Non-resident orders (NROs)

Current law

Under existing law, compulsory treatment can only take place in an in-patient hospital setting. However, as the Royal College of Psychiatrists points out in its submission to the Joint Committee, treatment in the community under compulsion does occur under the 1983 Act in the following circumstances:

a) Patients subject to guardianship under the Mental Health Act. They may be required to live in a particular place, to attend a health or social care facility for treatment, or education, or training. Patients subject to guardianship must permit access to health or social care professionals. There is no authority to administer medication in the absence of consent or compliance. There is no authority to convey a person.

b) Section 25 of the Mental Health Act. This is similar to guardianship other than it can only be applied once a person has already been detained in hospital under a treatment order (section 3 or section 37) but it does include a power to convey patients including the authority to compel a patient to attend a health care or social facility. Again, there is no authority to compel a patient to accept medication.

c) Section 17 leave of absence. Patients detained under section 2, 3 or 37 of the Mental Health Act may be sent on leave. Whilst they cannot be forced to have medication in the community there may be grounds for recall to hospital if the patient does not comply with their medication. Patients certainly believe they will be returned to hospital if they stop their medication. For practical purposes, therefore, this is a form of community treatment order.

d) Patients detained under section 37 with a 41 restriction order currently on conditional discharge. Such patients are in the same position as those on section 17 leave, i.e. they have a right to refuse medication whilst in the community but most patients feel they would be ill advised so to do given the authority to recall to hospital.[1]

For some time, the Government has been proposing to allow compulsory treatment to take place in the community, arguing that this may address the issue of repeated re-admissions to hospital and provide a less restrictive alternative to in-patient treatment. It is also hoped that this will further the objective of reducing pressure on scarce hospital beds.

Draft Mental Health Bill 2004

The Draft Mental Health Bill states that there shall be resident (in hospital) and non-resident (in the community) status for people subject to compulsory powers. During the

[1] Royal College of Psychiatrists, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004, Ev.60 61

examination stage, if any two of the three examiners decides that a person should not be detained in hospital for the assessment, and if that person falls within a group defined in Regulations, then assessment will take place in the community.

In the case of resident patients there is a duty on the clinical supervisor to keep under review whether it is appropriate for the patient to be detained in hospital. If this is not appropriate, then the clinical supervisor must discharge the patient from hospital and specify the conditions to be imposed on the patient as a non-resident patient. The clinical supervisor must consult the nominated person and carers before making this determination. The Mental Health Tribunal can also determine that a patient can be assessed or treated as a non-resident patient.

If the patient is treated in the community a range of stipulations may be made in addition to the requirement to receive medical treatment. These may be requirements that the person concerned:

i. attends a specified place at specified times;
ii. resides at a specified place;
iii. makes himself available for assessment during specified periods; and/or
iv. does not engage in specified conduct.

Subsequent tribunals would then reconsider individuals' cases and decide whether to repeat or alter the assessment or treatment order. At all stages the clinical supervisor appointed over the person's case has a duty to keep under review whether or not a patient should be a resident or non-resident patient.

Alliance position

The Government should abandon its current approach to non-resident orders.

Some members of the Alliance- including service user organisations and voluntary organisations representing service users (including Mind and MDF-The BiPolar Organisation) are opposed to NROs in principle as they believe that to bring coercion into community mental health care is misplaced. However, given the Government's commitment to NROs, the Alliance as a whole has agreed on a minimum set of requirements that would be necessary before any form of NROs could be viewed as acceptable and workable.

The current proposals do not meet these requirements. First, it is necessary to set NROs in the context of the gateway into compulsion (the definition and conditions provisions). Secondly, the provisions in the 2004 Draft fail to ensure that only a limited and strictly defined group of patients could be made subject to community treatment orders. The Draft Bill refers to the use of regulations to limit the group of patients who can be compulsorily assessed in the community without an immediately preceding hospital admission but there is no equivalent provision for a non-resident treatment order.

A clinical supervisor is given unfettered discretion to place a patient under compulsion in the community after the initial period of assessment (which may last no more than a day). Thereafter there are no limits on either Tribunal or clinical supervisor to change a patient's status from resident to non-resident. There is also a power for a nominated person to request to the Tribunal that a resident patient become non-resident, but not the reverse.

There is no power to challenge this. There is also a real danger that the facility to switch patients between resident and non-resident status could be led by bed shortages rather than patient needs.[2]

Christopher Heginbotham, Chief Executive of the Mental Health Act Commission, reported to the Joint Committee that under the current Act: "*It is fairly evident that leave is used as a way of managing beds at the moment. Many psychiatric units, particularly in our inner cities, run at over 100 per cent bed occupancy. Beds are allocated to two or three patients simultaneously: one is in the bed, one is in the day room and one is out in the community. This is a very significant problem and we think that the non-resident order arrangement may well be used as a way of managing that."*[3]

The Bar Council has also expressed concern about the failure of the Bill to ensure that community treatment orders are only limited to restricted number of patients:
"The Bill provides no additional threshold criteria for clinicians or the Mental Health Tribunal to determine whether compulsory treatment is to be imposed in the community (as a 'non-resident patient') or under conditions of detention (as a 'resident patient'). The 'relevant conditions' in Clause 9 require only that the threshold for treatment under compulsion be reached: but a lower threshold is necessarily required for treatment under a non-resident treatment order than for detention. At the assessment stage, if the examiners decide the relevant conditions in Cl. 9 are fulfilled, detention is automatic: see Cl. 16(5) (and bearing in mind the limited category of patients who are to be eligible for assessment in the community under Cl. 15(2)). See also Cl. 17(3) (emergency patients). At the stage at which the Mental Health Tribunal determines whether to authorise an order for medical treatment (Cl. 46) or further assessment (Cl. 49), no additional threshold criteria is required in deciding whether the patient is to be a resident or non-resident patient (Cl. 46(4), 49(4)))[4]*. On the face of it that is incompatible with Article 5(1). A contrast may be made, for example, with Cl. 147(6). There should be an additional threshold criteria to the effect that the patient must be treated/ assessed as a non-resident patient unless the examiner/ Tribunal are satisfied that treatment can only be given in hospital and it is necessary for the health or safety of the patient or the protection of the public from harm that he receive the treatment as a resident patient."*[5]

Compulsion in the community is one of the most controversial of the new measures in the Bill. If, as the Government proposes, a person complies with a compulsory care and treatment order they are, in effect, doing so voluntarily because enforcement can only take place in a hospital setting. This throws into question their whole rationale. The research evidence has therefore been considered in depth by the Alliance and a view taken that there is no case for introduction of non-resident orders (NROs) in the Bill as drafted.

Service user fears

Service users fear that NROs will increase their chances of being compulsorily detained if they disagree with the treatment recommended by their psychiatrist. Some consider that when they have been very unwell, hospital provided security because it is a contained environment, with regular monitoring of their condition and any medication. NROs cannot provide this, and consequently give rise to fears that compulsion will be used when people

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[2] The Alliance is also concerned about the provisions for Part 3 patients. This is argued in the chapter on criminal justice.
[3] Christopher Heginbotham, Mental Health Act Commission, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, 20 Oct 2004, Ev.41
[4] The same criticism may be made of mental health orders imposed by the Crown Court: see Cl. 119(1)
[5] Bar Council, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Nov 2004, Ev.41, para 11.8

are not severely unwell, or that people who are severely unwell will not be given appropriate and sufficient support to help them through this time. "*If I hadn't decided to stop taking that medication it would still be ruling my life - and ruining my life. My psychiatrist was of course most unhappy. He was sure I wouldn't cope*".[6]

Service users consider the element of control of their home life an infringement of their privacy and potentially a breach of their human rights under Article 8 of the European Convention on Human Rights. They fear the impact on other family members who must have the burden of their care in a situation in which they are opposing treatment. One service user stated that he thought his marriage would break down if his wife had to look after him at such times.[7] Another said; "*Treatment when you are ill carries bad memories. I would prefer to associate these with a place that is not my home*"[8], another: "*To be treated at home and that unwell with lots of people coming in attracting attention. If that were to happen again I don't think I could go home. My home is my castle, my husband, my children. I wouldn't want to ruin that for them again.*"[9]

They also fear that it will be difficult to come off an NRO, even if their mental health has improved, because clinical staff will practice defensively and "play safe" by ensuring treatment is continued. Service users fear that once they are placed on an NRO they might never be taken off, as clinicians might see it simply as a way of maintaining the person's "compliance" with medication. They believe that the security of being in a contained environment, with regular monitoring of their condition and any medication, is the safest option in the circumstances when compulsory powers may reasonably be used. The danger is that these quite realistic fears about NROs will further drive people away from the services and the treatment they need.

The Lack of a Capacity Test

With the absence of any form of capacity test in the Bill, such an order, once applied, will 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, given the breadth of the criteria for compulsion, it may be 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.

Increase in the use of coercion

Evidence suggests that these orders will increase the use of coercion in treatment of patients. It has been acknowledged that they can, "*tend to add further coercion to the existing inpatient coercion.*"[10] Studies have shown that when benevolent treatment and coercion operate together, coercion tends to become pervasive and treatment remains nominal. If this result is replicated, it is clearly a serious objection. It could impact most on people from black and minority ethnic backgrounds.

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[6] Service user comments (anonymous) Mental Health Bill seminar, held by Mind, 14 October 2004'
[7] Service user comments (anonymous) Mental Health Bill seminar, held by Mind, 14 October 2004'
[8] Service user comments (anonymous) Mental Health Bill seminar, held by Mind, 14 October 2004'

[10] Hoyer & Fernis: *Out patient Commitment: Some reflections on ideology practice and implications for research*, 2001. Journal of Mental Health Law 1, 56-62

Focus on drug treatment

If NROs are used as an alternative to hospital admission they are more likely to be drug-focused as that is the only treatment that can be effectively enforced. They may therefore increase the number of people on long-term medication who derive no benefit from it.[11] NROs are likely to increase the consumption of medications which may have unpleasant, harmful and in some cases irreversible side effects because people would previously have exercised their right to decline to take them. Non-medical forms of treatment, such as psychosocial interventions, need the person to want the treatment to ensure that s/he engages and actively participates. Compulsion does not encourage this.

Disruption of the therapeutic relationship

The clinical and therapeutic relationship developed between service users and their professional carers could be damaged by compulsory treatment. This relationship is central to the effectiveness of care and the development of successful engagement with services. Such a relationship may take several years to develop, is often fragile and requires an interactive, and participative approach from the clinician and the service user towards a shared goal of recovery. Introducing an element of coercion into this relationship will increase the likelihood of disengagement from mental health services with the risk of relapse and re-admission to hospital. The supervised discharge amendments to the 1983 Act failed largely because of professionals' unwillingness to implement them. "*From the viewpoint of patients admitted to hospital, the distinction between legal compulsion and voluntary treatment is not always clear. Many informal patients feel coerced, and only a minority are confident of their freedom to leave a ward. If compulsory treatment is extended to the community, it may be that even patients who are not in fact subject to compulsion will feel increased coercion in their relationship with services*".[12]

Use of compulsion in the community

Compulsion in the community is said to offer a less restrictive environment although some commentators dispute this.[13] However, service users want this principle to apply when deciding whether or not someone should be put under compulsory powers rather than where compulsion should occur. For example, the provision of home support may avoid the need for using compulsion; this is very different from imposing treatment at home under compulsory powers.

Developments for the care of people in the community offer alternatives to hospital admission but we are not persuaded that these should in general be linked to compulsory care. They may indeed substantively conflict with positive approaches to engagement and service user autonomy through new services (such as assertive outreach and intensive home treatment services) for a group of people who have often been unable or unwilling to engage with mental health services. The models upon which they are based emphasise a partnership approach with the users of their services, any element of coercion in that equation serving to provide a mixed message.

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[11] Moncrieff & Smyth, *Community Treatment Orders- A Bridge Too Far*, 1999. Psychiatric Bulletin 23, 644.

[12] Graham Thornicroft, *Supervision and Coercion Studies* in *Shaping the new Mental Health Act: key messages from the Department of Health research programme*, 2000 p.16.

[13] Davis. *Autonomy Versus Coercion: Reconciling competing perspectives in community mental health*. 2002. Community Mental Health Journal 38, 239-249

Research evidence of overseas experience

We have benefited from discussions with overseas experts. Professor Dawson, an international expert who is not opposed to community treatment orders (the commonly accepted term), nonetheless stated at a seminar in London in 1992 that in his view the conditions for success were not in force in the UK.[14] They include:

- Tight criteria for compulsion;
- Well-established community service provision geared towards high-risk groups;
- Public liability insurance; and
- Effective enforcement mechanisms.

The Government points to the reported benefits of community treatment orders in New Zealand and Australia. The Alliance disputes this finding. It is relatively rare for patients to be placed on a community order in some jurisdictions without first being admitted to hospital because the definition of mental disorder and the criteria are more restrictive in their legislation[15], and because community services are better resourced and more consistently available than in the UK.

The Orders in overseas jurisdictions are broadly of two types: - those intended to operate after a stay in hospital on a compulsory basis, in order to reduce the chances of readmission and revolving door syndrome, working as a conditional release system (a form of this is in force under the Mental Health Act) and those intended to act as a complete alternative to hospital admission, as a least restrictive alternative. The NRO in the 2004 Draft Bill falls into the first group.

Given the differences between the legal regimes comparison is very difficult, but even in those studies dealing with one jurisdiction the picture remains confused as to whether, and in what circumstances, NROs are effective, and indeed what that might mean for patients' recovery or quality of life. It is also striking that the views of service users do not seem to have been systematically researched. In studies where an arguably positive effect has been found, the community treatment order was combined with extensive community services. A lack of interagency working, communication breakdown, inadequate care planning and poor risk management were more significant issues in a patient's condition than the fact of being on an order.

Evidence shows no significant benefit in terms of hospital admissions. The most recent research found, in a matched-groups study, that community orders in Western Australia did not reduce numbers of hospital admissions or number of days spent in hospital in the year following placement on the order.[16] They further commented that it is impossible to tell whether any beneficial effects are due to the compulsory nature of the order or the increased community services made available. This concords with most other studies which have shown no significant difference in outcome between provision of well developed services and community based orders.[17]

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[14] Dawson, 2002, *Ambivalence about CTOs,* Institute of Psychiatry IJLP 2003, 243-255.

[15] For example: New Zealand's definition of mental disorder is"*an abnormal state of mind shown by delusions or disorders of mood, perception, volition or cognition and; this abnormal state of mind means that either: there is a serious danger to the person's health and safety, or the health and safety of another person; or the person's ability to care for him/herself is seriously reduced*". Exclusions: that person's political, religious, or cultural beliefs; or that person's sexual preferences; or that person's criminal or delinquent behaviour; or substance abuse; or intellectual disability.

[16] Preston, N J, Kisely, S, &Xioa, J:*Assessing the outcome of compulsory psychiatric treatment in the community: epidemiological study in Western Australia,* 2002. British Medical Journal*,* 324, 1244-1246

[17] Steadman, H J, Gounis, K, Dennis, D, Hopper, K, Roche, B, Swartz, M, Robbins, P C*, Assessing the New York City involuntary commitment pilot programme*, 2001. Psychiatric Services, 52, 330-336*.*

In conclusion we believe that there is a sufficient evidence base to justify rejecting the proposals in this Bill. These proposals, combining community orders with a wide definition of mental disorder and loose criteria, in an environment in which community services are insufficiently developed and defensive professional practice persists, will not work. The Joint Committee agrees with this saying: "*Non-residential compulsion could be applied to a far wider population than is appropriate, and in circumstances which could be unacceptable*."[18]

Is there a way forward?

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.

To repeat, some members of the Alliance – including all service user groups - are opposed to NROs in any circumstance. The Alliance recognises that, given the Government's commitment to introducing them, it is necessary to consider how they could be introduced in a constructive manner and with appropriate safeguards. Work by the Royal College of Psychiatrists in the 1980s and 1990s and overseas research gives some credence to the view that there may be a small group of patients for whom repeated access to hospital may not be necessary although compulsion might be beneficial.[19] These patients have multiple compulsory admissions but on discharge they relapse severely because they fail to take the medication which they are considered to need. We recognise that in this small number of cases an NRO may be appropriate as a less restrictive alternative than a long hospital admission.

However both Revolving Doors (see below) and RCN expressed caution about this categorisation in the Joint Committee:

"*Contemporary nursing practice and other disciplines have more to offer and more imaginative ways of assisting individuals than returning them to hospital and close supervision in the way that this is implied. There are ways of working with individuals, carers and families to have a positive impact on what we might call relapse requiring readmission. As a first point there is implicit within here some sort of belief that, if people are properly monitored, they properly consume the drugs for which they are prescribed, they are likely not to be revolving. There is good evidence to show that people who are very compliant with medication still relapse and still become unwell. I do not think it is quite as simple as is implied here… I know there are models of community treatment orders that are argued to be successfully used with a small specific group of clients, but I think the reservation that is strongly expressed by members of the RCN is that this element of supervision and possible coercion could be unhelpful*"

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[18] *Report of the Joint Committee on the Draft Mental Health* Bill, 2005. Volume I, p.70, para.197.

[19] Royal College of Psychiatrists, *Community Treatment Orders: A discussion document;* 1997. 1993 Community Supervision Orders

However, it is imperative that there should be more substantive criteria for their application and safeguards for their use and the conditions for compulsion must be narrower than at present. Again, this view is supported by the Joint Committee, who reported:
"*We are clear that for this (i.e. compulsion in the community) to operate satisfactorily it needs to be underpinned by high quality services to support those subject to non-residential orders.*"[20]

We consider that a hospital is a safer environment for the initial exercise of compulsory powers.[21] The decision over whether detention should be in the community or in hospital should be made at the time when the care and treatment order is before a Tribunal. The Tribunal should be guided by strict criteria to limit their discretion.

For instance, legislation in the Canadian province of Saskatchewan states:

i. A person must suffer from a mental disorder, for which he or she is in need of treatment or care that can be provided in the community;
ii. In the past two years, the service user must have:
    - Spent at least 60 days as an involuntary in-patient in a psychiatric facility, or
    - Been an involuntary in-patient in a psychiatric facility on three or more separate occasions, (or previously been the subject of a community treatment order);
iii. There must be a likelihood that if the person were not to receive treatment while residing in the community, he or she would be likely to cause harm to self or others or suffer substantial mental or physical deterioration as a result of the mental disorder;
iv. The services the person requires in order to reside in the community must be available in the community;
v. The person is unable to understand and to make an informed decision regarding his or her need for treatment, care or supervision as a result of the mental disorder; and
vi. The person must be capable of complying with the requirement for treatment and supervision contained in the order.

Non-resident orders need to be researched further

The issue of compulsory treatment orders has not been properly analysed by the government. It was not part of the Expert Committee's brief to question their desirability although they did not dissent to their use. Before such a radical shift in policy is introduced we believe that the Government should have undertaken such analysis.

The Joint Committee recommendations dealt with conditions for NROs. These are all welcome limitations on the government's proposals. They include:

- There must be a maximum time limit for treatment under a non-residential order - certainly of not more than three years in any five year period.

- The non-residential order must not authorise the use of force on the patient in the community (i.e. outside hospitals or clinics) beyond the powers currently available

[20] *Report of the Joint Committee on the Draft Mental Health* Bill, 2005. Volume I, p.73, para.205.
[21] The Expert Committee recommended that there should be a "formal assessment" in the community and a "compulsory assessment" only in hospital. *Review of the Mental Health Act 1983*, November 1999P.51, para 5.25

in the 1983 Act which provide for a patient to be conveyed to the place he is required to attend for treatment or to be conveyed to hospital. (Paragraph 199)

- We recommend that the provisions for non-residential orders be accompanied by a requirement on health and local authorities to provide adequate care. Further, adequate care means care other than that provided by families and carers, and any provision for non-residential orders must ensure that burdens are not placed upon families and carers that would fall more properly on clinicians, and the health, and social services

- The use of non-residential treatment under compulsion be explicitly limited to a clearly defined and clinically identifiable group of patients. (Paragraph 192)

- We therefore recommend the following series of amendments to the Bill which would focus the provisions of the Bill proper on a clearly defined and clinically identifiable group of patients, for example - patients who frequently relapse - and limit the scope and potential duration of non-residential compulsory treatment. (Paragraph 197)

- The primary legislation and its regulations should provide a robust safeguard against the emergence of any two-tier threshold for imposition of formal powers. (Paragraph 198)

The following parameters for the use of non-residential compulsory powers should be included on the face of the Bill.

a) A non-residential order should not normally be imposed without previous hospitalisation at least for the purposes of assessment.

b) There exists evidence of previous responsiveness to, and co-operation with, proposed treatment before a non-residential order is imposed.

c) Provisions for non-residential orders should be simple and be used to specify only:

i. requirements or limitations on a person's place of residence; and

ii. medical treatment.

d) There must be a maximum time limit for treatment under a non-residential order - certainly of not more than three years in any five year period.

e) The non-residential order must not authorise the use of force on a patient in the community (i.e. outside hospitals or clinics), beyond the powers currently available in the 1983 Act which provide for a patient to be conveyed to the place he is required to attend for treatment, or to be conveyed to hospital. (Paragraph 199)

We recommend that the provisions for non-residential orders be accompanied by a requirement on health and local authorities to provide adequate care. Further, adequate care means care other than that provided by families and carers, and any provision for non-residential orders must ensure that burdens are not placed upon families and carers that would fall more properly on clinicians and the health and social services. (Paragraph 205)