Provisions for People in the Criminal Justice System

Current law

The Criminal Justice sections (Part 3) of the 1983 Act have not been subject to detailed scrutiny or public consultation since the Reed Committee Report in 1992. The Expert Committee, which reported to the Department of Health and not the Home Office, was not able to consider Part 3 and stated that this required, "*Far more rigorous and comprehensive consultation and consideration*."[1] They believed an urgent review was needed and that an independent body should be set up to undertake it in the light of their recommendations. However, this has not occurred. We believe that this is a matter of great regret because mentally disordered offenders and those more generally within the criminal justice system are extremely vulnerable and they also account for many of the people brought within the 1983 Act. They are in contact with the police, the criminal Courts, possibly prison - none of which are specialised in mental health. The new definition of mental disorder has been grafted on to the current provisions in Part 3 of the 1983 Act with very few changes for the purpose of the new draft Bill. While there are some improvements in the procedures for Part 3 patients there are also matters of great concern.

With this in mind, the Mental Health Alliance believes that there is a need for greater consultation and scrutiny of the criminal justice provisions in the draft Bill.

Alliance position

The Alliance shares the concerns of Revolving Doors on the status of Part 3 patients under the draft Bill:
"Those principles are not lawful because they are going to form part of the Code of Practice, and basically go out of the window when you get to Section 3 … if you are going to have principles, you are going to have principles and they are going to go through the Bill or they are not. What happens is that once you commit a crime suddenly the risk element goes away and the last resort, in that there is no other option for you to engage with, has to be force because you are refusing to engage. This group want to engage but those services are not there for that to happen. What this Bill is suggesting is that the way ahead is to say, "As soon as you have committed a crime let us compulsorily treat you". I would make it very clear that this is not for our clients at all."[2]

The Alliance believes that Part 3 of the draft Mental Health Bill should reflect the following principles:

- the conditions for compulsory treatment of an accused person and a convicted person should mirror those available under the civil system.

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[1] November 1999. *Review of the Mental Health Act 1983*. Para.15.4
[2] Nick O'Shea, Revolving Doors Agency, Dec 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II,* Ev.366

- Criminal Courts should not be able to make care and treatment orders. These should, in all cases, be made by a Mental Health Tribunal (MHT).
- when considering disposal and sentencing the Courts should base their decisions on the presumption in favour of least restrictive regime.
- people within the criminal justice system should have the right to an assessment of their mental health needs and access to appropriate care and treatment.
- any person who appears to be suffering from a mental disorder should have the right of access to specialist mental health advocacy in a police station.

Criteria for compulsion

The conditions for remand or committal for compulsory medical treatment under Part 3 of the draft Bill are significantly broader than the criteria for compulsory treatment under Part 2. This provides greater opportunities to subject people to compulsory treatment as an alternative or in addition to a criminal disposal.

A person could be brought within the exercise of compulsory powers who is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment and where appropriate medical treatment is available. This is irrespective of whether treatment is necessary for their health or safety or the protection of others. In cases of remand, this would apply even if the person were not subsequently convicted of the offence.

We believe that the conditions for compulsory treatment of an accused person and a convicted person should mirror those available under the civil system.

People within the criminal justice system should only be subjected to compulsory treatment under the same criteria as those available under Part 2 of the draft Bill. The Alliance proposes the following criteria:

- the person is suffering from a mental disorder which is of such seriousness that s/he requires care and treatment under the supervision of specialist mental health services; and
- the care and treatment proposed for, and consequent upon, the mental disorder is the least restrictive and invasive alternative available consistent with safe and effective care; and
- there is a proposed care and treatment plan of direct therapeutic benefit to address the mental disorder; and
- the person has impaired decision making ability by reason of mental disorder and
- it is necessary for the health and safety of the person or for the protection of others from serious harm, that s/he be subject to such care and treatment, and that such care and treatment cannot be implemented unless s/he is compelled.

The Joint Committee agreed to a large extent with the Alliance in their recommendations they state:
"We recommend that when Courts are considering whether to make a mental health order or hospital direction, there be a requirement that the mental disorder of the offender/patient should be of a nature or degree which makes treatment under compulsory powers appropriate. If the offender/patient is to be resident, then the disorder should be of a nature or degree warranting detention". (Paragraph 271)

"We recommend, in the interests of non-discrimination, that the Bill proper and accompanying codes of practice be drafted in such a way as to make clear that Courts, in

making a mental health order or hospital direction, should base their assessment on whether the offender's mental disorder renders him a risk to self or others, irrespective of whether that risk could be minimised by a prison sentence. (Paragraph 272)"

Remands on bail and to hospital

We welcome the new power to remand on bail for a mental health report

The draft Bill introduces a new power for the Court to remand on bail for a mental health report. The Court must be satisfied, on the evidence of a single registered medical practitioner, that there is reason to suspect the person is suffering from a mental disorder. The Alliance welcomes this proposal which is consistent with Courts favouring the least restrictive regime. Although the Courts already have the power under the Bail Act 1976 to attach conditions to a bail order, such as requiring attendance for a mental health report or treatment, we believe this provision will remind Courts of less restrictive alternatives to remanding to hospital.

The time limit for remand to hospital for a mental health report should not be extended

The draft Bill retains the existing power of the Crown Court and magistrates' Courts to remand to hospital for a mental health report and extends this to the Court of Appeal. This must be based on the evidence of a single registered medical practitioner that there is reason to suspect the person is suffering from a mental disorder. The remand will be for a maximum of 28 days and be renewable by the Court at 28-day intervals for up to 16 weeks. This is a substantial lengthening from the current time period of 12 weeks and the Alliance opposes this extension.

The magistrate should be satisfied that the person committed the offence before remanding to hospital for a report

We are concerned that the draft Bill drops the requirement in the 1983 Act that an accused person cannot be remanded to hospital by a magistrate without the bench being satisfied that they committed the offence or if the accused person consents to the remand. We believe this is an important safeguard and should be reinstated.

We also recommend, as did the Joint Committee, that, where a Court wishes to send an offender or person on remand with a mental disorder to a hospital and hospital Trusts cannot agree to which hospital the person should be sent, the Bill contain a duty for the strategic health authority (or authorities, if more than one is concerned) to resolve the dispute.

Treatment under compulsion

The compulsory treatment of a patient who has been remanded to hospital for a report should only be authorised under Part 2 provisions

Under the 1983 Act, when a person is remanded to hospital for a report Part 4 provisions on consent to treatment do not apply. Therefore, the defendant can not be compulsorily treated. This has led to the practice of using Section 2 or Section 3 to run alongside Section 35 (therefore the same definitions and conditions as apply for Part II patients). The draft Bill changes this by allowing the Court to authorise compulsory medical

treatment to a person who is remanded for a mental health report based on the evidence of two registered medical practitioners. The Alliance is concerned that these patients will lose the right of appeal to a MHT and that the broader Part 3 criteria for compulsory treatment will be applied. We therefore believe that compulsory treatment should only be carried out under Part 2 where a person has been remanded to hospital for a report.

Courts should not have the power to authorise compulsory treatment on a remanded patient

The draft Bill retains the existing power of the Crown Court to remand to hospital for medical treatment and also allows the Magistrates' Courts to remand or commit someone for medical treatment. This must be based on the evidence of two registered medical practitioners that the person is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment. Appropriate treatment must be available and admission must take place within 7 days. The Alliance opposes this provision, believing that ordinary criminal Courts should not be able to authorise compulsory medical treatment on a remanded patient. This should only be provided under Part 2, where the narrower criteria for compulsion would be used and the patient would have the right of appeal to the MHT.

Treatment under compulsory powers in the community

The Alliance is extremely concerned about the use of non-resident orders for Part 3 patients. Revolving Doors argued the case in their oral evidence to the Committee:
"We are concerned by the emphasis in this Bill on compulsion and we think that compulsory powers should be used as a matter of last resort. The sorts of clients that Revolving Doors have been talking about very often have very chaotic lifestyles. They need a high degree of support, as has been indicated, from a variety of perspectives, not just from a mental health perspective but also help more generally in accessing services such as housing benefit and so on. In our view these are the types of people who are the most unsuitable candidates for compulsory treatment in the community. Non-compliance with medication and a failure to co-operate with aspects of care and treatment are not a recipe for a successful management structure in the community and we think that people who are so disordered or so mentally ill that they need compulsory treatment require that treatment to be provided in a hospital environment".

"We understand the views of those who think that there is a problem in getting people into hospital, but, in our view, this is not an issue for legislation; this is an issue for resources because one of the key problems is that there is a lack of resources in terms of community mental health services in existence at present. The services provided are variable and patchy. In some areas they are very good; in other areas they are not very good. A lot of these people need much more help than perhaps just a visit from a key worker once a week or once a fortnight. If the resources were provided to give a comprehensive structure of assertive outreach services, crisis teams and so on, we think that it is far more likely that it would be possible to engage with service users on a voluntary basis so that they could be helped to maintain their lives in the community without the use of compulsion and you would only then be talking about a smaller number of people whose illness might deteriorate to the point where compulsory treatment in hospital became necessary."[3]

[3] Sue Kesteven, Revolving Doors Agency, December 2004. *Report of the Joint Committee on the Draft Mental Health Bill, Volume II*, Ev.365-366

Orders and Directions

Criminal Courts should not be able to make care and treatment orders. These should, in all cases, be made by a Mental Health Tribunal.

The draft Bill provides a power for the Courts to issue mental health orders (MHO) for up to 6 months on a person subject to criminal proceedings. This has replaced the Hospital Order under Section 37 of the 1983 Act. This can authorise the provision of medical treatment as a resident or non-resident patient. The MHO is based on the evidence of two registered medical practitioners and an approved mental health professional that the person is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment and that appropriate medical treatment is available. A care plan must be submitted to the Court by an approved clinician and the Court may appoint members of the Expert Panel to assist it in determining whether to approve the care plan. The Alliance strongly opposes giving criminal Courts the power to issue MHOs. We are concerned about the role of ordinary Criminal Courts in approving care plans and believe they lack the benefit of the experience and expertise of the MHT.

The Joint Committee was also concerned about the role of criminal Courts and to the need to avoid discrimination. For instance they stated:
"We recommend that there be a duty on judges to consult a member of the Expert Panel when considering a care plan".

"We recommend that, when drawing up care plans for patients involved in criminal proceedings, Courts (directly or indirectly via the member of the Expert Panel) and clinical supervisors be subject to the same duties to consult as apply to non-offender patients".

Restricted patients should be entitled to a nominated person and rights for their carers

We welcome Schedule 8 which provides that unrestricted patients under a mental health order have broadly the same rights to a nominated person and as civil patients under Part 2. Similar duties to consult carers also apply. However we believe that a restricted patient should also be entitled to a nominated person and to consultation with his/her carer and nominated person about his/her care plan.

As Dr John O'Grady stated, "*The Mental Health Act in its draft form at least, in relation to mental health review tribunals, properly puts in three members. It very properly looks at treatment in the wider sense, not just medication but psychological treatment, habilitation, rehabilitation and all aspects of a patient's care. If it is right for most patients when we look at a care plan to have that level of specific expertise in the mental health review tribunal to address a care plan, why is it different in part three?"*

"It does not make sense and there does not seem to be any particularly practical reason for it. The Court's main determination is: is a mental health order the best disposal for this offender and is it in that person's interests and in the interests of society to proceed in that way? That is their expertise. Why get the Court involved in looking at treatment issues when you have a much better system in the Act in relation to mental health review tribunals? An obvious way of doing it would be to parallel the procedures for part two and simply give the Courts the job of determining the detention and, say, 28 days later asking a mental health review tribunal to address the care plan that the care team draws up. Given

that it is a very positive aspect to the Bill that you have mental health review tribunals properly addressing care plans, why not apply that to mentally disordered offenders?"[4]

Decisions regarding restriction orders should only be taken by the MHT

The draft Bill provides the Crown Court with the power to make a restriction order where it makes a MHO. The special restrictions are that the patient can only be given leave of absence, be transferred to another hospital or be treated as a non-resident patient with the agreement of the Home Secretary. The restriction order must be based on the additional (oral) evidence of at least one of the registered medical practitioners who have already given evidence about the suitability of a MHO that this is necessary to protect the public from serious harm. These are the same grounds that currently exist under Section 41 of the 1983 Act. Under these provisions the Home Secretary's consent is required for the discharge of restricted patients, granting leave or transferring a restricted patient to another hospital or transferring a prisoner to a psychiatric hospital or vice versa. The Alliance believes it is essential that such decisions are taken by an independent judicial authority, i.e. The MHT.

We believe that the Bill should provide an enforceable right to treatment in the least restrictive environment which is consistent with the needs of the patient and the need to protect the public. The problem of patients stuck in inappropriately high conditions of security is longstanding[5] and while we welcome Government policy to increase the provision of medium and low secure facilities, we consider that these decisions are of such importance to the individual's liberty that they should lie in the hands of the MHT. We concede that Article 5(4) of the Human Rights Act, as currently interpreted, does not require the Tribunal to have jurisdiction to take such essential decisions.[6] Nevertheless, detention of a patient in inappropriate conditions of security may violate their rights under Article 8 of the Act. The Tribunal is best placed to make decisions about the level of security a patient requires having heard all the medical evidence with representations from the patient, and it is both wasteful and unjust not to allow the Tribunal to act upon that information.

We support the recommendation of the Richardson Committee that the Tribunal should have power not only to order a restricted patient's discharge but also to order such steps as are a necessary precondition to the patient being discharged, in particular a power to order transfer between hospitals and leave of absence.

The Alliance welcomes the abolition of specified restriction orders

Under the 1983 Act, restriction orders can be for a specified or unlimited period. The draft Bill only allows for restriction orders of an unlimited period, which can be discharged by the Home Secretary or the MHT. The Alliance welcomes the abolition of specified restriction orders, which according to research were only applied to a small minority of all restriction orders and were often issued against medical advice by the trial judge to introduce a punitive element to treatment orders[7].

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[4] Dr John O'Grady, 27 October 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Ev.87
[5] Department of Health, February 2000. *Report of the Review of Security at the High Security Hospitals.*
[6] Ashingdane v United Kingdom (1985) 7 EHRR 528
[7] Romilly et al, 1997. *Limited Duration Restriction Orders,* Journal of Forensic Psychiatry 8(3).

Criteria for hospital and limitation directions should mirror the criteria for compulsory medical treatment in Part 2

The Bill provides the Crown Court with the power to issue a hospital direction when imposing a prison sentence (except where sentence is fixed). The person would be removed and detained in hospital and be subject to special restrictions. To issue a hospital direction the Court must have considered making a MHO before it decided to impose a sentence of imprisonment. The hospital direction must also be based on the evidence of two registered medical practitioners and an Approved Mental Health Professional that the person is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment. Appropriate medical treatment must also be available and admission must take place within 28 days. The Alliance believes that the criteria for these orders should mirror the criteria for compulsory medical treatment set out in Part 2. We welcome the inclusion of a right of appeal to the MHT.

The Government should consider re-introducing Interim Hospital Orders

We are disappointed that the draft Bill makes no provision for Interim Hospital Orders. These have proved a useful option under the 1983 Act to send a convicted offender to hospital initially for up to 12 weeks to assess the treatability of their disorder and the appropriateness of making a hospital order or direction. The Alliance notes that hospital and limitation directions are rarely used at present and suggest that an Interim Hospital Order can be a more useful alternative.

Transfers to hospital

As under the 1983 Act, the draft Bill provides that offenders can be simultaneously liable to serve a prison sentence and be subject to compulsion. The Alliance believes this issue should be viewed against the assumption that the best place for the treatment of mentally disordered offenders is in hospital (albeit on occasions in a secure facility) rather than in prison.

We welcome the power to transfer sentenced persons for a mental health report

The draft Bill introduces a new power for the Home Secretary to direct the transfer of a prisoner for the purposes of a mental health report for up to 16 weeks. This must be based on the evidence of a registered medical practitioner that there is reason to suspect that the prisoner is suffering from a mental disorder. This can last for up to 16 weeks. The Alliance welcomes this power, which will provide a less restrictive alternative to transfer for treatment.

Criteria for transfer for medical treatment should mirror the criteria for provision of medical treatment under Part 2

The draft Bill also provides that a prisoner can also be transferred for the provision of medical treatment, including those remanded or committed in custody. This must be based on the evidence of two registered medical practitioners that the person is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment and that appropriate medical treatment is available. The Alliance believes that the criteria for transfer should mirror those for the provision of medical treatment those under Part 2.

Improvements are needed to the provisions for transfer between prison and hospital

The Alliance also remains concerned that despite advances in recent years the process of transferring mentally ill prisoners remains slow and characterised by unacceptable delays

at each stage of the process. Consideration should be given to reducing the transfer period for sentenced prisoners from 14 to 7 days in line with remands to hospital, time limits on the period between medical recommendations and an increase in the provision of secure units.

Criteria for compulsion

The conditions for remand or committal for compulsory medical treatment under Part 3 of the draft Bill are significantly broader than the criteria for compulsory treatment under Part 2. This provides greater opportunities to subject people to compulsory treatment as an alternative or in addition to a criminal disposal.

A person who is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment, and where appropriate medical treatment is available, could be brought within the exercise of compulsory powers. This is irrespective of whether treatment is necessary for their health or safety or the protection of others. In cases of remand, this would apply even if the person were not subsequently convicted of the offence.

We believe that the conditions for compulsory treatment of an accused person and a convicted person should mirror those available under the civil system.

People within the criminal justice system should only be subjected to compulsory treatment under the same criteria as those available under Part 2 of the draft Bill. The Alliance proposes the following criteria:

- the person is suffering from a mental disorder which is of such seriousness that s/he requires care and treatment under the supervision of specialist mental health services; and
- the care and treatment proposed for, and consequent upon, the mental disorder is the least restrictive and invasive alternative available consistent with safe and effective care; and
- there is a proposed care and treatment plan of direct therapeutic benefit to address the mental disorder; and
- the person has impaired decision making ability by reason of mental disorder and
- it is necessary for the health and safety of the person, or for the protection of others from serious harm, that s/he be subject to such care and treatment, and that such care and treatment cannot be implemented unless s/he is compelled.

Remands on bail and to hospital

We welcome the new power to remand on bail for a mental health report

The draft Bill introduces a new power for the Court to remand on bail for a mental health report. The Court must be satisfied, on the evidence of a single registered medical practitioner, that there is reason to suspect the person is suffering from a mental disorder. The Alliance welcomes this proposal which is consistent with Courts favouring the least restrictive regime. Although the Courts already have the power under the Bail Act 1976 to attach conditions to a bail order, such as requiring attendance for a mental health report or treatment, we believe this provision will remind Courts of less restrictive alternatives to remanding to hospital.

The time limit for remand to hospital for a mental health report should not be extended

The draft Bill retains the existing power of the Crown Court and Magistrates' Courts to remand to hospital for a mental health report and extends this to the Court of Appeal. This must be based on the evidence of a single registered medical practitioner that there is reason to suspect the person is suffering from a mental disorder. The remand will be for a maximum of 28 days and be renewable by the Court at 28-day intervals for up to 16 weeks. This is a substantial lengthening from the current time period of 12 weeks and the Alliance opposes this extension.

The magistrate should be satisfied that the person committed the offence before remanding to hospital for a report

We are concerned that the draft Bill drops the requirement, in the 1983 Act, that an accused person cannot be remanded to hospital by a magistrate without the bench being satisfied that they committed the offence or if the accused person consents to the remand. We believe this is an important safeguard and should be reinstated.

We also recommend that, where a Court wishes to send an offender or person on remand with a mental disorder to a hospital and hospital Trusts cannot agree to which hospital the person should be sent, the Bill contains a duty for the strategic health authority (or authorities, if more than one is concerned) to resolve the dispute.

Treatment under compulsion

The compulsory treatment of a patient who has been remanded to hospital for a report should only be authorised under Part 2 provisions

Under the 1983 Act, when a person is remanded to hospital for a report Part 4 provisions on consent to treatment do not apply. Therefore, the defendant can not be compulsorily treated. This has led to the practice of using a Section 2 or Section 3 to run alongside Section 35 (therefore the same definitions and conditions as apply for Part II patients). The draft Bill changes this by allowing the Court to authorise compulsory medical treatment to a person who is remanded for a mental health report based on the evidence of two registered medical practitioners. The Alliance is concerned that these patients will lose the right of appeal to a MHT and that the broader Part 3 criteria for compulsory treatment will be applied. We therefore believe that compulsory treatment should only be carried out under Part 2 where a person has been remanded to hospital for a report.

Courts should not have the power to authorise compulsory treatment on a remanded patient

The draft Bill retains the existing power of the Crown Court to remand to hospital for medical treatment and also allows the magistrates' court to remand or commit someone for medical treatment. This must be based on the evidence of two registered medical practitioners that the person is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment. Appropriate treatment must be available and admission must take place within 7 days. The Alliance opposes this provision and believes that ordinary criminal courts should not be able to authorise compulsory medical treatment on a remanded patient. This should only be provided under Part 2, where the

narrower criteria for compulsion would be used and the patient would have the right of appeal to the MHT.

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The Alliance is extremely concerned about the use of non-resident orders for Part 3 patients. Revolving Doors argued the case in their oral evidence to the Joint Committee: *"We are concerned by the emphasis in this Bill on compulsion and we think that compulsory powers should be used as a matter of last resort. The sorts of clients that Revolving Doors have been talking about very often have very chaotic lifestyles. They need a high degree of support, as has been indicated, from a variety of perspectives, not just from a mental health perspective but also help more generally in accessing services such as housing benefit and so on. In our view these are the types of people who are the most unsuitable candidates for compulsory treatment in the community. Non-compliance with medication and a failure to co-operate with aspects of care and treatment are not a recipe for a successful management structure in the community and we think that people who are so disordered or so mentally ill that they need compulsory treatment require that treatment to be provided in a hospital environment".*

"We understand the views of those who think that there is a problem in getting people into hospital, but, in our view, this is not an issue for legislation; this is an issue for resources because one of the key problems is that there is a lack of resources in terms of community mental health services in existence at present. The services provided are variable and patchy. In some areas they are very good; in other areas they are not very good. A lot of these people need much more help than perhaps just a visit from a key worker once a week or once a fortnight. If the resources were provided to give a comprehensive structure of assertive outreach services, crisis teams and so on, we think that it is far more likely that it would be possible to engage with service users on a voluntary basis so that they could be helped to maintain their lives in the community without the use of compulsion and you would only then be talking about a smaller number of people whose illness might deteriorate to the point where compulsory treatment in hospital became necessary."[8]

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[8] Sue Kesteven, Revolving Doors Agency, December 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II,* Ev.365-366

Restricted patients should be entitled to a nominated person and rights for their carers

We welcome Schedule 8 which provides that unrestricted patients under a mental health order have broadly the same rights to a nominated person and as civil patients under Part 2. Similar duties to consult carers also apply. However we believe that a restricted patient should also be entitled to a nominated person and to consultation with his/her carer and nominated person about his/her care plan.

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"It does not make sense and there does not seem to be any particularly practical reason for it. The Court's main determination is: is a mental health order the best disposal for this offender and is it in that person's interests and in the interests of society to proceed in that way? That is their expertise. Why get the Court involved in looking at treatment issues when you have a much better system in the Act in relation to mental health review tribunals? An obvious way of doing it would be to parallel the procedures for part two and simply give the Courts the job of determining the detention and, say, 28 days later asking a mental health review tribunal to address the care plan that the care team draws up. Given that it is a very positive aspect to the Bill that you have mental health review tribunals properly addressing care plans, why not apply that to mentally disordered offenders?"[9]

Decisions regarding restriction orders should only be taken by the MHT

The draft Bill provides the Crown Court with the power to make a restriction order where it makes a MHO. The special restrictions are that the patient can only be given leave of absence, be transferred to another hospital or be treated as a non-resident patient with the agreement of the Home Secretary. The restriction order must be based on the additional (oral) evidence of at least one of the registered medical practitioners who have already given evidence about the suitability of a MHO that this is necessary to protect the public from serious harm. These are the same grounds that currently exist under Section 41 of the 1983 Act. Under these provisions the Home Secretary's consent is required for the discharge of restricted patients, granting leave or transferring a restricted patient to another hospital, or transferring a prisoner to a psychiatric hospital or vice versa. The Alliance believes it is essential that such decisions are taken by an independent judicial authority, i.e. The MHT.

We believe that the Bill should provide an enforceable right to treatment in the least restrictive environment which is consistent with the needs of the patient and the need to protect the public. The problem of patients stuck in inappropriately high conditions of security is longstanding[10], and while we welcome Government policy to increase the provision of medium and low secure facilities, we consider that these decisions are of such importance to the individual's liberty that they should lie in the hands of the MHT. We concede that Article 5(4) of the Human Rights Act, as currently interpreted, does not require the Tribunal to have jurisdiction to take such essential decisions.[11] Nevertheless,

[9] Dr John O'Grady, 27 October 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Ev.87
[10] Department of Health, February 2000. *Report of the Review of Security at the High Security Hospitals.*
[11] Ashingdane v United Kingdom (1985) 7 EHRR 528

detention of a patient in inappropriate conditions of security may violate their rights under Article 8 of the Act. The Tribunal is best placed to make decisions about the level of security a patient requires having heard all the medical evidence with representations from the patient, and it is both wasteful and unjust not to allow the Tribunal to act upon that information.

We support the recommendation of the Richardson Committee that the Tribunal should have power not only to order a restricted patient's discharge but also to order such steps as are a necessary precondition to the patient being discharged, in particular a power to order transfer between hospitals and leave of absence.

The Alliance welcomes the abolition of specified restriction orders

Under the 1983 Act, restriction orders can be for a specified or unlimited period. The draft Bill only allows for restriction orders of an unlimited period, which can be discharged by the Home Secretary or the MHT. The Alliance welcomes the abolition of specified restriction orders, which according to research were only applied to a small minority of all restriction orders and were often issued against medical advice by the trial judge to introduce a punitive element to treatment orders.[12]

Criteria for hospital and limitation directions should mirror the criteria for compulsory medical treatment in Part 2

The Bill provides the Crown Court with the power to issue a hospital direction when imposing a prison sentence (except where sentence is fixed). The person would be removed and detained in hospital and be subject to special restrictions. To issue a hospital direction the Court must have considered making a MHO before it decided to impose a sentence of imprisonment. The hospital direction must also be based on the evidence of two registered medical practitioners and an Approved Mental Health Professional that the person is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment. Appropriate medical treatment must also be available and admission must take place within 28 days. The Alliance believes that the criteria for these orders should mirror the criteria for compulsory medical treatment set out in Part 2. We welcome the inclusion of a right of appeal to the MHT.

The Government should consider re-introducing Interim Hospital Orders

We are disappointed that the draft Bill makes no provision for Interim Hospital Orders. These have proved a useful option under the 1983 Act to send a convicted offender to hospital initially for up to 12 weeks to assess the treatability of their disorder and the appropriateness of making a hospital order or direction. The Alliance notes that hospital and limitation directions are rarely used at present and suggest that an Interim Hospital Order can be a more useful alternative.

Transfers to hospital

As under the 1983 Act, the draft Bill provides that offenders can be simultaneously liable to serve a prison sentence and be subject to compulsion. The Alliance believes this issue should be viewed against the assumption that the best place for the treatment of mentally disordered offenders is in hospital (albeit on occasions a secure facility) rather than in prison.

[12] Romilly et al.,1997. *Limited Duration Restriction Orders,* Journal of Forensic Psychiatry 8(3).

We welcome the power to transfer sentenced persons for a mental health report

The draft Bill introduces a new power for the Home Secretary to direct the transfer of a prisoner for the purposes of a mental health report for up to 16 weeks. This must be based on the evidence of a registered medical practitioner that there is reason to suspect that the prisoner is suffering from a mental disorder. This can last for up to 16 weeks. The Alliance welcomes this power, which will provide a less restrictive alternative to transfer for treatment.

Criteria for transfer for medical treatment should mirror the criteria for provision of medical treatment under Part 2

The draft Bill also provides that a prisoner can also be transferred for the provision of medical treatment, including those remanded or committed in custody. This must be based on the evidence of two registered medical practitioners that the person is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment and that appropriate medical treatment is available. The Alliance believes that the criteria for transfer should mirror those for the provision of medical treatment those under Part 2.

Improvements are needed to the provisions for transfer between prison and hospital

The Alliance also remains concerned that despite advances in recent years the process of transferring mentally ill prisoners remains slow and characterised by unacceptable delays at each stage of the process. Consideration should be given to reducing the transfer period for sentenced prisoners from 14 to 7 days in line with remands to hospital, time limits on the period between medical recommendations and an increase in the provision of secure units.

Police powers (Part 7)

The Bill should provide the right to advocacy at the place of safety

Under the draft Bill the police will continue to have power, currently provided for under Section 136 of the 1983 Act, to remove a person from a public place who appears to be suffering from a mental disorder and in need of immediate care and control, to a place of safety for assessment. The power will as now last for up to 72 hours. A person can also be removed to a place of safety where a magistrate has issued a warrant under clause 400 authorising entry to premises if need be by force. The place of safety can be a hospital or police station. The Alliance believes that the draft Bill should provide the right of access to specialist mental health advocacy from the moment the person arrives at the place of safety, whether it is a psychiatric hospital or police station.

The place of safety should, wherever possible, be a psychiatric hospital

The Alliance is concerned about the use of a police station as the place of safety. This is not a therapeutic environment for someone experiencing mental health problems and could delay the provision of effective treatment. As Lord Adekebowale said in his evidence to the Joint Committee: *"While there are no official figures, we do know that Section 136 could be used as many as 10,000 times a year".*

"The detention of people with mental health problems in police cells has hit the headlines, and Nick Hardwick, who is the co-chair of the Police Complaints Commission, estimates that 50% of deaths in police custody have involved people with mental health problems. He puts it quite bluntly: 'Whatever a police cell is, it is not a place of safety for people with

mental illness'. Despite the fact that the current Code of Practice states that police cells should not generally be used, in practice they are".

"Mind estimates that police cells are used in about 80% of occasions when section 136 powers are invoked. This is very relevant to African and Caribbean communities, given the fact that black people are more likely, as you have already heard, to have a negative experience with the police and to be over-policed—without opening up that whole debate again, recalling the McPherson report and the death of Stephen Lawrence, et cetera. Racism aside, it acknowledges that the police, particularly custody officers, do not have adequate training, if any, about mental health issues, especially when a person is distressed and causes disturbed behaviour. To add to that, the Mental Health Act Commission has repeatedly stated in their biannual reports, as many other stakeholders have mentioned, that police stations should not be regarded as places of safety. A police station is not an appropriate place for the care of someone with a serious mental disorder. It is not appropriate for someone to be held there for up to three days whilst arrangements are made for their examination, and the Bill should state that, because we know it disproportionately affects members of BME communities."[13]

The Bill should include a requirement that the place of safety must, wherever possible, be a psychiatric hospital.

Where a police cell is used as a place of safety, preliminary examination or transfer should occur within a 6 hour limit

Where this is not possible there must be clear time limits to arrange an assessment and transfer the person to hospital. We welcome the provision in the draft Bill allowing patients to be moved from one place of safety to another, which should mean that patients originally taken to the police station could be moved, if appropriate, to another, more suitable, setting. The White Paper stated that where a police cell is used as the place of safety there will be a duty on the local Trust to arrange a preliminary examination within 6 hours or to transfer the person to hospital for examination during that period[14]. This was a welcome limit but this has been dropped. The Bill should also address the problem of where assessments are made within 6 hours but the patient remains in the police station awaiting a bed. We therefore suggest a time limit for transfer, if appropriate, to hospital.

We oppose the new police power to enter premises and remove a patient without a warrant

The draft Bill provides a new power for the police to enter premises without a warrant and remove a person suffering from mental disorder. This must be based on the evidence of an Approved Mental Health Professional that the patient is in urgent need of care and control to prevent serious harm to him/herself or to other people, and that the urgency makes their removal under a warrant impractical. The person can be detained at a place of safety for up to 6 hours, which can be extended by a magistrate for up to 72 hours. The Alliance strongly opposes this extension of police powers since we believe it would be open to abuse. It is a fundamental civil rights principle that there should be no power to remove a person from his or her own property without Court authority. If a crime has been committed, the police powers for this already exist.

We are concerned that this power may be used simply to avoid the trouble of obtaining a warrant and this is a potential violation of human rights. Under Section 17 of the Police and Criminal Evidence Act 1984 the police already have the power to enter premises for

[13] Lord Victor Adekebowale, 26th January 2005. Evidence given to the Joint Scrutiny Committee.
[14] December 2000. *Reforming the Mental Health Act 1983- Part I,* para 3.84

the purpose of saving life and limb or preventing serious damage to property. We believe this power to be a disproportionate and unnecessary interference with the right to family and private life under Article 8 of the Human Rights Act.

Diversion schemes in police stations should be properly funded and developed

The Alliance recognises the important development of diversion schemes set up in police stations. These have helped to ensure that people can be screened for mental health problems at an early stage and diverted, where appropriate, to the care of mental health services. We call for such schemes to be properly funded and developed in all police stations across the country.