Conditions for Compulsion

Current law

The Mental Health Act 1983 sets out the criteria for compulsory admission to hospital as follows:

- The person must be experiencing a mental disorder of a nature or severity to make admission appropriate;
- If the person is being detained because of psychopathic disorder or mental impairment there must be treatment which will improve or prevent deterioration in the person's condition;
- Voluntary admission must have been refused;
- All options for a less restrictive alternative must be explored;
- Admission must be in the interest of the person's own health or safety, or for the protection of others;[1]
- Persons may not be dealt with under the Act by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.

The reduction in the number of hospital beds has made it harder to be admitted to hospital, so people are often admitted at a later stage of a crisis. There have also been a number of high profile incidents where people with personality disorder have been turned away by services because their condition is not treatable and they have then gone on to commit violent crimes. These situations have spurred demand for change to the law.

White Paper policy – reduction of compulsion

"*Grievous is the wrong of unjust imprisonment of an alleged criminal. I apprehend that its colours pale beside the catastrophe of unjust imprisonment on an unfounded finding of insanity. ….. It is the effect on the mind sane, even if feeble, that knows itself wrongly adjudged unsound that produces the most poignant suffering*."[2]

The Government's White Paper of December 2000 states as its aim the reduction of compulsion. The reasons for a reduction in compulsion are compelling. Compulsory admission can be a traumatic experience for the person being admitted, and for those close to them. The fact of compulsory admission can have a damaging effect on the person's condition, and can delay recovery.

2004 Draft Bill

[1] Compulsory admission can be for assessment (section 2), which can last for up to 28 days; or for treatment (section 3), which can last for up to six months and can be renewed for a further six months initially and for further periods thereafter. Criteria which must be fulfilled for renewal to be lawful include that the treatment must alleviate or prevent deterioration in the patient's condition or, for those suffering from mental illness, that continued detention will prevent serious abuse or neglect. There are also powers to make an emergency admission (section 4), which can only last for 72 hours unless a second medical recommendation is obtained, which converts the admission to one for assessment.

[2] Atkin L.J. Everett (pauper) v. Griffiths 1920

The Bill lists the following conditions:

A) The first condition is that the patient is suffering from mental disorder.

B) The second condition is that that mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him.

C) The third condition is that it is necessary –
(1) For the protection of the patient from –
- Suicide or serious self-harm, or
- Serious neglect by him of his health or safety, or

(2) For the protection of other persons,
that medical treatment be provided to the patient.

D) The fourth condition is that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part.

E) The fifth condition is that medical treatment is available which is appropriate in the patient's case, taking into account the nature or degree of his mental disorder and all other circumstances of his case.

F) The fourth condition does not apply in the case of a patient aged 16 or over who is at substantial risk of causing serious harm to other persons.[3]

G) For the purposes of this Part, a determination as to whether a patient is at substantial risk of causing serious harm to other persons is to be treated as part of the determination as to whether all of the relevant conditions appear to be or are met in his case.

Alliance position

While the 2004 Draft Bill has tightened the conditions for compulsion in relation to those set out in the 2002 Draft (which the Alliance welcomes) they remain broader even than those in the current law, let alone those delineated by the Expert Committee. We have not discovered any other developed country with a Mental Health Act which has such an all embracing definition of mental disorder combined with such loose criteria.[4] The Draft Bill provides the legal framework for an increase rather than a reduction in the amount of compulsion.

In particular:-

(i) The Bill significantly lowers the threshold for compulsion because it simply requires the disorder to be "of nature or degree to warrant…medical treatment" rather than "of nature or degree to *require compulsory detention in hospital*".

[3] It should be noted that this deviates from the 'least restrictive option' principle.

[4] For a discussion of Canadian jurisdictions see Gray and O'Reilly, *Clinically Significant Differences Among Canadian Mental Health Acts*, Canadian Journal of Psychiatry, Vol.46 No 3, p.315. Of 12 jurisdictions one (Newfoundland) has arguably broader powers: See also the Irish Mental Health Act ; Scottish Mental Health Act(2003); NSW Mental Health Act(1990); S.A. Mental Health Act 1993; Australian jurisdictions.

(ii) There will be increased use of compulsion over people with a mental disorder who are seen to pose a threat, however slight, to others. This also contrasts with the higher threshold for those who are a risk to themselves.

(iii) A person who poses a significant risk of serious harm to others would need to be detained despite his/her willingness to receive treatment on a voluntary basis.

(iv) There is no residual discretion for the decision-makers to not treat a patient compulsorily if s/he fulfils the criteria but has the capacity to accept treatment voluntarily.

(v) Because the criteria for compulsion are so broad it will be difficult for a patient to establish the grounds for his/her discharge if the clinical supervisor opposes it.

(vi) Unlike the 1983 Act, compulsory powers can be used for people who are not ill enough to warrant admission to, and compulsory treatment in, hospital but who will be assessed and treated in the community.

(vii) The broader criteria for "appropriate treatment" fail to require a person to receive a benefit from treatment.

Overall, we believe that this will lead to increased demands on a health and tribunal system that is already over stretched and characterised by patchy services.

Cases where the law will be practicable due to the loose criteria for compulsion:

The depressed woman who fails to keep her appointments with the psychiatrist because she doesn't think the medication is helping her; the woman with a dual diagnosis of drug addiction and depression who is self harming but wants to be left alone to be with her boyfriend; the young woman with learning difficulties whose unruly behaviour is offending the neighbours; the young person with behavioural problems at school and a diagnosis of attention deficit disorder who is aggressive to other children and the school feels that he needs clinical treatment; the man with schizophrenia who, although he has gone off his medication and is hearing voices, is managing to cope with the help of a support group but whose mother is worried he will relapse; a young woman with a borderline personality disorder who is acting aggressively and whose relatives want her out of the way.

Each of these people may well need supportive mental health services – home treatment, assertive outreach, early intervention, or crisis resolution services- but none of them might be considered ill enough to warrant hospitalisation. However if they refuse to take the treatment proposed for them and come into contact with inexperienced professionals they could be, indeed might have to be, made subject to compulsion. People in this situation tend to disengage from services. Disengagement may mean that someone who, with the appropriate support and treatment, could have been reintegrated back into, and contributed to, society, instead loses that potential and becomes a cost to society.

The need for hospital

While we appreciate that community services are being developed to cater for people in crisis we remain persuaded that admission to hospital is an appropriate threshold. We do not believe that compulsory powers should be used for patients who do not need hospital attention at least in the initial stage.

Capacity and impaired decision-making

The British Psychological Society evidence to the Joint Committee states:
"[W]e note that the Human Rights Act legitimises such compulsion only in the case of "persons of unsound mind". As psychologists, it is axiomatic that being "of unsound mind" equates to being significantly impaired in decision-making—in this case being harmfully and significantly influenced by the mental disorder.

We believe that the vast majority of patients currently detained under the Mental Health Act (1983) who have serious mental illnesses would quite clearly be demonstrably and significantly impaired in their decision making because of their mental disorder. We believe that psychologists and psychiatrists already make these judgements frequently in their clinical practice. Therefore, we do not believe that such a criterion would be unworkable in practice.

As healthcare professionals, we are naturally distressed when we hear of those very few patients who threaten, or commit suicide and who appear unimpaired in their decision-making. We do not believe that these people should merely be "allowed to kill themselves". We believe that these issues can best be addressed through the provision of appropriate consensual services. We think that all necessary services should be available, offered and assertively provided. Indeed, it is important to stress that the Mental Health Act does not prevent suicide. If it were implemented perfectly, it could not prevent all suicide. Unfortunately, the best quality available treatment frequently does not prevent suicide. We should not bias the Mental Health Act inappropriately away from the principle of autonomy, in a vain attempt to do the impossible."[5]

The conditions for compulsion should include the need to show that the person has significantly impaired decision-making capacity in relation to treatment

The current Act treats people with mental illness differently from those with physical illness- this is discriminatory. People who are physically ill are not detained in hospital against their will because they refuse to take the treatment that should improve their condition; nor should people with mental illness.

The Alliance accepts the view of the Expert Committee that, in the face of a mentally ill person at risk of committing suicide for example, professionals would find it difficult to just stand by on the grounds that the person could not be shown to lack capacity. The temptation to broaden the definition of incapacity might be considerable. In the light of the clear definition of capacity in the Mental Capacity Act 2005, it would be unfortunate to cause confusion around this concept and to create a situation where different approaches to the same concept were used for different groups of patients.

[5] British Psychological Society, *Report of the Joint Committee on the Draft Mental Health Bill, Volume II*, Nov 2004. Ev. 606-607.

An alternative is to acknowledge that mental illness may impair decision-making ability. This is seen as a softer option to mental capacity in that it may permit a more relative approach. It does not ask whether a person is unable to understand and make a decision in relation to a particular issue, rather whether their ability to make decisions is *"impaired".* The more serious the decision, the less evidence of impairment may be required. It also relates more closely to the way in which clinicians assess patients for clinical reasons.

Dr Tony Zigmond of the Royal College of Psychiatrists has stated: *"One of the acknowledged difficulties with the current definition of "incapacity" is that it relies almost entirely on a person's ability to think, what we call cognitive ability, and we recognise that in the field of mental health, of course, emotions play a large part, and so at a very practical clinical level we think that the notion of impaired decision-making by reason of mental disorder would be much easier for people to understand and relate to patients with mental health problems and, of course, it would keep us in line with the provisions in Scotland."*[6]

The Scottish Mental Health Act permits compulsion only if the person has impaired decision-making in relation to medical treatment. Under the Scottish Mental Health Act, a compulsory treatment order requires that:

i. The patient has a mental disorder;
ii. Medical treatment:
    a. would be likely to prevent the mental disorder worsening or alleviate any of the symptoms or effects of the disorder;
    b. is available for the patient;
iii. If the patient is not provided with the treatment there would be a significant risk to health, safety, welfare of the patient or safety of others;
iv. Because of the mental disorder the patient's ability to make decisions about the provision of such treatment is significantly impaired;
v. That making the order is necessary.

This approach was supported by the Joint Committee:
"*We recommend that the Bill, as in the Mental Health (Care and Treatment) (Scotland) 2003 Act, include a condition at clause 9 that by reason of mental disorder the patient's ability to make decisions about the provision of medical treatment is significantly impaired*".[7]

There should be room for discretion on the part of decision makers, including the tribunal, over whether to subject to compulsion a patient who meets the conditions.

The Bill makes clear that while there is room for clinical judgement as to whether the person is at risk, or treatment is "appropriate", if the conditions are met there is no residual discretion for the decision-makers (Clause 16). Under the 1983 Act the presence of the conditions permits but does not compel detention, and the absence of a condition does not prohibit it. The British Association of Social Workers has stated that in their view, with the removal of the discretion which at present allows them to take into account the person's capacity and other circumstances of their case, they will be forced to detain, "*very large numbers of people suffering from self neglect caused by drug or alcohol misuse but who retained capacity to make their own decisions and would not be seen as detainable at*

[6] Tony Zigmond, Royal College of Psychiatrists, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, 27 October 2004, Ev.80
[7] *Report of the Joint Committee on the Draft Mental Health* Bill, 2005. Volume I, p.55

present."[8] Given that hospitals could not cope with the numbers of people involved, examiners would have to use non-resident assessment and treatment even where this was impracticable because of the patient's situation.

In further explaining the situation Roger Hargreaves for BASW said:
"*The discretion can only be exercised to a limited extent within each condition and not globally. In particular, it cannot be used to take into account factors that are not envisaged in the conditions, capacity being one of them, the views of relatives and carers being another. There is very extensive provision in the Bill for consultation with relatives and carers, but if all the conditions are satisfied and the carers nevertheless say, "We would like to carry on caring", the discretion to allow that to happen does not exist because there is no provision for that to be taken into account. At the moment that is one of the main reasons why ASWs do not proceed with an admission.*"[9]

The conditions should include the need to show that it is necessary to use compulsory powers in order to effect treatment in all cases

We disagree with the decision to impose compulsion on those in the more serious category of risk irrespective of their willingness to comply with medical treatment. Case law makes clear that practitioners can impose compulsion on patients whose fluctuating or perhaps self-serving consent (as shown by past history) makes it unreliable.[10] No extension to this should be permitted. It is also unnecessary since professionals can always use compulsory powers if cooperation changes to resistance. If people are partners in their care and treatment, they will take responsibility; coercion where it is not needed disregards personal autonomy and may contravene human rights.

Treatment and notion of therapeutic benefit

The Alliance supports the inclusion of psychological treatment in the definition of treatment. It is recognised that drug treatment alone may not be the best treatment and is considerably more effective if combined with talking therapy.

However, treatment in the Draft Bill is very broadly defined - to include education and training, habilitation (including social skills) and rehabilitation.[11] This is to take place under an approved clinician who, unlike now, may not be a psychiatrist. With the breadth of the definition as it is, "*a person who is drug-dependent and whose behaviour is anti-social and alarming may be said to have a mental disorder that warrants providing medical treatment, in the form of work training or social skills training, under psychological supervision.*"[12] Coupled with a vague notion of "appropriateness" it will provide any "clinician" with sweeping requirements to detain. What may seem "appropriate" to the clinicians may not be so for the patient.

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[8] British Association of Social Workers *Report of the Joint Committee on the Draft Mental Health Bill,* Volume II, Nov 2004. Ev..578, para.10.

[9] Social Services Inspectorate (SSI) report "Detained", published in February 2001 was based on an inspection of ASW services in 10 local authorities. This found that 35% of patients assessed by ASWs for possible compulsory admission were not subsequently detained in hospital.

[10] *Jones Mental Health Act Manual*, 8th Edition, 2002, p33.

[11] "The court's interpretation of treatment under the 1983 Act is so wide that it has reduced the requirements of the necessary effect of that treatment to the point where it is difficult to exclude anything done to the patient within the hospital from its ambit as long as a person is contained in a therapeutic environment." A. Foster QC, *Treating People: Conflict of Rights* Conference Paper, 15 Oct 2004.

[12] IMHAP, *Report of the Joint Committee on the Draft Mental Health Bill,* Volume II, Nov 2004. Ev..93.

The conditions should state that the use of compulsory powers must have a therapeutic benefit for the patient

Therapeutic benefit could be defined as treatment which is likely to bring about an "improvement in the symptoms, or signs, of mental disorder, or reduce or prevent deterioration in the person's mental health".

The vagueness of the fourth condition falls short of a requirement to show that the individual will receive some benefit from the treatment. Given the breadth of the concept of treatment we consider it essential to include a concept of benefit. Again this view is supported by the Joint Committee:
"*We recommend that the Government amend the fifth condition at clause 9(6) of the draft Bill so as to include a test of therapeutic benefit as used in the Scottish Mental Health (Care and Treatment) (Scotland) Act 2003.*"[13]

Without it, the possibility of the Act being used as a form of preventive detention cannot be excluded. It is important to avoid the situation where people with severe personality disorders, deemed to be dangerous, are made subject to compulsion with a view to indefinite containment without a demonstrable benefit to them. The Joint Committee is quite clear that such people should not be dealt with through mental health legislation:
"*We conclude that people with serious mental disorders who cannot benefit from treatment pose a very challenging problem, but recommend they be dealt with under separate legislation.*"[14]

It is an unethical use of resources for mental health facilities to be used to warehouse dangerous people. Given the scarcity of hospital beds, this could only occur at the expense of those patients who could be helped but for whom no bed is available. Indeed, Professor Eastman in his evidence argued that one, *"should never use civil powers for preventive detention where there is no therapeutic benefit"*[15] for a number of ethical and practical reasons.

Extra support for this argument can be found from a human rights perspective. Although ministers have made clear their view that their proposals are compatible with human rights legislation, the Alliance believes the Draft Bill's proposals for non-convicted offenders are particularly open to challenge in this respect. Psychiatric units, if retaining patients they can no longer treat, will be seen as facilities practising a form of social control, rather than health care. Mental health legislation must not be misused for detention simply to address failings of the criminal justice system in containing dangerous individuals. Such extension of an exception to the right to liberty and security was severely criticised by the European Court in the case of *Guzzardi v. Italy* (in which an admitted Mafioso was detained beyond any sentence on the supposed grounds of being a "vagrant").

Not including a treatability clause would also give too much leeway for disputes between lawyers and clinicians at tribunal hearings. The Expert Committee considered the need to show positive clinical measures which were likely to prevent deterioration or secure improvement in the patient's mental condition and concluded that "*a health intervention of likely efficacy*" was required.[16]

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[13] *Report of the Joint Committee on the Draft Mental Health* Bill, 2005. Volume I, p.50
[14] ibid.
[15] Professor Nigel Eastman, *Report of the Joint Committee on the Draft Mental Health Bill,* Volume II, 8 Dec 2004. Ev. 347
[16] *Review of the Mental Health Act 1983*, November 1999, para 5.98.

Risk and Dangerousness

The Draft Bill is distorted by an emphasis on the protection of others from dangers posed by those with mental disorder. Throughout the legislation the duty to detain dangerous people (i.e. those who pose a significant risk of serious harm) takes precedence over both the human rights of the detainees[17] and the clinical judgment of the decision-makers.[18] As the Joint Committee stated, "*The primary purpose of mental health legislation must be to improve services and safeguards for patients and to reduce the stigma of mental disorder.* [19] The Alliance acknowledges that the protection of others is a legitimate goal of the law. However, we believe that the overemphasis on risk is misplaced and will backfire and far from protecting public safety, it will undermine it.

As the Institute of Mental Health Act Practitioners states:
"*Even if people are inadequately protected from the actions of people who have a mental disorder, this may not be a fault of our laws. It may be due to insufficient resources, poor government, poor service management, poor risk management, faulty practice, a faulty understanding of the law, or simply part of the human condition. In other words, a problem or limitation that is to a significant extent replicated across a world full of different mental health laws."*

"Implicit in any discussion about the need for new laws is the assumption that modifying their content modifies outcomes. However, the extent to which this is true is unclear. Legislation is actually a relatively ineffective means of modifying behaviour. Although it can provide a framework for managing violence associated with mental disorder, it cannot significantly reduce these risks. That this is so is clear from the many homicide inquiry reports. Had the professional carers foreseen what was about to happen, they already had power under the present law to intervene. That they did not intervene was due, not to any lack of legal powers, but to the fact that they did not foresee what was about to occur. Yet no amount of new legislation can improve foresight."[20]

The Bill bases the need for compulsion on the risk that a person poses to themselves or to others as a result of their mental disorder. In the case of people who pose a risk to others there are two categories- those who need compulsion for the protection of others and those who are deemed to be *"at substantial risk of causing serious harm to other persons."*

King's College London states:
"Thus, the 'protection of others' applies to risk which may be substantial but not serious, or serious but not substantial, or neither serious nor substantial. It is thus very unclear what it meant by the 'protection of others' and what others are to be protected from."[21]

The Alliance supports the recommendation of the Joint Committee: "We recommend that the criterion at clause 9(4)(b) of the draft Bill be changed to read "for the protection of other persons from significant risk of serious harm."*[22]*

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[17] The right to detain a person who is willing to accept treatment, but also the right to disapply general principles to this group.
[18] By permitting the Tribunal to reserve to itself the power to discharge a patient who has not committed a criminal offence.
[19] *Report of the Joint Committee on the Draft Mental Health* Bill, 2005. Volume I, p. 5
[20] IMHAP, *Report of the Joint Committee on the Draft Mental Health Bill,* Volume II, Nov 2004. Ev.103.
[21] King's College London, *Report of the Joint Committee on the Draft Mental Health Bill,* Volume III, Nov 2004. Ev.780, para.2.4.1
[22] *Report of the Joint Committee on the Draft Mental Health* Bill, 2005. Volume I, p.47

To apply the provisions set out in the Draft Bill, practitioners will need to use very refined tools of risk assessment which are generally impracticable due to time constraints and lack of information and inaccurate when applied to large populations, as opposed to their considerable value in the confined setting of long stay forensic patients in high and medium security hospitals. As the Joint Committee stated, "*Nor are we persuaded that current techniques of risk assessments are so precise and reliable, or seen as such by professionals and the public, as to be reliably used to determine anything other than the most imminent and serious scenarios.*"[23]

As the MHAC points out:
"…it is difficult to arrive at a clear conceptual picture of a patient who may be made subject to civil compulsion "for the protection of other persons" (clause 9(4)(b)) who does not pose, "a substantial risk of serious harm to others", although the Bill appears to intend the latter group as an especially dangerous subset of the former. The courts have interpreted "substantial risk" as a risk that is more than remote and not merely minimal, which we believe should be the standard for any definition of risk that meets the most basic threshold for the civil use of psychiatric compulsion. It is similarly difficult to accept that harm which is not "serious" can, or should be, considered to provide justification for compulsory powers. As such the Bill appears either to provide a wide-ranging exception to the principle of last resort, or, in an attempt to specify a particular group of patients posing a risk to others, extends too greatly the potential meaning of "protection of others" as a basic reason for the civil use of mental health law."[24]

Much of the application of the Draft Bill hinges on assessing whether a person poses 'a substantial risk of causing serious harm'. However, there are significant problems with current risk assessment tools. These are not sufficiently accurate to ensure that only people who pose an unacceptable danger would be incarcerated under the proposals. Many believe that current methods lack sufficient sensitivity and specificity, but despite this, some people have unrealistic expectations of what they can do. Professor Eastman concluded that; "*it would be wrong to put great store by substantial improvements on risk assessment being on the horizon."*[25]

Furthermore, professionals themselves are sceptical of their ability in predicting risk as Dr Anthony Zigmond clearly stated in his oral evidence to the Committee: "*…the notion of predicting that somebody is a clear danger either to themselves or, indeed, anybody else, I have to say, is rather a fallacious one. My colleagues and I are not good at it."*[26] Professor Nigel Eastman echoed this concern: *"The difficulty with this Bill is that it… suggests that mental health professionals can predict a whole range of events before they happen."*[27]

The most frequently cited principle on risk assessment is that *"nothing predicts behaviour like behaviour."* George Szmukler estimates for example that using the most accurate data available, if 5 per cent of the population of interest is violent, the test will be wrong 92 times out of 100.[28] It would require the unnecessary detention in hospital of between 2000 and 5000 people to prevent a single homicide. Over-reliance on risk assessment may

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[23] ibid.
[24] Mental Health Act Commission, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II,* Nov 2004. Ev.22, para. 2.23.
[25] Professor Nigel Eastman, *Report of the Joint Committee on the Draft Mental Health Bill,* Volume II, 8 Dec 2004. Ev. 347
[26] Tony Zigmond, Royal College of Psychiatrists, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, 27 October 2004, Ev.81
[27] Professor Nigel Eastman, *Report of the Joint Committee on the Draft Mental Health Bill,* Volume II, 8 Dec 2004. Ev. 347
[28] George Szmukler: *Risk assessment: 'numbers' and 'values'*, 2003. Psychiatric Bulletin 27, p.205

divert scarce resources towards those assumed to be 'high risk' and away from the majority of those with mental illness, who pose no danger. The NHS Confederation reports that around 2000 additional people with personality disorders, currently not liable for detention, will be eligible under the Draft Bill.[29] At the same time it will be ineffective since there is no reliable way of assessing risk for people who have not yet committed an offence. It will also deter people from seeking help and increase risk for that reason.

Dangerousness is not an enduring trait. It can be exacerbated by some factors and restrained by others and can be modified over time. There is evidence that quality of care makes the biggest difference to offending behaviour. Analysis of 40 homicide enquiries between 1988 and 1997 concluded that in 11 cases (27.5%) violence could have been predicted, but in 72% there had been insufficient evidence to alert professionals. Even more significantly, the findings suggest that "*more homicides could have been prevented by good mental health care which detected relapse earlier (17 cases) than would be averted by attempts at better risk assessment and management (11 cases).*"[30]

The Bill will lead to greater stigma attached to mental disorder

The bias in the Draft Bill reinforces the common but false perception in the public's mind that people with a mental disorder are dangerous. In fact they are broadly speaking about as prone to violence as the rest of the population, although for people with psychotic illness there is a modest increase in levels of violence. Being young, male and of low social status are far more important factors than psychotic illness.[31] In that respect people with mental illness have been unfairly singled out for preventive detention.[32] This is borne out by Taylor and Gunn's research: "That compared with about 40 homicides by the mentally ill per year, the public is at risk from 600-700 offences per year recorded as homicide"[33] and by other studies in the UK and abroad. We question whether the provisions in the Bill are a proportionate response to the issue that Government wants to address, i.e. protecting the public from around 40 homicides a year by detaining thousands of people.

It will particularly stigmatise people with personality disorders, most of whom live safely in the community but who may be wrongly labelled as being dangerous.[34] The NIMHE Personality Disorder Capabilities Framework states: "*In recent years, the emphasis on risk and dangerousness associated with a very small number of people with a personality disorder has obscured the fact that very many people with the diagnosis are highly vulnerable to abuse and violence themselves - and to self-harm and suicide*."[35]

Reinforcing such misconceptions only strengthens a vicious circle: negative views in the community deter people from seeking treatment, when we know that seeking help early on

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[29] Tessa Crilly, *NHS Confederation Assessment of Implications of New Mental Health legislation on Mental Health Service Organisations Report*, 2nd edition, May 2003

[30] Munro & Rumgay: *Role of risk assessment in reducing homicides by people with mental illness*, 2000. British Journal of Psychiatry 176, p.116-120

[31] Walsh and Fahy, British Medical Journal, 7 September 2002; with reference to Applebaum, Robbins and Monahon, *Nacro Report on Violent Offenders,* American Journal of Psychiatry 2000, 157;1998

[32] George Szmukler: *Mental Health Legislation is now a harmful anachronism*, 1998. Psychiatric Bulletin 22, 662-665.

[33] Taylor & Gunn, *Homicides by people with mental illness: myth and reality* 1999. British Journal of Psychiatry 174 9-14.

[34] The Health Select Committee in July 2000 took this view*: "we are concerned at the use of what could be described as a "quasi-medical" definition [of Dangerous Severe Personality Disorder], which runs the risk of being highly stigmatising for the many people suffering from personality disorder who are not judged by anyone to be dangerous.*" *Provision of Mental Health Care Services*, Health Select Committee First Special Report, Jan 2001

[35] NIMHE: *Breaking the cycles of rejection: The Personality Disorder Capabilities Framework,* Nov 2003, citing Paul Moran, *The epidemiology of antisocial personality disorder.* (1999) Social Psychiatry & Psychiatric Epidemiology. 34, 231-242

a voluntary basis and receiving prompt care is the best way to stop problems escalating and to minimise risk. Both service users and clinicians report that the development of a trusting and non coercive relationship is the most effective way to reduce risk.

Dr Anthony Zigmond considered the issue of risk assessments for mental health professionals in the Royal College of Psychiatrist's evidence to the Joint Committee:
"…the only way that I can generally decide that somebody is a danger to themselves is because they have come to see me, I have interviewed them and they have told me what is in their mind. If they do not do that, I will not know about it; and so any law that drives people away from the service, I have to say, increases risks for everybody and damages health, and so on; so we need to get people to come and see us."[36]

The conditions should include the need to show that the protection of others is from "significant risk of serious harm"

The application of the conditions to people who are at risk of harming others is most worrying. It differentiates between levels of seriousness of risk to others. "For the protection of others" is an extremely broad category embracing emotional as well as physical harm, as demonstrated by interpretation of the 1983 Act. Compulsory powers should not be used in these circumstances. They will particularly impact on people who misuse drugs or alcohol, those with learning disabilities or a personality disorder who react aggressively to attempts to control their behaviour or who have done so on some previous occasion. In the context of a history of misunderstanding and discrimination in the use of compulsory powers on people from black and minority ethnic backgrounds, we can see that it could perpetuate that discrimination all too easily. We note that legislation in other jurisdictions tends to require "imminence" and "seriousness" of harm to others to justify the intervention of compulsory powers.[37]

Clause 9(8) should be removed

Clause 9(8) sates that "…a determination as to whether a patient is at substantial risk of causing serious harm to other persons is to be treated as part of the determination as to whether all of the relevant conditions appear to be or are met in his case."

The purpose of this clause is unclear. It appears to require practitioners to consider risk to others as the overriding consideration. This small group of patients should not be overemphasised in this way- it exemplifies the distorted picture of the nature of mental disorder in this Bill. The Joint Committee considered this clause to be 'obsolete'.[38]

The most appropriate place for setting out legislation to deal with issues of dangerousness for those who are accused of an offence is the criminal justice system, not the health system.

Professor Nigel Eastman has stated: "*I gave evidence to the Home Affairs Select Committee in relation to the DSPD proposals some years ago now, and in front of me Mr Boateng said the problem is that judges will not make enough life sentences. In fact, the Home Office's own paper at that time said that the judges made a life sentence on 2 per*

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[36] Dr Anthony Zigmond, Royal College of Psychiatrists, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, 27 Oct 2004, Ev.81.

[37] For instance 10 of (the then) 15 States in the EU specify a level of danger that is "serious", "immediate", "significant" or "substantial"; the US law specifies a higher level of danger -for instance suicidal behaviour or harmful attacks- and provides clear time frames for this behaviour. *Compulsory Admission and Involuntary Treatment of Mentally Ill Patients –Legislation and Practice in EU-Member States*, European Commission, 2002, p23

[38] *Report of the Joint Committee on the Draft Mental Health* Bill, 2005. Volume I, p.53.

cent of occasions when they could make a life sentence, including in relation to people with personality disorder. That rather starkly, if you like, puts the issue. What I said to the Select Committee then, which was rather incautious of me, was that lots of psychiatrists and other mental health professionals in hospitals were saying that the Government essentially were saying "We cannot get the judges to roll over, so let's get the shrinks to roll over."[39]

The Alliance believes that, for people with mental disorder who have capacity, criminal law should provide for sentencing options that balance public safety with individual rights. However, we strongly support the general assumption that *"when people break the law, the law takes its course and the disposal at the end of the process may well be influenced by whether there is a mental disorder."*[40]

The criminal justice system already has adequate options for protecting the wider public from people who have already committed serious violent or sexual offences and are considered dangerous, without recourse to mental health legislation.

- The Criminal Justice and Court Services Act 2000 places a statutory duty on police and probation services to assess and manage relevant sexual, or violent sexual or violent offenders.[41]
- The Criminal Justice Act 2003 gives courts the option of imposing indeterminate sentences and extensions to mandatory life sentences for dangerous offenders, including where the offences relate to mental disorder.[42] Where an offender is found guilty of a serious violent or sexual offence, the Court is obliged to consider the risk of further offences and danger to the public. Courts must assume that there is a risk unless it considers that it would be unreasonable to conclude that there is such a risk.
- The Sex Offences Act 2003 does not specifically mention mental disorder but it does allow for longer sentences for people who commit violent sex offences, some of whom may also have a mental disorder.[43]

In Scotland, separate legislation for offenders provides for indefinite detention for those who may not be treatable. The Mental Health (Public Safety and Appeals) (Scotland) Act 1999 has been upheld as compatible with the European Convention on Human Rights.[44] The Home Office should undertake a review of existing provisions to assess the need for more criminal legislation of this kind.

People with a mental disorder who harm others in circumstances in which they lack the capacity to be responsible for their own actions clearly need the care and protection of mental health law. The conditions we propose (in which an incapacitous patient with a mental disorder who poses a serious danger to others can be detained if there is a therapeutic benefit and if s/he is not accepting treatment on a voluntary basis) together

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[39] Professor Nigel Eastman, *Report of the Joint Committee on the Draft Mental Health Bill,* Volume II, 8 Dec 2004. Ev. 344.

[40] Professor Tony Maden, *Report of the Joint Committee on the Draft Mental Health Bill,* Volume II, 8 Dec 2004. Ev. 346.

[41] Under the Act, the relevant statutory agency will then refer the individual for an official and initial assessment and then the normal provisions for others will apply. Those already within the prison system will also be able to be referred by the Home Secretary for assessment.

[42] (Part 12, Sections 205-207).

[43] The offences of rape and sexual assault by penetration carry a mandatory life sentence. These provisions ensure that all those convicted of these serious crimes will always be sentenced. Those who are also mentally disordered can only access treatment in hospital via a transfer and not an order.

[44] Anderson, Doherty and Reid v Scottish Ministers & Advocate General of Scotland, (2003) 2 A.C. 602

with discretion in the clinician and the development of more robust risk prediction tools are the best way to keep such people engaged but not deter them from seeking help.

Non-resident orders for compulsory assessment and treatment

The Alliance's arguments against the provisions for non-resident orders are explained in greater depth elsewhere.

We believe that the conditions should include that the patient requires assessment in hospital

Any form of compulsory order in the community should require narrower conditions for compulsion, be of a finite time and only as ordered by Tribunal when particular criteria are satisfied. These are:

- A history of several previous admissions within a short period of time;
- Impaired decision-making;
- Demonstrated capability of community services to deliver;
- That if there was no order, the person's condition would deteriorate; and
- Capability of the patient to undertake the treatment and supervision required, taking into account his personal circumstances.

Conditions for assessment and care of Part 3 patients

The conditions for compulsion under Part 3 are too wide

The exercise of compulsory powers under Part 3 over people within the criminal justice system is a cause of concern. The conditions for remand or committal for medical treatment are significantly broader than the relevant conditions for compulsory treatment under Part 2. A person can be detained irrespective of whether it is necessary for their own protection from suicide, serious self harm or serious neglect or for the protection of other persons. This applies to people on remand as well as those who have been convicted of an offence.

The Bill's definition of mental disorder, coupled with the wide definition of treatment and the loose criteria for compulsion could have a significant impact on the number of people subject to the provisions of Part 3. As Professor Maden stated: "*I have seen no sensible discussion within the Department of Health of how the mental health services will guard against the wholesale transfer of prisoners, for example – most of whom have a mental disorder – straight into health service beds*."[45]

[45] Professor Tony Maden, *Report of the Joint Committee on the Draft Mental Health Bill,* Volume II, 8 Dec 2004. Ev.340

Discharge from compulsory treatment

The Draft Bill makes it difficult for a patient to oppose detention or to be discharged from a compulsory order

The vagueness and breadth of the key concepts (for instance "appropriate", "for the protection of"," treatment", "all the circumstances of his case") increase the difficulty for the patient to oppose his/her detention. As Fennell states "*The Tribunal is more likely to respect the view of the supervisor that the patient whose symptoms are in remission is benefiting from medication and that without it he would relapse than the view of the patient that he no longer needs treatment. It is difficult to see what convincing evidence the patient could bring in support of his own position.*"[46]

With the absence of any form of capacity test in the Bill, a non-resident order, once applied, might also be too longstanding in its application. Clinicians are likely to face real pressure to continually renew such powers, forcing patients to remain on NROs almost indefinitely. In addition, just as in the case of treatment administered in hospital, the breadth of the criteria for compulsion may make it difficult for a patient to oppose the renewal of an order successfully if the clinical view is that the medication is keeping the patient well.

The Alliance is also gravely concerned that given the breadth of the criteria, compulsion on grounds of risk to others could last for many years and it will be difficult for a person to satisfy the conditions for their release. The annual right of appeal to a Tribunal will be crucial to keep the period of compulsion to the minimum necessary compatible with public safety.

[46] Phil Fennell: *Balancing care and control: guardianship, community treatment orders and patient safeguards,* 1992. International Journal of Law and Psychiatry;15(2):p.229.