

Working with Concepts of 'Dangerousness' in the Context of Mental Health Law

Jill Peay examines the legislation giving powers to detain or treat people described as 'dangerous'.

The relationship between mental disorder and offending, let alone mental disorder and dangerous offending, is an 'uncertain' one (Prins, 1990). Nonetheless, powers exist under the *Mental Health Act 1983* to detain patients for treatment. These include the grounds (together with others) that it is 'necessary for the protection of the health or safety of the patient or for the protection of other persons' (emphasis added s.3(2)(c) a civil section) and to detain offender patients on an indefinite basis where it is 'necessary for the protection of the public from serious harm' (s.37/41 – a hospital order with restrictions). Both clearly entail prospective grounds of risk.

Whilst the restriction order can only be made by the Crown Court, and necessarily involves lawyers in its application, the civil section will be authorised in the first instance by non-lawyers; namely (normally) approved social workers together with psychiatrists and general practitioners. But what do these terms mean to the non-lawyers and are they adequate for consistent application?

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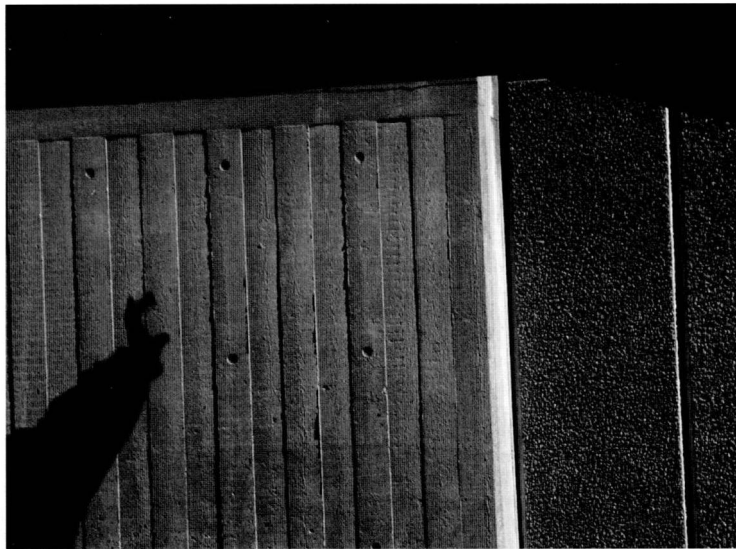
These are important questions, not only because decisions made by these non-legal professionals can lead to loss of liberty and the subsequent imposition of medical treatment against the wishes of the detained patient (who in other circumstances would retain the right to refuse treatment), but because the terms remain central to the Government's intentions in respect of a new mental health act. Moreover, predictions of "a substantial risk of causing serious harm to other persons" (clause 6(4) *Draft Mental Health Bill 2002*) is the key test underpinning the Government's proposals in respect of those it formerly deemed 'Dangerous People with Severe Personality Disorder' (DSPD). Given a prediction of risk of this nature under the Government's proposals it would become possible to detain and medically treat an offender on the basis that it is "necessary for the protection of those persons" (emphasis added clause 4(a)). No explicit mention is made that any benefit should accrue to the offender per se as a result of this treatment. The notion of giving treatment to person A to benefit persons B, C and D is indeed a curious one.

It remains possible that the Government will still re-think this approach, and the proposals are highly contentious (Prins 2002; and see the synopses of the responses to the *Draft Mental Health Bill 2002* by the Law Society, the Royal College of Psychiatrists and Liberty, all in the *Journal of Mental Health Law*, December 2002). Nevertheless notions concerning the future protection of other persons will remain key to any new Bill. Accordingly, mental health practitioners' understanding and application of these terms are critical.

Unpacking practitioners' thinking is problematic. Observational studies of real world/real time decision-making do not lend themselves to careful and detailed deconstruction, particularly since in the maelstrom which often surrounds such decisions there is rarely an appropriate moment to challenge practitioners. Studies involving hypothetical cases usually suffer from a lack of ecological validity. However, in a study to be published in May (Peay, 2003), many of these limitations have been overcome through the use of detailed case studies based on both

written and video evidence and through asking real life practitioners to take part in the decisions. The methodological niceties are available elsewhere; what matters here is how terms which emphasise a potential for harm rather than relying upon proven harm are utilised.

It will come as no surprise to learn how readily the current criteria, which envisage physical harm or serious persistent psychological harm (DoH/Welsh Office 1999: para 2.9), can be satisfied. In practice, little risk is required and the nature of the harm practitioners would want to obviate ranges upwards from what would constitute a mere scuffle. Moreover, the notion of psychological harm raises difficulties explored elsewhere about victim vulnerability (Von Hirsch and Ashworth, 1996). It implies that the likelihood of a patient being detained might depend not on his or her mental state and behaviour, but on the degree of vulnerability of those who might be harmed. Indeed, since violence constitutes an interaction between at least two people, it is possible that physical harm might result from the degree of 'provocativeness' of the potential victim, who might



wind the patient up, perhaps even by playing upon his or her psychopathology. Thus, in the study, fear, apprehension, and/or other forms of psychological distress, precipitated by the behaviour of the patient, were the basis for some practitioners invoking the 'protection' criterion. In so doing, layer upon layer of future possibilities were invoked as a potential basis for satisfying a criterion that is designed to have a constraining, not an inclusionary, impact. Similarly, the *Code of Practice* exhorts practitioners to consider whether there are alternative options for managing the risk, what the degree and nature of the risk is and how reliable the evidence is for it (DoH/Welsh Office 1999). Yet, the reasoning of the practitioners would suggest that, in the presence of broadly drawn attributed risk, objectivity is jeopardised, and such exhortations to detailed thinking have limited impact. The reasoning of one psychiatrist, disagreeing with an approved social worker who held a different view, perhaps typifies this:

"It is very interesting that I hold a different opinion. I am basing my opinions from what we already know, from what we have read. I think this person has been known to get very ill very soon once he stops medication. He has been ill enough to cause serious concerns to others in the past. He has a history of violence. At the present time it is very clear that he is hearing voices, he hears his neighbours shout at him in the middle of the night, which clearly can't be true so we can assume that it is the voices that he hears and responds to. I am very concerned... the man (neighbour) seems to have got very worked up about what he is doing. It is very likely, I think, that an incident might happen." Psychiatrist, pair 21

A preparedness to predict the occurrence of violence so as to satisfy the statutory criteria was common-place in the study; those practitioners who invoked such risk were likely to hold sway in any joint decision about the use of compulsion.

This does not bode well for the likely number of people who could be detained on grounds that they pose a risk to others. The Government's *Draft Mental Health Bill (2002)* cuts away most of the restraint on the current use of compulsion. It recommends the adoption of a broad definition of mental

disorder (thus bringing into the net those currently excluded by the 1983 Act's use of defined categories and its exclusionary sections (see s.1(2) and s.1(3)); and the Bill makes no mention of a treatability criterion. This is one of the current Act's features that prevents patients suffering from 'psychopathic disorder' from being admitted and detained under a health statute where they are deemed wholly untreatable. In short, the White Paper's prediction that there may be some 2,400 men (currently in the community, in prison and in the Special Hospitals; DoH/Home Office 2000: Part II p.6) who would qualify for detention on grounds of DSPD looks like a hopeless underestimate. Notwithstanding, the Government's rhetoric about its limited intentions in respect of this group, in practice, mental health practitioners may well perceive risk in any case of doubt. After all, it's better to be safe than sorry.

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