CHAPTER 1

Legislation relevant to the management of violence by persons with mental disorders

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This chapter provides an overview of the legislative frameworks that are relevant to the management of violence by persons with mental disorders in the UK. As three jurisdictions apply (England and Wales, Scotland, and Northern Ireland), individual frameworks and their variants are not discussed in detail. Rather, substantial differences relevant to the management of violence are highlighted. Professionals should refer to the respective frameworks for detailed guidance.

Management of violence refers not only to acute episodes, but also to the prevention or reduction of the risk of future violence. The core principles guiding routine medical practice of 'consent' and 'do no harm' remain relevant. Legislation provides a framework when coercion may be necessary to manage an acute violent act, manage the immediate risk of further violence or manage longer-term risk of violence.

Three strands of legislation are relevant to this report: the Human Rights Act 1998, mental health acts and mental capacity acts. The Human Rights Act applies to all three jurisdictions. The Mental Capacity Act 2005 and the Mental Health Act 1983 apply to England and Wales. Scotland is covered by the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000. Mental health legislation in Northern Ireland comprises the Mental Health (Amendment) (Northern Ireland) Order 2004. In certain circumstances, common law 'duty of care' may also be relied on, which remains necessary in Northern Ireland and which does not yet have an equivalent to the Mental Capacity Act.

Human Rights Act 1998

Compliance with the Human Rights Act is required when a function is of a public nature. The Act requires public authorities to act in accordance with the European Convention on Human Rights and the European Court of Human Rights (ECHR) which came into force in 1953. The Act would, for example, apply to the NHS and local authorities. It recognises certain rights and freedoms, with the ECHR hearing alleged breaches. The Act

serves to allow UK citizens to seek redress in the UK regarding possible contraventions without having to apply immediately to the ECHR.

The Human Rights Act includes the notion of proportionality, which is highly relevant in the management of violence. It recognises that on occasions it may be necessary to restrict someone's rights, but any restriction must be kept to the minimum necessary to achieve the required objective.

Articles 2, 3, 5 and 8 are most relevant to this report and are described in more detail. Article 6 relates to the provision of the Mental Health Act, but less so violence; however, it does state that everyone has the 'right to a fair trial' in relation to both civil rights and criminal charges. The tribunal or court should be independent and impartial. The remaining articles are less relevant.

Article 2: Right to life

Article 2 states that 'Everyone's right to life shall be protected by law' and 'Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:

(a) in defence of any person from unlawful violence
(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained
(c) in action lawfully taken for the purpose of quelling a riot or insurrection.'

It has been held that Article 2 implies 'in certain well defined circumstances a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual' (*Osman v. United Kingdom* [2000]).

The work of public authorities may be affected by Article 2 in a variety of ways. A public authority with knowledge of the 'existence of a real and immediate risk to someone's life from the criminal acts of another individual' should act to protect that person. A public authority should ensure those in its care are safe. If 'planning an operation which may result in a risk to life', then 'the minimum necessary force' must be used. If working with 'persons known to be dangerous', then steps should be taken to protect public safety (Ministry of Justice, 2006).

Article 3: Prohibition of torture

Article 3 states that 'no one shall be subjected to torture or to inhuman or degrading treatment or punishment'. Measures need to be taken to ensure this does not occur in psychiatric hospitals where individuals are potentially more vulnerable. The exact scope of this article has been regularly considered by the ECHR, which has found that 'compulsory treatment is capable of being inhuman treatment (or in extreme cases even

torture) contrary to Article 3, if its effect on the person concerned reaches a sufficient level of severity'. But that 'a measure which is convincingly shown to be of therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading' (*Herczegfalvy v. Austria* [1993]).

Article 5: Right to liberty and security

Article 5 states that everyone has the right not to be 'arrested or detained' apart from exceptions such as 'the lawful detention of a person after conviction by a competent court' and 'persons of unsound mind'. Lawful detention in relation to persons of unsound mind would more likely be under the auspices of the Mental Health Act, although circumstances may occur where detention under the Mental Capacity Act or, in limited circumstances, under common law 'best interests' is necessary.

Article 8: Right to respect for private and family life

Although everyone has the right to private and family life and their correspondence, certain restrictions exist. Relevant exclusions include public safety, prevention of crime, protection of health or morals and the protection of rights and freedoms of others. Compulsory administration of treatment would infringe Article 8 unless it is covered by law, such as the Mental Health Act. Such treatment would need to be proportionate and legitimate, such as reducing the risk associated with a person's mental disorder and improving their health (Department of Health, 2008).

Mental Capacity Act 2005

England & Wales

The Mental Capacity Act 2005 provides a statutory framework for professionals and others who care for people with impaired capacity. Any action resulting from the use of the Act must be assessed as being in the person's best interests (*Herczegfalvy v. Austria* [1993]). Consideration must also be given as to whether the decision can be deferred until the person regains capacity. It is important to recognise when the Act may be indicated or when the Mental Health Act is more appropriate: a patient with a mental disorder who lacks capacity to consent to treatment in a psychiatric hospital is liable to be detained under the Mental Health Act rather than receive treatment under the Mental Capacity Act (Department for Constitutional Affairs, 2007).

In relation to the management of violence, the Mental Capacity Act *Code of Practice* attempts to make clear the nature of restraint that is acceptable. Section 6 of the Act provides authority to restrain a person who lacks capacity. Restraint is defined as: (1) 'the use, or the threat of

the use of force against a person who resists the action'; and (2) 'restricts a person's liberty of movement, whether or not the person resists'. Two conditions are applied to the use of restraint: (1) 'to reasonably believe that it is necessary to prevent harm to a person' and (2) 'that it is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm' (Department for Constitutional Affairs, 2007). In addition, the *Code of Practice* describes circumstances where the Mental Capacity Act may be relevant in the prevention of violence: 'a person may also be at risk of harm if they behave in a way that encourages others to assault or exploit them (for example, by behaving in a dangerously provocative way)' (p. 107).

Restraining a person who is likely to cause harm but is not at risk of suffering harm themselves appears not to be covered by the Mental Capacity Act. Any such action would have to be justified in terms of the professional's duty of care to the person at risk of suffering harm, and may need to be managed under common law.

If restraint is used frequently, this may amount to a deprivation of liberty. This is not covered by Section 6, and if a patient in a hospital or a resident in a care home is at risk of deprivation of liberty, authorisation should be sought under the Deprivation of Liberty Safeguards (DoLS) from the appropriate supervisory body. It should be noted that DoLS cannot normally be used for a patient in hospital if the necessary care or treatment consists in whole or in part of the medical treatment for a mental disorder (Department of Health, 2005).

Under the provisions of 'advance decisions to refuse treatment' (Sections 24–26), it is possible to make an advance decision to refuse any specified medical treatment – this might include medication for the management of potential violence (Department for Constitutional Affairs, 2007). Medication given under Part IV of the Mental Health Act is not covered by these provisions.

Scotland

Adults with Incapacity (Scotland) Act 2000

This is broadly similar to the Mental Capacity Act. Guidance specific to violence is found in Section 47(7). This states that the use of force or detention is not authorised unless it is immediately necessary. The use of force or detention should only be for as long as is necessary and be consistent with a decision that may be made by a competent court. The Act should not be used to treat a patient for a mental disorder in hospital against their will.

Northern Ireland

To date, equivalent legislation has not been introduced in Northern Ireland.

Mental Health Act 1983

England & Wales

The potential for a mental health service user to imminently be responsible for acts of violence is frequently the reason for seeking detention under the Mental Health Act. It is recognised that: 'Where a patient has been detained under the [Mental Health Act], there is an implied right for staff to exercise a degree of control over the activities of the patient' (*Pountney v. Griffiths* [1976]).

When detaining a person under the Mental Health Act, appropriate medical treatment needs to be available, as defined by Section 145(1) of the Act, and paragraph 6.2 of the *Code of Practice* (Department of Health, 2008). The *Code of Practice* states that medical treatment also includes interventions other than medication. This may consist of nursing treatment only, which could include restraint.

In the statute, specific reference to violence is made in two places in relation to emergency treatment. Section 62 authorises treatment which is immediately necessary and of minimum interference to prevent a 'patient from behaving violently or being a danger to himself or to others'. In Section 64C there is provision for treatment which would normally require either consent from the patient or authorisation from a second opinion appointed doctor (SOAD) in certain circumstances where the treatment 'is immediately necessary, represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others and is not irreversible or hazardous'.

The *Code of Practice* contains extensive guidance on responses to violence, principally in Chapter 15 'Safe and therapeutic responses to disturbed behaviour' (Department of Health, 2008). Recommendations include suitable assessment for potential risk of violence, identification of warning signs, de-escalation, control and restraint, and seclusion policies.

Community treatment orders

Supervised community treatment (SCT) was introduced in England and Wales in November 2008. Under SCT, patients who have been detained in hospital for treatment under Section 3 and unrestricted Part III (forensic) patients will, on discharge, become subject to a community treatment order (CTO), requiring them to comply with certain conditions. Patients have to be considered for SCT if they are receiving more than 7 days of home leave under Section 17. Supervised community treatment can only be imposed on patients directly following a period of compulsory detention in hospital.

Patients with mental disorders who do not continue with their treatment (in particular, their medication) when they are discharged from hospital may, if their mental health deteriorates, become a danger either to themselves or to other people, and eventually have to be compulsorily readmitted to hospital. The aim of SCT is to maintain stability and reduce

the risk of relapse through the use of conditions that ensure the patient receives necessary treatment. Supervised community treatment allows for recall to a designated hospital. This may allow risks associated with relapse, such as violence, to be more effectively managed and reduced through earlier readmission. Ideally, the conditions of the CTO will have prevented a relapse in the first case. The use of SCT is further described in Chapter 25 of the *Code of Practice* (Department of Health, 2008).

Before the advent of SCT, the Mental Health Act included various powers to manage patients by compulsion in the community and these included guardianship (Sections 7 and 37), supervised aftercare (Section 25) and leave of absence (Section 17). Of these, guardianship remains relevant (with Section 17 used only for short-term leave) and enables patients to receive care in the community where it cannot be provided by the use of compulsory powers (Department of Health, 2008). The powers of a guardian (who may be a local authority or a named private individual) may include requiring a person to live at a specified address, to attend for treatment at a specified place and allow health professionals access to their home. However, unless the patient consents, treatment cannot be imposed. Further, the guardian does not have powers to use force to make a patient attend for treatment or to enter their home.

Community treatment orders have been in place for some years in the USA, Canada, Australia and New Zealand and were introduced into Scotland in October 2005. The difficulty in predicting a risk incident has been acknowledged. The benefits of CTOs have long been questioned (Moncrieff & Smyth, 1999). It has also been suggested that thousands of people may have to be placed under compulsion in the community to prevent one homicide (Crawford, 2000; Szmukler, 2000).

There have been a number of reviews of the effectiveness of CTO systems across the world, although research is limited and patchy and many reviews are subject to methodological limitations (Atkinson *et al*, 2005; Churchill, 2007). A Cochrane review of two randomised controlled trials in the USA found little evidence to indicate that compulsory community treatment was effective in any of the main outcome indices: health service use, readmission to hospital, social functioning, arrests, mental state, quality of life, homelessness or satisfaction with care (Kisely *et al*, 2005). People receiving compulsory community treatment were, however, less likely to be victims of violent or non-violent crime (Churchill, 2007). A retrospective case-note review suggested that CTOs halved the number of episodes of aggression (Ingram *et al*, 2009).

One relevant question that has been asked is what impact will SCT have on homicides by people with a mental illness? There is no reliable way of calculating exactly how many homicides might be prevented by a CTO. There has been no discernible reduction in the overall rates of homicides by people with a mental illness in Canada, Australia or New Zealand as a result of CTOs having been in place for some years. In England, independent inquiries into cases of homicide committed by those who

have been in contact with the psychiatric service, mandatory since 1994, have commonly cited non-adherence to medication as one factor leading to the incident (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006). In such cases it is possible that had the individual been under SCT they may have adhered to their treatment regime, potentially averting a homicide.

Restriction orders

Restriction orders (such as Section 41) may be imposed by a Crown Court alongside a hospital order (e.g. Section 37) if the court thinks it necessary for protecting the public from harm. Restriction orders can last indefinitely and require consent from the Secretary of State for Justice to approve aspects of management such as discharge from hospital and the approval of community placement. Although the order may be indefinite, it may be lifted by the Secretary of State when the order is no longer considered necessary for the protection of others.

Scotland

Mental Health (Care and Treatment) (Scotland) Act 2003

The key differences between this Act and the Mental Health Act have previously been described (Zigmond, 2008). These relate to capacity, compulsion for more than 28 days, and responsibilities of practitioners, of which capacity is most relevant to this report. Scottish legislation does not allow compulsion when a person retains capacity, whereas the Mental Health Act will allow compulsion when there is risk to the safety of others (as well as risks to self and health), even when capacity is retained.

Northern Ireland

Mental Health (Amendment) (Northern Ireland) Order 2004

Legislation in Northern Ireland does not provide for the use of CTOs; it is otherwise not substantially different to the Mental Health Act.

Indeterminate sentences for public protection

This legislation is not specific to mental health patients, but it may be applied to offenders with a mental health disorder. The sentence of Imprisonment for Public Protection was created by the Criminal Justice Act 2003 and implemented in April 2005. It is issued to those offenders who are seen by the courts as dangerous but who do not require a life sentence. Similar to a life sentence, prisoners are given a tariff or minimum term which they must serve before being considered for release. After release they are subject to recall if they breach the terms of their licence. Similar arrangements were legislated for in Northern Ireland by the Criminal Justice (Northern Ireland) Order 2008.

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