Mental Health Alliance

Treatability

House of Commons Committee stage amendment briefing

The Government has introduced an amendment (No. 17) to amend clause 5, page 3, line 13. Other amendments No. 19 and No. 20 also deal with treatability, to the same effect.

This will have the effect of reversing the Lords amendment on treatability and restoring the provisions in the original Bill.

We consider (a), the Bill at present and (b) the effect of the original Bill

(a) Effect of treatability amendment passed by the House of Lords (Clause 5 (3))

"In this Act, references to appropriate medical treatment , in relation to a person suffering from mental disorder, are references to medical treatment which is likely to alleviate or prevent a deterioration in his condition"

The government amendments would delete the words underlined and substitute **appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case."'.**

The reason for keeping the Lords' amendment and rejecting the government amendment is very fundamental and very simple. It is to ensure that those people who lose their liberty under mental health law because of the need to treat them against their will receive, or at least are likely to receive, a reciprocal health benefit. To remove this requirement, whatever the government intentions, is to permit indefinite preventive detention and to change the law from a health measure to one of social control.

It is instructive to recall the basis of the 1983 Act. The Parliamentary Under-Secretary of State, Department of Health and Social Security (Lord Elton) in introducing it stated:

> If I were asked to list briefly the most important and beneficial provisions in this Bill, they would be: the requirement that, except in particular circumstances[1], people should not be admitted to detention for treatment in hospital if their condition is not treatable[2];

To remove a therapeutic benefit test is to penalise and to stigmatise the large numbers of mental health patients, who pose no threat to anyone other than themselves, in order to ensure that a

[1] The exception to which Lord Elton referred was for people with learning disabilities. This group of people is now protected by the Mental Capacity Act, including the Bournewood provisions for those deprived of liberty, so to that extent and that extent alone the situation has changed.

[2] *Mental Health (Amendment)Bill* [1 DECEMBER 1981] *Bill* [H.L]

small minority who are dangerous but untreatable will be kept under lock and key. The government has in mind a small group of people but there is nothing in the Act to ensure that it is only applied to that group. It is a classic case of hard cases making bad law.

It would also be detrimental to other patients and services in general.

As one practising psychiatrist put it *" I have 10 beds and 150 patients in a year are admitted to those beds in my unit. If I had to keep people because I feared they were a risk to others even though I could not treat them there could be 140 patients not treated"*

Detailed argument

1. What the "treatability" amendment achieves

The amendment retains a type of test of therapeutic benefit that exists under the current act, the so-called "treatability" test but places it differently so that it becomes a test of what is "appropriate" medical treatment "available" to the patient. At present "appropriate medical treatment" is defined as "appropriate in the patient's case, taking into account the nature or degree of his mental disorder and all other circumstances of his case".
The criterion for admission to compulsory treatment under section 3 of the Act would remain as in the Bill that "appropriate medical treatment is available to him".

2. What are the advantages of this approach?

1.
2. 1. Combining the test with the Bill's test of 'appropriate treatment' overcomes one of the two major difficulties that the government has with the current 'treatability' test. The Government claims that people with personality disorder can refuse to accept the psychological treatments that are appropriate for them thereby forcing the psychiatrist to release them because they are untreatable. Under this amendment, so long as the treatment is <u>available</u>, whether or not the patient agrees to accept it, s/he can be kept under detention. The MHA considers that the Lords amendment has taken the law as far as it reasonably can be taken.

2. The treatability test in the 1983 Act is well established in law and understood by legal practitioners and the courts as well as health professionals. <u>It is very broad in its interpretation of health benefit,</u> permitting, in some circumstances, that containment within a therapeutic environment under the supervision of health professionals is enough[3] so long as there is likely to be some benefit to the patient[4]. The Joint Scrutiny Committee concluded that under current law it is difficult to envisage many mental health patients whose conditions or symptoms cannot be

[3] *R v Cannons Park* MHRT [1994] stated that a person could be detained if hospital treatment would prevent a deterioration in his condition, make him more co-operative and insightful, or if detention was likely to impact on his symptoms, even if it wouldn't touch the substantive illness.
In *Reid v Secretary of State for Scotland* [1999] the House of Lords stated that the definition of treatment may in some circumstances extend 'from cure to containment'. The case concerned a restricted psychopathic patient whose anger management was improved by the supervision he received in the structured setting of a State Hospital.

4 In *Reid v Secretary of State for Scotland* [1999] are following dicta: "I consider that the balancing of the protection of the public as against the claim of a psychopath convicted many years ago that he should not continue to be detained in hospital when medical treatment will not improve his condition, is an issue for Parliament to decide and not for judges". Lord Lloyd of Berwick "Anxiety might well be felt over the proposition that a sheriff is bound to discharge a psychopath where he is not satisfied from the evidence before him that treatment is no longer likely to alleviate or prevent a deterioration of his condition, so that he no longer qualifies under paragraph (i). In the civil context the balance may properly fall in favour of the liberty of the individual if further detention in hospital can serve no further purpose in alleviation or securing the stability of his condition" Lord Clyde

alleviated or deterioration prevented by some form of clinical intervention, that, in short, the law is extremely broad as it is.

3. The test does not, as the government alleges, require a prediction that a particular outcome will be achieved for the patient but simply a likelihood that the situation will improve or that the deterioration will be prevented – and this includes any symptoms of the condition. It does not need to address the underlying disorder. Despite what was said by Lord Warner–[5] this level of predictability is not so different from physical health and is no barrier to detention. Indeed, as Lord Warner admitted at Committee Stage[6], this is a less onerous test to satisfy than the therapeutic benefit test that was proposed by the Mental Health Alliance in its evidence to the Joint Scrutiny Committee. Indeed it could be said that the difference between this and a form of preventive detention is paper thin.

4. The 'appropriate treatment' test must be understood together with the new very broad definition of medical treatment in the Bill. "Medical treatment includes nursing, psychological intervention and specialist mental health rehabilitation and care". By including psychologists, nurses, social workers and occupational therapists as responsible clinicians as well as medical practitioners the range of therapeutic interventions that will be used to alleviate the person's condition is extremely broad.

3. Addressing the other problems with the treatability test

As Lord Hunt made clear in the House of Lords practitioners are said to use the treatability test as a way to deny services to people with personality disorder and this in turn has caused those services not to be provided. The Alliance does not deny that there have been problems with the treatability of patients with personality disorder in the past, but does not believe that legislation is necessary to achieve the government's goal.

1. First, until the development of psychological therapies it was difficult to treat people with personality disorders because the services were not in place. In a recent speech Professor Appleby acknowledged that there is now evidence that many people with a personality disorder can be treated and that services are being developed. This being so, it is hard to understand how clinicians, or MHRTs, could exclude such patients from detention on the grounds of the 'treatability' criterion.

Extract from Professor Appleby's speech, National Personality Disorder Conference 18th January 2007

"After many years of emphasising the policy priority of severe mental illness, we published "No longer a diagnosis of exclusion". This placed the care of PD patients firmly in mainstream services and pointed out the need for local expertise, suitable skills and multi-agency working.

- The NHS has funded a substantial body of research on the treatment of PD and we have asked NICE, the National Institute for Health and Clinical Excellence, to turn this evidence into clinical guidelines. NICE guidelines help drive clinical practice and service development and are a crucial step in changing the way that care is delivered.
- Projects around the country are showing what can be achieved by innovative staff. For example, I have met staff and service users at the excellent SUN project in south west London. In Peterborough last year I heard how regular psychotherapy for a small number of PD patients had prevented a pattern of expensive out-of-area admissions.
- Mental health is central to the Government's social inclusion initiative. It highlights the need for prevention; and early intervention in children with behavioural problems, who may be affected by poor parenting and multiple family problems.

[5] H of L Debates, 10 Jan 2007 : Col. 309
[6] ibid.Col. 308

- We are revising the care programme approach – the consultation period has recently finished. One likely change is that it will become more responsive to the needs of PD patients.

……." I should say straight away that most people with PD can be treated without the Mental Health Act – its use can even be counter-productive." (Professor Appleby)

2. Professor Appleby has acknowledged that the 'cultural problem' against PD among psychiatrists is beginning to change[7]. Training and the development of services will help to deliver a new generation of practitioners who are versed in the new approaches to treatment.

3. As explained above, this Bill makes a major change to the system of compulsory treatment. It gives psychologists and other clinicians the role of responsible clinicians. That in itself changes the cultural climate and increases the likelihood of interventions to benefit patients with personality disorder.

The Government has failed to provide significant evidence that the treatability test is at present being misused by clinicians leading to patients being inappropriately excluded from care and treatment. Even if this does occur the government continues to state that poor practice (for instance that illustrated by the disproportionate representation of black men in compulsory care) is to be solved by education and training, not by legal change.

5. Inquiries do not show a need for legal change. Probably the most often quoted case is that of Michael Stone. The independent report into his care and treatment describes, in detail, the considerable care provided to him, including detention under the Mental Health Act, and informal admission to hospital, over many years. At no point was he excluded from services, or detention, on the basis of his failing to meet the 'treatability' criterion. Nor did the Report of the Inquiry into his case conclude that a change in the law was required. Furthermore, to set it in context, it must be emphasized that cases like Michael Stone represent only a tiny fraction of a much wider spectrum. Personality disorders are common with huge variations in type and severity. The vast majority of people with personality disorders are not violent although they may well need treatment from mental health services. Studies indicate prevalence of 10-13% of the adult population[8], with much higher estimates for the psychiatric population[9].

(b) Rejection of the Government's appropriate treatment test (will be restored by govt amendment 17)

Vagueness

The appropriate treatment clause ("appropriate in the patient's case, taking into account the nature or degree of his mental disorder and all other circumstances of his case") is so vague that it gives almost unlimited powers to clinicians and too little basis for a legal challenge against a person's

[7] The second effect is cultural. The treatability test contributes to a culture in which PD patients are seen as undeserving of mental health care – not only under the Act, but undeserving of any mental health care. I must say I think this is changing – and meeting like this are evident of that – but it remains a problem. Professor Appleby, National Conference on Personality Disorder, 18th January 2007.

[8] Personality Disorder: No longer a diagnosis of exclusion DH 2003

[9] Some studies have suggested prevalence rates among psychiatric outpatients that are in excess of 80 per cent. Between 50 per cent and 78 per cent of adult prisoners are believed to meet criteria for one or more personality disorder diagnoses, and even higher prevalence estimates have been reported among young offenders (Understanding Personality Disorder: A report by the British Psychological Society Feb 2006'9.

detention. It will prove a fertile ground for disputes between lawyers and clinicians at tribunal hearings.[10] The Code of Practice states (emphasis added)

> "Medical treatment can only be considered appropriate if it is intended to address the mental disorder(s) from which the patient is suffering… "Intended to address" means that the purpose of the medical treatment is to alleviate, prevent deterioration in or otherwise manage the disorder itself, its symptoms or manifestations or the behaviours arising from it".

Increase in scope of compulsory powers

The scope of the appropriate treatment test, being wider than the treatability test, will bring within reach of compulsion many people who are not within the current Act and should not be. Indeed the effect of placing this test in the 1983 Act is to broaden it even further than in the 2004 Bill which had a higher threshold for admission to compulsory powers for people at harm to themselves than does the amended 1983 Act. (That Bill required the protection of the patient from suicide or serious self-harm, or serious neglect by him of his health or safety rather than merely necessary for the health or safety of the patient).

The government believes this increase in scope of the powers does not matter because it gives people a chance to be treated. But it is precisely because it goes beyond that that we oppose it.

Instead the possibility for keeping people under compulsion is wide ranging. The depressed woman who is given vocational training, the ex offender doing community service as a volunteer, the young person recovering from eating disorder on a regime of nutrition and exercise and the man with a problem of committing domestic violence on an anger management course could all be under the supervision of one of the professionals covered by this law.

The government says that no responsible clinician will do what is not necessary. But that is to discount the blame culture within which practitioners operate.

No therapeutic benefit is required

The test is intended to fall short of providing a therapeutic benefit. This is made clear in the Code

> "2A.5. Where appropriate treatment is available no one should be excluded from detention, or discharged, solely because it cannot be shown that it is likely to produce any particular benefit or outcome ….

The result is a very broad reach for the legislation, a concept of health benefit which is almost meaningless and no requirement that the patient receives any benefit at all beyond that of confinement in a therapeutic environment.

Criticism of the test

As the Expert Committee had done before them[11] so the Joint Scrutiny Committee concluded that a proper test of therapeutic benefit was an essential component of the law. The Joint Committee on Human Rights has criticised the breadth of the test

> "Whatever this Government's intention, the wide definition of 'medical treatment' in the draft Bill would allow people to be detained where the only treatment that could be offered was 'care' under the supervision of an approved clinician. The draft Bill does not, in terms, say that the powers could be used only where professionals believed that they could offer

[11] 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. *Review of the Mental Health Act 1983*, November 1999, para 5.98.

effective treatment in the wider sense of a therapeutic programme with a reasonable chance of mitigating the patient's condition". [12]

More recently in its Report on this Bill the Joint Committee on Human Rights has stated that

"We consider that the principal legitimate aim for which medical treatment may be imposed under Article 8(2) is health, even if incidental purposes may be the prevention of crime or the protection of the rights and freedoms of others".

What group is the Government targeting? They talk of the "treatment resistant "patient. Certainly what the patient chooses improves outcome and this is particularly so with therapies in which the cooperation of the patient is a necessary ingredient of behavioural change. Patients may have been through imposed treatment programmes without success. This could be for many different reasons. They may not feel ready to engage with treatment or it could be that the interventions offered or the setting is unsuitable -for example if a mother with personality disorder is pressured to move into a residential facility which prevents her from seeing her children. We do not know how many are in this category. The Government wants the "appropriate treatment" test precisely because it falls short of requiring a benefit to the patient – even one as weak as that in the Reid case but whom they wish to detain indefinitely.

The problems with this approach

First it is inherently unethical to permit people to be detained in hospital or otherwise have their lives controlled because of their ill health or their personality when they are not obtaining any benefit from it. This would be profoundly discriminatory towards a particular group of people who are already unfairly stigmatised within society and who are therefore easy, even popular, targets for further discrimination. One wonders how uneasy society would feel if it were proposed to detain all young adult males with acknowledged problems of anger management so that they could be subjected compulsorily to treatment programmes which may have no impact.

Secondly if the government wants to introduce preventive detention for people with personality disorder who are dangerous they should do so honestly[13]. They have virtually done the same with the terrorist suspects with the control orders and Parliament has approved, having had the debates. The Scots have come up with some such answer[14]. As Lord Carlile stated in debates at Committee stage

But I do criticise the Government for failing to grasp the nettle on the whole question of therapeutic benefit and dangerousness. A responsible government should be intellectually honest enough to grasp that nettle. If it is the case that this Government believe that certain people should be locked up as a result of certain criteria, a sort of control order regime for dangerous people—and there is a precedent to start with—let them bring forward a Bill to this House and the other place and it will be considered on its merits. Parliament will then be able to adjudge whether it is necessary, and if so in what terms, to place restrictions on dangerous people who cannot be treated. But in terms of a mental health Bill, if this really is a Bill on mental health and not, as has been suggested by another Member of your Lordships' House, merely a Home Office Bill in disguise—a way of securing, as Professor Eastman put it,

[12] Draft Mental Health Bill 25th Report Session 2001-2002

[13] It is compatible with Article 5 of the European Convention on Human Rights for people who have been convicted of a crime to be detained in a therapeutic environment under clinical supervision even if there is no treatment for them. Explicit powers of preventive detention established by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 had been deemed compatible with the (ECHR) Article 5 by the Judicial Committee of the Privy Council.

[14] The **Mental Health (Public Safety and Appeals) (Scotland) Act 1999**which removed the treatability test for the discharge of all offenders who were either under a hospital order with restrictions or were transferred from hospital to prison before the end of their sentence. They could not be discharged by the Tribunal unless they no longer posed a risk of serious harm

> "locking somebody up"—the Government really need to accept that their appropriate treatment test simply does not add up to anything involving improvement to health.15

Unintended effects of the new test

These provisions are likely to fail because they will have the effect of driving the group to whom they are targeted away from services. This point has been made repeatedly by Alan Franey for instance, the previous Director of Broadmoor, who reports conversations with patients on this issue. The starting point in risk reduction is encouraging patients to seek help and talk about their thoughts and feelings. The following remarks were made in the House of Lords during Committee stage of the Bill by Lord Carlile and Baroness Meacher.

> "Mentally ill people often go to services voluntarily but only when they have a sense that they will be safer in the hands of the mental health services than out on their own. If they are aware that a very vague test is being applied so that they run a far greater risk of long-term, compulsory detained treatment, they are significantly less likely to go to the mental health services. That must surely be a matter of common sense. The prospect, therefore, under the vaguer test of more potential homicides being brought within the system is very small"[16].
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> " If the Bill became law unamended it would probably not even be effective. It could indeed increase the risks to the public. The very small number of really dangerous people along with many others would steer clear of mental health services. Safety can best be improved by making services accessible and effective. That is what assertive outreach teams are working so hard to achieve. Their remit is to make and maintain a therapeutic relationship with patients in the community who are most resistant to contact with the psychiatric services, most resistant to treatment and most at risk of harming others. The job of any legislation must surely be to support rather than hinder that precious work[17].

Members of the black and minority ethnic community fear, with justification, that black people are likely to be disproportionately affected by this provision as a result of prejudice and stereotyping. Black people have higher rates of admission to mental health wards, and higher rates of detention. In particular, people from Black communities are more likely to be viewed in the course of assessment as being likely to become violent, and there is evidence that this is a reflection of institutional racism within mental health services, as found by the Blofeld Inquiry report[18]. The absence of a requirement that treatment be of direct therapeutic benefit could compound the problem

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.

.Given the scarcity of hospital beds, the use of resources for mental health facilities to warehouse dangerous people could only occur at the expense of those patients who could be helped but for whom no bed is available.

The Joint Scrutiny 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

15 H of L Debates, 10 Jan 2007,Col. 305
[16] Ibid. Lord Carlile of Berriew Col.303
[17] Ibid. Baroness Meacher Col. 316
[18] Blofeld Inquiry (2003) Independent Inquiry into the death of David Bennett, Cambridge, Norfolk, Suffolk and Cambridgeshire SHA.

benefit from treatment pose a very challenging problem, but recommend they be dealt with under separate legislation".[19]

[19] ibid.