him, nor apply for Guardianship under Part IVB.)

### Sections 31, 32, 36

For the purpose of **Form 1/2/3, 4 or 7, the requirement for the signature of a magistrate or judge may be removed.** (Rationale — the requirement that a judge be involved has created a lot of administrative difficulties and potentially harmful delays in treatment for the patient. If the requirement for a judge is removed, prevention of abuse can be provided by a more stringent statutory review of the case after detention. This is what is being done in the UK.)

### Section 39

If a certified patient has been granted **leave of absence continuously for a prolonged period, say more than 6 months or a year, the medical superintendent should no longer have the power to recall him** to the mental hospital. (Rationale — absence on trial should not be used as a means to control a patient indefinitely. If long-term control is required, we should apply a proper Conditional Discharge [CD] or Community Treatment Order [CTO].)

### Section 42B

- (i) The law should **empower the Immigration Department to inform the Hospital Authority** whenever a psychiatric patient on CD (who by definition is a potentially dangerous person) crosses the HK border. (Rationale — at present, patients on CD may leave the HK SAR, and thereby breach the conditions stipulated in the CD, without our knowledge. Nor do we know when they return to HK. This can sometimes lead to disastrous consequences, which should be preventable.)
- (ii) The Mental Hospital should have the **power to recall a patient on CD when he relapses, even if he is**

**still complying with the conditions.** (Rationale — at present we cannot recall a patient on CD so long as he is complying with the conditions. Given that patients on CD are potentially dangerous people, we should facilitate their re-hospitalisation when they relapse, otherwise they have to undergo unnecessary delay by being routed through accident & emergency departments and then undergoing all the procedures involved during an application for a Form 1/2/3.)

- (iii) At present in HK, compulsory community treatment is available in 2 forms, viz. CD for violent patients discharged from psychiatric hospitals, and S&TO for insane offenders, in other words both are for the “protection of others”. If we wish to extend the scope of compulsory community treatment, we **may consider adopting the new CTO used in the UK**, which is equivalent to our CD but also covers non-violent patients, in other words these are for the “patient’s health and safety” in addition to the “protection of others”. (Rationale — the chief controversy over whether we should extend the scope of compulsory community treatment lies in what level of potential human rights infringements that society is willing to accept in order to enable greater access to treatment for non-consenting mental patients within the community. The UK model appears to represent the lowest and therefore most prudent, and likely-to-be-accepted, step that we may move to. The Australian model applies also to never-hospitalised patients, and may therefore arouse greater objections from society. The North American model, on the other hand, puts too much emphasis on human rights, as it operates on a competency principle, in such a way that the CTO would cease once the patient recovers competency. This results in a revolving door between putting somebody on a CTO then taking him off a CTO after a short while. A Cochrane review [2005] showed that 2 randomised controlled trials in the USA found little evidence that the American CTO was effective.<sup>3)</sup>

## Part IIIA & IIIB — Guardianship Order and Supervision & Treatment Order

A GO and S&TO **should be available to all kinds of mentally abnormal offenders.** (Rationale — at present, these 2 orders are applicable to only 2 categories of offenders, viz. those not guilty by reason of insanity, and those not fit to stand trial. We think that other categories of mentally abnormal offenders may also benefit from these 2 orders.)

## Part IV — Admission of Criminal Cases

### Section 47

For patients **under a HO, the doctor should be given the power to grant home-leave or discharge** according to their clinical condition, unless specifically prohibited by a Restriction Order. (Rationale — at present, the doctor

has no such power, unless specifically endorsed under Section 45(1A). As a consequence, a patient who has clinically recovered to such an extent that he is suitable for discharge may have to remain longer in a psychiatric hospital unnecessarily, in order to serve the remaining pre-set duration of the HO.)

### **Sections 52 & 53**

The *scope of a Transfer Order (TO) should be extended* to cover the transfer of prisoners, not only to psychiatric hospitals, but also to Correctional Services Department Psychiatric Centres (CSDPC). (Rationale — at present, when a patient is transferred from prison to CSDPC, the psychiatrist has no authority to treat him if he refuses treatment. This can be rectified if such a patient can be placed on a TO.)

### **New Proposals for Part IV**

- (i) We may consider setting up a *specialist court to deal with mentally disordered offenders*, such as the Mental Health Courts in the USA and the Mental Health Tribunal in Queensland. (Rationale — although the structure of mental health courts varies across jurisdictions, common features include a separate dock for defendants with psychiatric disorders; a designated judge [and typically also designated prosecution and defence counsels]; a non-adversarial team approach involving cooperation and joint decision-making by criminal justice and mental health professionals; and therapeutic goals. A recent study has provided evidence of the effectiveness of a Mental Health Court as a means of reducing criminal recidivism and violence.<sup>4</sup>)
- (ii) We may set up laws to *protect the rights of victims of mentally disordered offenders*, e.g. the right to be informed about such offenders' discharge, and if it is a CD, what those conditions are. (Rationale — HK has no such law at this moment. Potential victims of a violent offender should be protected, although the victim should also have the right not to be informed should he prefer this.)

## **Part IVA — Mental Health Review Tribunal (MHRT)**

### **Section 59B(1)**

The law should state clearly what is expected when a patient detained under Form 1/2/3 (which lasts 7 days) or Form 4 (which lasts 21 days) applies to the MHRT. Even if the MHRT starts processing the application immediately, *the actual hearing cannot normally take place until a date which falls beyond the expiry date of Form 1/2/3 or Form 4*. (Rationale — the time-frames stipulated in the MHRT rules are in terms of weeks or months rather than days, in order to allow adequate time for giving notice to relevant parties and preparation of the required statements and medical and social reports. In addition, present resources

only allow the MHRT to sit once per week. Consequently, if a patient detained under Form 1/2/3 or Form 4 applies to the MHRT, it only becomes meaningful if that patient eventually becomes a Certified Patient under Form 7. Such a patient would have his hearing date a few weeks earlier than he would if he postponed his application until he became a Certified Patient.)

### **Section 59B(2)(c)**

Applications for review from *persons on Guardianship under both Part IIIA & Part IVB should go to the MHRT rather than the Guardianship Board (GB)*. (Rationale — at present there is inconsistency here, in that reviews on Guardianship under Part IIIA go to the MHRT, but reviews on Guardianship under Part IVB go to the GB. Since the GB is the body that appoints the guardian under Part IVB, it may not be appropriate for it to review complaints against its own decisions. All reviews of Guardianship should therefore go to the MHRT rather than the GB.)

## **Part IVB — Guardianship**

### **Section 59R(3)**

The guardian should be given a *power to admit the MIP to a psychiatric hospital*. (Rationale — while the guardian has many powers in relation to the care and treatment of the MIP, at present he has no statutory power to admit the MIP to a psychiatric hospital when the MIP is non-compliant. The guardian will be more effective, if he is given the power to either sign a Voluntary Form on behalf of the MIP [just like he can sign a Consent Form for surgery on behalf of the MIP], or to act as an applicant on Form 1 [just as a relative can].)

### **Section 59Z**

Procedures for *application to the GB should be simplified*. (Rationale — at present Guardianship is still under-utilised for many of the MIPs who need it. One reason may be that the application procedures are too complicated, deterring the mental health workers concerned from using it. This is called the “virtual discharge” phenomenon.)

## **Part IVC — Medical and Dental Treatment**

### **Section 59ZF(3)**

For an adult MIP who is incapable of giving consent and who does not have a legal Guardian, the status of “second opinion” is at present not stated in the law. We may consider *creating a new category of treatments for which a second opinion is mandatory*. (Rationale — for such patients, there is at present a hierarchy of 3 levels according to the stringency of requirements:

Level 1 — The treatment should never be done in the absence of the patient's own consent. [This includes donation of the MIP's organ (while alive) to another person, or any treatment on which the MIP has previously executed a valid Advance Refusal.]

Level 2 — The treatment cannot be done unless consent is provided by the High Court. [This is called “Special Treatment”, and at present includes only sterilisation.]

Level 3 — All other treatments can be carried out if only one registered medical practitioner considers that treatment is necessary and in the best interests of that MIP.

In view of the broad range of treatments covered by Level 3, it may be reasonable to insert 1 additional level between the existing second and third levels specifying treatments that cannot be done unless supported by a specified second opinion. For instance, all treatments carried out under general anaesthesia [including electro-convulsive therapy] can be put here.)

## Part V — General Provisions

### Section 70

We may also include the following as *offences under the MHO*: (a) forgery, (b) false statements, (c) assisting detained patients or those under guardianship to absent themselves without leave, (d) obstruction of an authorised person under the ordinance. (Rationale — these are meant to protect the best interests of the MIPs.)

### Sections 71A & 71B

Aside from accident & emergency departments, a “*Place of Safety*” may also include: (a) hospitals, (b) police stations, (c) residential homes for the mentally disordered or mentally handicapped, (d) any other suitable place where the occupier is willing to temporarily receive the patient. (Rationale — this provides more options to mental health workers and police, and would therefore meet the different needs of different patients.)

### New Proposals for Part V

- (i) *Patients aged below 18 admitted to hospital for mental disorders* should be accommodated in an age-appropriate environment. (Rationale — at present, child / adolescent patients are often mixed with adults in psychiatric hospitals, with potentially adverse effects on these youngsters.)
- (ii) *Any member of the Legislative or Executive Council who is detained in a mental hospital* should be examined by independent doctors appointed by the HK College of Psychiatrists. (Rationale — in society’s interests, it is prudent to evaluate clearly whether these councillors are able to continue to serve in their positions of influence. For political reasons, it is advisable that such evaluations be done by independent psychiatrists. This will also give the

College status.)

## Do We Need a Separate Mental Capacity Ordinance (MCO)?

- (i) Putting everything into a single *MHO is preferable to having 2 separate ordinances*. (Rationale — since both the MHO and the MCO are dealing with persons who lack mental capacity, having 2 separate laws is confusing because people may not know which ordinance they should refer to in which situation.)
- (ii) We may then *add 1 new Part to the MHO on Mental Capacity*, covering such subjects as Advance Directives (AD), Lasting Power of Attorney (LPA), and the Court of Protection. The 2 newly invented patient advocate categories in the UK MHA (2007), the Independent Mental Capacity Advocate (IMCA) and the patient’s Deputy, are probably unnecessary for HK. (Rationale — AD and LPA are decisions made by the person himself before he loses his mental capacity, and therefore provide a new horizon worthy of consideration. On the other hand, the IMCA and the Deputy are not really needed in HK because their roles can be covered by the Guardian role, which already exists. These 2 new entities are needed in the UK because their guardians have more limited powers than their equivalent in HK, e.g. he / she cannot consent to treatment or control patient’s money.)

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